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

Jared Forde,

Petitioner,

vs. NO: 17 WC 5933

20IWCC0142

Forde Windows & Remodeling,

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, 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 February 19, 2019, 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.

J. Forde v. Forde Windows & Remodeling, 17 WC 05933

20 IWCC0142

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

Jared Forde
Employee/Petitioner

v.

Forde Windows & Remodeling
Employer/Respondent

Case # 17 WC 05933

Consolidated cases: 17 WC 05934

An *Application for Adjustment 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 **10/24/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of 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 6/28/2016, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $49,114.31; the average weekly wage was $963.05.

On the date of accident, Petitioner was 24 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 $0.00 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 $147.11 under Section 8(j) of the Act.

ORDER

Claim for compensation denied. Petitioner failed to prove that his current condition of ill-being is causally related to the injury of June 28, 2016.

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

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

Signature of Arbitrator

February 19, 2019
Date

FEB 19 2019

INTRODUCTION

This case was tried with a companion case, No. 17 WC 05934. Both cases are claims for alleged concussion/closed head injuries that occurred while Petitioner was working for Respondent. Accident was stipulated to in both cases. The accident date in Case No. 17 WC 05933 is June 28, 2016. The accident date in Case No. 17 WC 05934 is August 3, 2016.

The Findings of Fact in this case shall operate as the Findings of Fact in case No. 17 WC 05934.

FINDINGS OF FACT

Petitioner was employed by Respondent as a lead carpenter. He had been so employed for 2 years. He had previously worked part time for Respondent for 4 years. Respondent is a company owned by Petitioner's parents. Petitioner's job duties include the installation of doors and windows and involve the handling of weights from 10 to 600 pounds.

Petitioner testified that prior to June 28, 2016, he had sustained two concussions. One was when some scaffolding broke and he was hit by a board. The second resulted from helmet to helmet contact while playing hockey in 2015. (PX 2) He had mild symptoms for a little more than a week after these incidents. According to Petitioner, he was symptom free and extremely active for years. He played hockey 3 times a week and was fit. He worked out several times a week. He had no headaches and no dizziness.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on June 28, 2016. Petitioner was installing a steel security door and he was hit in the forehead by the old door. He was wearing a hardhat. He did not think much of the accident and continued his work for Respondent. He continued with his outside activities as well, with no problems until 4 days after the accident. He then began to experience dizziness, which worsened over time.

Petitioner first sought medical care at Northwestern Medical Care in Deerfield, his PCP facility. The first visit was on July 5, 2016 at the ICC (Immediate Care Center?) for vertigo. No records were submitted regarding this visit. Petitioner was then seen by Dr. Freilich, on July 7, 2016, for complaints of dizziness for the past week, headache, photophobia and seeing spots as of today. The work up was for Urethitis and Vertigo. The assessment as to the vertigo was probable labyrinthitis, possible migraine. Petitioner was given vertigo instructions and was told to take Tylenol and NSAIDs. Petitioner then was seen by Dr. Levinson on July 11, 2016 for dizziness: follow up/Vertigo. The patient's dizziness continues. Awakens mostly ok, but then starting at noon seems to get worse. Works as a carpenter-ok for most of the day until noon. The assessment was likely BPPV (benign paroxysmal postural vertigo). Paroxysmal means abrupt or sudden onset. The plan was refer for vestibular therapy. The records from Northwestern contain no history of any head trauma sustained at work. On cross examination, Petitioner agreed that he did not give Dr. Freilich or Dr. Levinson a history of being hit on the head by a door. Of course, because there was no history of any head trauma, no physical findings involving the head were noted in these July examinations. (PX 2)

Petitioner testified that he had PT with Michelle Dwyer, DPT. Respondent's IME physician, Dr. Elizabeth S. Kessler, MD, refers to records from Ms. Dwyer in her report. (RX 1) Neither party submitted records from Ms. Dwyer.

Petitioner was referred by Dr. Levinson to Jodi Zuckerman, MD, an ENT physician. He was seen by Dr. Zuckerman on July 12, 2016, for a chief complaint of vertigo and dizziness. The onset was about 10 days ago and the condition was said to be gradually getting worse. There was no nausea or vomiting and no migraine history. The inspection of the head and face was benign (as would be expected some 2 weeks after head trauma that did not result in a LOC and did not result in any immediate symptoms). The ear and vestibular exam was normal. The audiogram showed an acoustic notch at 4000 Hz, bilaterally, and normal hearing. Musician's ear plugs were prescribed, along with VNG testing. The diagnosis was Aural Vertigo-unspecified ear. There was no history of any head trauma sustained at work. (PX 3)

Petitioner testified that from July 4, 2016 through August 2, 2016, he worked less hours, earning less money due to his inability to perform the work required of him for his job. Petitioner testified that, although there were no written work restrictions given him, the doctors at Northwestern advised him to work as tolerated. Petitioner seeks $1,944.57 in TPD benefits for this time period. (ArbX 1)

Petitioner testified that in the days before the second accident he was improving, but he was still not at 100%.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on August 3, 2016. Petitioner testified that he was hit on the back of his head by the top of a window frame. The frame weighed 40 pounds. He was wearing a hardhat at the time of the accident. He did not lose consciousness. His symptoms increased. He was dizzy. He had a headache. He experienced photophobia and increased noise sensitivity. He experienced "haziness."

Petitioner then began treatment with Dr. Andrew Hunt, MD at Illinois Bone and Joint. This was on a referral by his PCP. Petitioner agreed on cross-examination that Dr. Hunt was an orthopedic physician. Dr. Kessler said that Dr. Hunt was a pediatrician, internist and sports medicine doctor. (RX 1) Petitioner gave Dr. Hunt the history of the 2 accidents involving head trauma at work in June and August of 2016, as well as of the prior concussions. Dr. Hunt diagnosed a recurrent concussion and provided Petitioner with a light work restriction, as tolerated. Dr. Hunt also recommended vestibular therapy and ocular therapy. Petitioner testified that he again suffered a loss of wages in decreasing his work activities. His symptoms did not resolve and, in fact, got worse. Dr. Hunt's phone note of August 26, 2016 shows that the patient complained of recurrent headache and dizziness. There was another head bump incident about 4 or 5 days prior. Dr. Hunt recommended a further decrease in activities. Petitioner claims TTD from 8/22/2016 to 12/30/2016, although it does not appear that he was medically authorized off work. He also claims TPD of $831.50 for the time period of 8/4/2016 to 8/19/2016. (ArbX 2)

Dr. Hunt's chart note of November 2, 2016 says that Petitioner is improving well (70% improvement) with vestibular therapy (individual therapy notes were not submitted by the Parties). Petitioner said that he was not working full time and would be claiming "Workmen's Compensation". On December 20, 2016, Dr. Hunt charted further improvement. Petitioner was able to skate for nearly an hour without symptom aggravation. At the next visit, he would hopefully be released to unrestricted work. Petitioner was given a work note to allow light duty, as tolerated. Petitioner last saw Dr. Hunt for treatment on January 26, 2017. He was essentially symptom free at rest. He was back to work full duty and has tolerated this well. Petitioner felt back to normal

and had cleared physical therapy. The exam was benign. The assessment was resolved postconcussion syndrome. He was at MMI and was capable of all activities. He was released, PRN. (PX 4)
Petitioner was seen at Respondent's request for a Section 12 examination on January 31, 2017, by Dr. Elizabeth Kessler, a neurologist. Dr. Kessler examined Petitioner and reviewed medical records. The reviewed medical records included PT notes from Michelle Dwyer, DPT and records from IBJI Rehabilitation Services, Morton Grove that were not submitted into evidence by the Parties. Petitioner testified that the report contained an inaccuracy about medication usage, but offered no other criticism of the report. Dr. Kessler opined that the absence of initial symptoms following the June 28, 2016 event, as well as the lack of any positive objective testing results, led her to conclude that there was no physiologic explanation related to the alleged work injuries. There was no basis to conclude that the headaches that started days after the accident were causally related. Petitioner traveled after the accidents and reported fewer symptoms when he was on vacation despite engaging in exertion. Dr. Kessler concluded that Petitioner sustained head contusions that caused no symptoms as a result of the accidents. He did not suffer a concussion or vestibular injury. He was not disabled from work or any personal activities as a result of the work injuries. (RX 1)

Dr. Kessler also noted the following regarding her review of the medical records that she reviewed. On 9/22/16, it was noted that Petitioner was working half days, with increased headache symptoms. He had been on vacation the week before, with minimal symptoms after adjusting to jet lag. He reported walking miles in Europe without any increasing symptoms. On 9/27/16, Petitioner reported that he had "shot around" in his back yard for about an hour (hockey?) and he worked perhaps too much the day of the visit. On 10/11/2016, he reported that he felt dizziness at work. On 10/18/16, Petitioner reported feeling better after getting sleep in Mexico. (RX 1) The Arbitrator notes that Petitioner claimed that he was entitled to TTD from 8/22/2016 to 12/30/2016, although he was able to work, walk for miles and travel to Europe and Mexico during that time.

Petitioner testified that he sought treatment from Dr. Nicole Reams several months after being released from care by Dr. Hunt. Dr. Reams saw Petitioner on May 1, 2017, July 31, 2017 and February 22, 2018. Petitioner was referred to Dr. Reams by Dr. Hunt to be evaluated for sports-related concussion. On May 1, 2017, Dr. Reams charted that she was not certain that Petitioner had a concussion, given the significant delay to the onset of symptoms. Dr. Reams diagnosed vestibular migraine and recommended treatment. On February 22, 2018, Dr. Reams charted that she did not think either the 6/28 or the 8/3/2016 events resulted in a concussion. The patient was doing well on medication. The diagnosis continued to be Vestibular Migraine. He had reluctance to be on medication and reluctance to believe his symptoms were not concussion-related, "probably due to ongoing litigation". (RX 2)

Dr. Hunt authored a rebuttal to Dr. Kessler's IME on February 22, 2017. He disagreed with Dr. Kessler. He thought that Petitioner sustained a slowly resolving mild concussion as a result of the work accidents. He concurred that the patient's report of symptoms was subjective. Because the reported mild deficits began after the June 28, 2016 work accident, they were consistent with Dr. Hunt's diagnosis of concussion. Petitioner met with Dr. Hunt on February 28, 2017 to discuss the IME report. (PX 4)

Petitioner testified that he was doing well and had resumed all work and non-work activities.

The Parties agreed that Respondent was entitled to a Section 8(j) credit for bills paid by Blue Cross. (PX 1)

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)

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

Petitioner's current condition of ill-being is not causally related to the accident of June 28, 2016.

The Arbitrator bases this finding first on the fact that Petitioner did not begin to experience any significant symptoms until four days after the accident. Second, there was no history of the work accident in the initial treatment records form Northwestern Medicine. "It is presumed that a declaration to a treating physician as to one's physical condition and the cause thereof is true because the patient will not falsify such statements to the one from whom he expects to get medical aid." Shell Oil Co. v. Industrial Commission, 2 Ill.2d 590, 602 (1954) Here, the history was consistent with the assessment of BPPV and the physical exam did not support any evidence of head trauma. Third, Dr. Zuckerman's records contain no history of work related head trauma and the diagnosis was Aural Vertigo. Fourth, Dr. Reams did not endorse causation, either, even after being advised of Dr. Hunt's diagnosis and being advised of the work incidents by the patient. She thought that the symptoms were not triggered by a head injury.

The Arbitrator finds the opinions of Dr. Kessler to be persuasive on the issue of causation. Dr. Hunt's opinions are not persuasive, given the delayed onset of symptoms, the medical records and the Arbitrator's finding regarding Petitioner's credibility, below.

Petitioner's testimony is found to be not credible. First, he made a claim for TPD in this case in the absence of written restrictions from any physician, indeed claiming benefits prior to being seen by a doctor (7/4/2016). Also, he claimed TTD when he went on vacation and walked miles, went to Mexico (photophobia?, decreased exposure to noise?) and when he told his therapist that he was working part time, per Dr. Kessler's report.

Given the above, there has been a failure of proof on the issue of causation and the claim for compensation is denied.

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, ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE AND ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS:

As the Arbitrator has found that Petitioner failed to prove a causal connection between his current condition of ill-being and the accident of June 28, 2016, the Arbitrator needs not decide the above issues.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jared Forde,

Petitioner,

vs. NO: 17 WC 5934

20IWCC0143

Forde Windows & Remodeling,

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, 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 February 19, 2019, 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.

20IWCC0143

The party commencing 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 - 2020
MP:yl
o 2/25/20
68

Marc Parker

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FORDE, JARED
Employee/Petitioner

Case# **17WC005934**

17WC005933

FORDE WINDOWS & REMODELING
Employer/Respondent

20IWCC0143

On 2/19/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5019 SEIDMAN MARGULIS & FAIRMAN LLC
RYAN A MARGULIS
500 E LAKE COOK RD SUITE 350
DEERFIELD, IL 60015

0445 RODDY LAW LTD
ROBERT DOHERTY
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

J. Forde v. Forde Windows & Remodeling, 17 WC 05934

20IWCC0143

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

Jared Forde
Employee/Petitioner

v.

Forde Windows & Remodeling
Employer/Respondent

Case # 17 WC 05934

Consolidated cases: 17 WC 05933

An *Application for Adjustment 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 **10/24/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of 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. [x] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **8/03/2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$49,114.31**; the average weekly wage was **$963.05.**

On the date of accident, Petitioner was **24** 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 **$0.00** 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 **$1,205.77** under Section 8(j) of the Act.

ORDER

Claim for compensation denied. Petitioner failed to prove that his current condition of ill-being is causally related to the injury of August 3, 2016.

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

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

Signature of Arbitrator

February 19, 2019
Date

FEB 19 2019

ICArbDec p. 2

FINDINGS OF FACT

The Arbitrator adopts the Findings of Fact in Case No. 17 WC 05933 as the Findings of Fact herein.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner failed to prove a causal connection between the accidental injury of August 3, 2016 and his current condition of ill-being, for the reasons set forth regarding this issue in the decision in Case No. 17 WC 05933, including the report of Dr. Kessler, which is found to be credible and persuasive in this case.

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, ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE AND ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS:

As the Arbitrator has found that Petitioner has failed to prove a causal connection between his current condition of ill-being and the accident of August 3, 2016, the Arbitrator needs not decide the above issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Steve McCullough,

Petitioner,

vs.

NO: 17 WC 21460

20IWCC0144

Chicagoland refreshments and
Hartford Accident and Indemnity Co.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 27, 2018, is hereby affirmed and adopted.

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

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

20IWCC0144

The party commencing 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 - 2020
MP:yl
o 2/25/20
68

Marc Parker

Maria E. Portela

Kathryn A. Doerries

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

McCULLOUGH, STEVE
Employee/Petitioner

Case# **17WC021460**

CHICAGOLAND REFRESHMENTS AND HARTFORD ACCIDENT AND INDEMNITY CO
Employer/Respondent

20IWCC0144

On 9/27/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.32% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5625 GRAUER & KRIEGEL LLC
KARINA B MEJIA
1300 E WOODFIELD RD SUITE 205
SCHAUMBURG, IL 60173

2837 LAW OFFICE OF JOSEPH MARCINIAK
ROBERT P SABETTO
200 W MADISON ST SUITE 501
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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Steven McCullough,
Employee/Petitioner

v.

Chicagoland Refreshments and Hartford Accident and Indemnity Co.,
Employer/Respondent

Case # **17 WC 21460**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert M.Harris**, Arbitrator of the Commission, in the city of **Chicago** on **6/28/18; 7/26/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

20IWCC0144

FINDINGS

On the date of accident **June 14, 2017**, Respondent **Chicagoland Refreshments** ***was*** operating under and subject to the provisions of the Act.

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

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 **Chicagoland Refreshments**.

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

In the year preceding the injury, Petitioner earned $**31,444.92**; the average weekly wage was $**604.71**.

On the date of accident, Petitioner was **54** years of age, ***single*** with **1** dependent child.

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

Respondent shall be given a credit of $**1,612.56** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**1,612.56**.

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

ORDER:

Petitioner has failed to prove that he sustained an accidental injury arising out of and in the course of his employment with Respondent on June 14, 2017; therefore, his claims for compensation 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.

Robert M. Harris

September 26, 2018

Signature of Arbitrator

Date

ICArbDec19(b)

SEP 27 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION

Steven McCullough,

Employee/Petitioner

v.

Chicagoland Refreshments and

Hartford Accident and Indemnity Co.,

Employer/Respondent

Case # **17 WC 21460**

20IWCC0144

MEMORANDUM OF DECISION OF ARBITRATOR 19(b)

FINDINGS OF FACT

Petitioner, Steve McCullough, a 55-year old male, testified he was employed by Chicagoland Refreshments, Inc. as a delivery driver and vending machine operator at the time of his June 14, 2017 work injury (Tr. pp. 13-14). Petitioner worked for Respondent for approximately 2 years prior to his work injury (Tr. pp. 13-14). Petitioner worked 8-10 hour shifts and about 70 percent of the time was spent "walking and maneuvering the cart and in and out of the van" and 30 percent of the time was spent driving. (Tr. pg. 20). This testimony was corroborated by his supervisor, Debbie Pecora (Tr. p. 69).

Petitioner performed two types of services: driving to businesses to deliver custom orders and servicing vending machines (Tr. p. 15). Petitioner's day began at the warehouse where he would fill trays with snacks, pull orders, and put away shipments that came in the night before (Tr. p. 14). Before starting his route, Petitioner loaded a van by stepping in and out of the van about 2 ft. off the ground with office supplies, cases of soda and water, boxes and trays weighing an average of 25 lbs. (Tr. pp. 14-16).

The route had 7 to 12 stops and some stops required more than one delivery in addition to having to service vending machines (Tr. p. 17). Petitioner's stops started north on Division and State St. to 63rd Street in the south, and most stops were downtown (Tr.

p. 19). Petitioner parked in loading dock areas and in alleys (Tr. pp. 17-18). Petitioner unloaded boxes, trays, cases of soda and water by using a two-wheeled dolly and cart which he would maneuver with his feet (Tr. pp. 18-19). Petitioner testified that he would spend 15 to 90 minutes at each stop. Some locations had a few deliveries while others required Petitioner to collect money from vending machines and return to the van for product to replenish them (Tr. pp. 16, 19).

Supervisor, Debbie Pecora, who has worked for her family business, Chicagoland Refreshments, Inc., for over 30 years testified that Petitioner accurately described his job duties (Tr. pp. 69-70).

The record shows no dispute regarding Petitioner's job duties. Petitioner's job duties are not at issue.

On June 14, 2017 Petitioner testified the following regarding his alleged injury: "It was at 1:45 in the afternoon at 200 West Monroe. I was filling the vending machine and I was walking in with the cart. And I felt a pain in my foot, and I continued to fill the machines. And then I came down and went to mu next location, finished that. And then I told them when I got n. I talked to my boss, Debbie, to let her know I hurt my foot."

Petitioner testified he felt severe left foot and ankle pain around 1:45 p.m. when he was walking and pushing a cart to 200 W. Monroe in Chicago, IL (Tr. p. 22).

Petitioner testified that he continued to work through his last stop on the route despite having severe left foot and ankle pain (Tr. p. 22). Upon returning to the warehouse, Petitioner notified Debbie, supervisor of Chicagoland Refreshments, Inc., of the left foot and ankle injury (Tr. p. 23).

Respondent's witness **Debbie Pecora** has worked for Chicagoland for 30 years. (Tr. p. 62). Chicagoland is a small family business with approximately eight employees. (Tr. pp. 62, 70). Pecora is a supervisor. (Tr. p. 62.) On June 14, 2017, Petitioner walked into the office and told her he hurt his foot. (Tr. p. 63.) Pecora's initial reaction was, "Oh my gosh! We probably should get some ice on it." (Tr. pg. 63-64). Furthermore, Debbie testified that she gave Petitioner a frozen water bottle as an ice pack. (Tr. pg. 64).

Pecora asked Petitioner how he hurt it and Petitioner said he did not how he did it or know what happened. (Tr. pp. 63, 67). Petitioner did not report that he twisted it. (Tr. p. 63.) Pecora testified that she asked Petitioner to remove his boot and sock and noted that his left foot was "definitely" visibly red and swollen (Tr. pp. 64, 71). Pecora testified there was obviously something wrong with his foot. (Tr. p. 71). Pecora gave him a frozen bottle of water to put on it. (Tr. p. 64). Pecora recalled Petitioner wanting to get in touch with "workmen's comp" and that she made sure to do, and seeing a doctor, but she denied that she told him to go home and take Ibuprofen. (Tr. pp. 64-65.) Pecora reported the incident to her workers' compensation carrier, Respondent Hartford Accident and Indemnity Co. ("The Hartford"). (Tr. p. 65).

Pecora further testified she had "numerous" conversations with Petitioner about his foot after his claimed accident date, but Petitioner never indicated what happened. (Tr. pp. 66, 68). Pecora testified Petitioner just knew his foot hurt. (Tr. p. 68). Before his claimed accident, Petitioner mentioned to Pecora that he had some numbness in his feet from time to time. (Tr. pp. 70-71).

Afterwards, Petitioner finished unloading the unused product from the van by stepping in and out about 2 ft. off the ground (Tr. p. 23). Debbie also testified that when she saw Petitioner's left foot at the end of the workday on June 14, 2017, "it was obvious something was wrong" (Tr. p. 71). Debbie testified that she told Petitioner that if he was in that much pain that he should see someone at an emergency care (Tr. pp. 64-65).

Petitioner testified that he was diabetic and experienced minor numbness to his feet prior to the June 14, 2017 work injury (Tr. p. 37). Moreover, Debbie testified that she knew Petitioner was diabetic and that he was open about it, and had made her aware of having, "some numbness in his feet from time to time." (Tr. pp. 68, 70-71).

Petitioner testified that he did not seek medical attention for his diabetes because he controlled it through dieting and exercise (Tr. p. 61). Furthermore, Petitioner testified that he has never been to urgent care for his diabetes (Tr. p. 61). Petitioner did not have any difficulties with driving or walking prior to June 14, 2017 (Tr. p. 37).

On June 14, 2017, Petitioner went to Loyola's Urgent Care Center because the left foot and ankle pain was unbearable (Tr. p. 25). Petitioner explained to the doctor that the pain to his left foot began on June 14, 2017 around 1:45 p.m. while he was walking and making a delivery at the 200 W. Monroe location (Tr. p. 24). Petitioner explained to Dr. Ra-Hurka that the pain in the left foot had worsened in the afternoon she examined his left lower extremity and noted:

> "There is an area of significant tenderness at the lateral mid foot and distal aspect of the 5th metatarsal. I suspect sprain/strain. Ice, wrap, rest. Off from work for a couple of days. " (PX. 10).

Petitioner was ordered to remain off work from 6/15/17 - 6/16/17 and to return to urgent care if the symptoms worsened or failed to improve (PX 10). Petitioner took ibuprofen for the swelling and pain as instructed (Tr. p. 26).

On June 20, 2017, Petitioner went to Loyola Gottlieb Memorial Hospital because of the continued severe left foot pain and increased swelling (Tr. p. 26). Dr. Ahmed noted:

> "Aching and sharp left foot pain, decreased range of motion, joint swelling with tenderness, and the x-rays revealed a dorsal midfoot spurring with a calcaneal plantar spur in the left foot (caused by exposure to constant stress). Pt. diagnosed with a sprained foot." (PX. 11).

Dr. Ahmed ordered Petitioner to use crutches, prescribed tramadol and gave an off work note from 6/20/17 - 6/27/17 (PX 11). On June 29, 2017, Petitioner was again seen at Gottlieb because of the continued severe left foot pain and increased swelling (Tr. pp. 27-28). The medical records state:

> "Patient presents to the ER with left foot pain, redness, and swelling. The patient had a work related injury 2 weeks prior, was seen in ER and diagnosed with acute sprain of the foot and ankle ... Patient now presents again with unrelieved pain, but now foot has increased swelling and pain with redness. Patient is barely able to bear weight on foot. Has been elevation the foot with ACE wrap...Throbbing pain and worsening progression. " (PX 11).

The x-rays revealed left foot diffuse soft tissue swelling and Petitioner was diagnosed with swelling of limb, cellulitis and abscess of foot (PX 11). Petitioner was referred to Hugar Foot & Ankle Specialists (PX 11).

On July 5, 2017, Petitioner was seen by Dr. Biermann from Hugar Foot & Ankle Specialists who noted in his medical records:

> "54 y/o male patient presents to office for initial examination. Pt relates he has a foot sprain that has gotten progressively worse as the week have gone on. Pt related his foot started to feel uncomfortable while at work on 6/14/17 around 1pm. Pt works for a vending company and goes in and out of his truck and buildings delivering vending products to machines and throughout the city. Pt relates he may have twisted or sprained his foot while at work. Pt did go to urgent care that day and was diagnosed with sprain. Pt related the pain started at work ... the swelling has persisted. Pt relates he has slightly less pain than when at ER but still cannot put weight on his foot. Pt relates a history or numbness in his feet " (PX 12).

On examination, Dr. Biermann noted increased left foot temperature, extreme edema in the left foot and ankle, bounding pulses, bruising, pain at the ankle gutters and inability to bear weight (PX 12). Dr. Biermann noted that Petitioner has a history of diabetes with neuropathy and is on his feet all day creating extra force through his foot (PX 12).

Dr. Biermann diagnosed Petitioner with pain in the left foot, localized edema and possible Charcot arthropathy of the left ankle and foot (PX 12). Petitioner was instructed to remain non-weight bearing to not risk deformation of the foot, was given a CAM walker boot and an MRI of the left foot was scheduled at Loyola Gottlieb Hospital (PX 12). On July 10, 2017 Petitioner underwent MRI of the left ankle/hindfoot (PX 11).

On July 13, 2017, Dr. Biermann reviewed the MRI and noted continued pain on the dorsum of the left foot and around the ankle joints (PX 12). Dr. Biermann ruled out CRPS and confirmed Charcot foot and neuropathy of the feet and prescribed Norco for pain (PX 12). Petitioner was to remain off work for the next 4-8 weeks (PX 12).

On August 17, 2017, Dr. Biermann recommended ACE wrap to control the edema and ordered Petitioner to remain off work for the next 1-3 months (PX 12). Thereafter, Petitioner had monthly office visits with Dr. Biermann who continued to order that he remain off work.

At Respondent's request, Petitioner attended a Section 12 examination with Dr. Anand Vora on October 27, 2017. (Tr. pp. 53-54). Dr. Vora testified in his evidence

deposition on May 14, 2018. (RX 1). Dr. Vora is a board-certified orthopedic surgeon who specializes in foot and ankle conditions. (RX 1, pp. 3-5). Dr. Vora is currently involved in designing a type of instrumentation system for Charcot foot surgical procedures. (RX 1, p. 7).

Petitioner reported a history of a foot injury on June 14, 2017, and at the time of his exam complained of swelling. (RX1, pp. 8, 11, 15, 19). According to Dr. Vora, Petitioner indicated that he sprained his foot but also indicated that no specific injury occurred. (RX1, pp. 15-16). Petitioner told him he had to get in and out of a truck "often" and "constantly" for his job as a delivery vendor for candy and pop machines. (RX1, p. 16). He also expressed some concern about walking through alleys and indicated that he "may have" rolled his foot or ankle walking on uneven surfaces but did not specifically recall doing so. (RX1, p. 16). Dr. Vora noted Petitioner's history of untreated diabetes and Charcot osteomyelitis and neuropathy. (RX1, pp. 13-15). Although he declined to say what normal sugar levels are, he testified that Petitioner's reported sugar level of 300 was high. (RX1, pp. 17-18).

Dr. Vora examined Petitioner's left foot. (RX1, pp. 11, 18). On exam, Petitioner reported discomfort with palpation of the midfoot and exhibited decreased two-point discrimination and pinprick, but sensation was otherwise intact. (RX1, p. 19). He also exhibited diffuse swelling and redness of the entire left lower extremity, which Dr. Vora called a "hallmark of Charcot [foot]." (RX1, p. 20). The doctor took x-rays at his office on the day of his exam, and the results confirmed Charcot in Petitioner's left foot. (RX1, p. 21).

Dr. Vora concluded that Petitioner has diabetic Charcot neuropathy, or neuroarthropathy, a condition he conceded is controversial but one that nonetheless most commonly occurs in people with diabetes. (RX1, pp. 22, 50). Dr. Vora described Charcot as a condition in which "the bones have become arthritic and/or are collapsing" as a result of "neurologic lower extremity compromise and altered extremity vascular flow." (RX1, p. 23). He likened the condition of the bones to butter. (RX1, p. 34). According to

him, "the blood supply eats away the bone and causes it to dissolve and collapse." (RX1, p. 23). Although he conceded that trauma can worsen anything, he testified that Charcot is not aggravated by trauma. (RX1, pp. 24-26). Dr. Vora further testified that getting in and out of a truck, walking on uneven surfaces, and simply walking are not what cause Charcot. (RX1, pp. 27, 47-48, 68-69). Petitioner demonstrated typical or "classic" Charcot foot: swelling that got worse, which is related to the underlying disease process and not a traumatic injury. (RX1, pp. 28-29, 31). Dr. Vora concluded that there is no relationship between Petitioner's employment and his left foot condition. (RX1, pp. 30-31). According to Dr. Vora, the history, presentation, findings on exam, and diagnostics all clearly suggest that Petitioner has neurovascular Charcot from uncontrolled diabetes. *(RX1, 71).*

On December 26, 2017, Dr. Biermann took x-rays of the left foot and ordered Petitioner to remain off work through March 2018 (PX 12). On January 23, 2018, Dr. Biermann noted that bone appeared to be consolidating and had reduction in warmth, erythema, edema, and ordered weight-bearing to begin as tolerated in the CAM walker boot. Dr. Biermann also noted that Petitioner had an increased loss of protective sensation (PX 12).

On February 20, 2018, Dr. Biermann ordered Petitioner to remain off work to prevent destruction of his left foot because regular activity and weight-bearing could not yet be tolerated. Dr. Biermann recommended extra depth shoes with multiple density and full contact insoles because of his podiatric deformities put Petitioner at risk for diabetic foot ulcerations and severe infections (PX 12).

On March 20, 2018, Dr. Biermann noted stiffness in the left midfoot and opined that Petitioner needed to begin physical therapy for rehabilitation and strengthening of his left foot lower extremity and recommended a custom shoe gear with custom inserts (PX 12). Petitioner was to remain off work for the next 1-2 months (PX 12).

On April 6, 2018, Dr. Biermann instructed Petitioner to remain in the CAM walker boot at least 50% of the time and the other time in the custom shoe gear. Petitioner was to remain off work for 1-2 months while he underwent physical therapy (PX 12).

On April 18, 2018, Petitioner began physical therapy at Advocate Good Shepherd Hospital (Tr. pp. 34 -35). Petitioner was having difficulty walking and using stairs, had impaired range of motion and occasional numbness and severe left foot pain (PX 18). At the initial session, Petitioner reported his prior level of function as being a truck driver and being able to carry heavy objects in and out the truck without any difficulty (PX 18). On May 17, 2018, Petitioner continued to experience pain in his left arch and top foot. Petitioner underwent therapy through May 24, 2018.

On May 25, 2018, Dr. Biermann noted that Petitioner continued to have some stiffness and pain every now and then, especially during damp weather. Petitioner was released to return to work without restrictions on July 2, 2018 (PX 12). Petitioner credibly testified that he had no previous problems with the left ankle or foot before June 14, 2017 (Tr. p. 37). Petitioner has not returned to work since June 14, 2017 (Tr. p. 38).

CONCLUSIONS OF LAW

REGARDING ISSUE (C): DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?; AND ISSUE (F): IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY? THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

It is Petitioner's burden to establish all of the elements of his claim by a preponderance of the credible evidence. *Ingalls Memorial Hospital v. Industrial Commission*, 241 Ill. App. 3d 710 (1993). This burden includes proving an accident that arose out of and in the course of his employment, *Parro v. Industrial Commission*, 260 Ill. App. 3d 551 (1995), and a causal connection exists between the accident and Petitioner's condition of ill-being, *Lee v. Industrial Commission*, 167 Ill. 2d 77 (1995). A claimant alleging a repetitive trauma injury must meet the same standard of proof as an employee who alleges a sudden injury from a discrete event. *Durand v. Industrial Commission*, 224 Ill. 2d 53 (2006). **Liability cannot rest on imagination, speculation, or conjecture**. *Chicago Park District v. Industrial Commission*, 263 Ill.App.3d 835 (1994).

Petitioner claims a compensable accident occurred under potentially three conflicting legal theories: (1) Petitioner sustained "repetitive trauma" to his left foot from walking in and out of his van to service vending machines and making deliveries which injury "manifested" on June 14, 2017; (2) pursuant to his testimony, a "specific trauma" sustained at 1:45 p.m. on June 14, 2017 when he was walking in the building at 200 W. Monroe with the cart and felt a pain in his foot; and, argued most, (3) that Petitioner suffered an "exacerbation" of a pre-existing condition in his foot based on either a repetitive trauma (argued strongest) or specific trauma theory, during the course of his work day on June 14, 2017.

The Arbitrator finds and concludes that regardless of which theory is analyzed and applied, Petitioner failed to prove he sustained a compensable injury arising out of and in the course of his employment with Respondent on June 14, 2017. Petitioner's claim rests **"on imagination, speculation, or conjecture."** Petitioner does not know how he was injured.

The following is black-letter law axiomatic: "An injury is **accidental** within the meaning of the Act when it is **traceable** to a **definite time, place and cause** and occurs **in the course of employment** unexpectedly and without affirmative act or design of the employee." *International Harvester Co. v. Industrial Comm.*, 56 Ill. 2d 84, 89 (Ill. 1973). Here, the essential issue and problem is that Petitioner has failed to identify, explain or articulate the specific "cause" (origin/how and why, mechanism or injury) of his injury.

While it is true Petitioner has asserted at one point in his testimony (Tr. p. 22) the "where" (200 W. Monroe) and the "when" (1:45 p.m.), **he has failed to assert and identify the "cause"**. In fact, Petitioner's ambiguous - or absent - testimony regarding the "cause", that is, how the injury occurred/mechanism of injury, does not support a claim that a compensable injury occurred. Petitioner's trial testimony only indicates - **at best** - he was "walking in with the cart" and he felt pain in his foot, testimony lacking in details and therefore insufficient to prove an accident. That description, standing alone, with no accompanying facts or explanations detailing how or why he was injured, does not

amount to an "accident." Further, "walking" under the vague facts presented in this case, does not amount to a compensable accident, even if that "walking" is what occurred to cause his injury, which remains doubtful.

Further is the fact that Petitioner's testimony and histories in his medical records clearly indicate that he did not know what, if anything, happened on June 14, 2017 to cause his injury. As found in treating medical records, Petitioner denied any trauma occurred on June 14, 2017 when he went to Loyola Gottlieb Hospital (see below). Further, Petitioner agreed with Pecora's testimony that he did not know what happened (see below). This all points squarely to the conclusion that Petitioner did not prove accident.

Further, neither Petitioner nor Pecora in their testimony established or asserted that anything in particular happened on June 14, 2017 to cause an injury. Although Petitioner speculated that he **somehow** sprained his foot, **he admitted that he could not identify any event or activity that brought on his symptoms.** Pecora, to whom Petitioner reported his symptoms and who observed his foot in her office and asked him what happened, testified Petitioner said **he did not know – and** Petitioner did not testify he told Pecora how he was hurt. This clear absence of testimony leads to the conclusion that Petitioner did not prove a compensable accident occurred. Again, a specific cause/event must be identified. Guesswork is not proof.

Yet further, Petitioner's own medical records go against his claims. While some records do contain short "causation opinions" embedded within, these opinions are mere statements or conclusions; they were not explained and were **based on either speculation** or **inaccurate histories**, or both, as discussed below:

On July 5, 2017, Petitioner was seen by Dr. Biermann from Hugar Foot & Ankle Specialists who noted in his medical records:

> "54 y/o male patient presents to office for initial examination. Pt relates he has a foot sprain that has gotten progressively worse as the week have gone on. Pt related his foot started to feel uncomfortable while at work on 6/14/17 around 1pm. Pt works for a vending company and goes in and out of his truck and buildings delivering vending products to machines and throughout the city. **Pt relates he**

may have twisted or sprained his foot while at work. Pt did go to urgent care that day and was diagnosed with sprain. Pt related the pain started at work ... the swelling has persisted. Pt relates he has slightly less pain than when at ER but still cannot put weight on his foot. Pt relates a history or numbness in his feet " (Px. 12).

This treating medical record clearly indicates Petitioner did not offer his treating physician an accident history (either under a repetitive trauma or acute trauma theory). Petitioner's comment that he "may have" twisted or sprained his foot while at work shows the speculative nature of his comments and the total lack of any detail as to how or why. One would reasonably expect a worker who sprained his ankle and suffered injury to the serious extent Petitioner did would recall how and when and under what circumstances he did so, only three weeks after the alleged event.

Further, on October 27, 2017, Petitioner was seen by Dr. Vora, Respondent's Section 12 examining expert. Dr. Vora testified that Petitioner told him that he injured his left foot on June 14, 2017 **when he was getting in and out of the truck and from having to walk on uneven surfaces in alleys** (RX 2, p. 15). The history Petitioner gave to Dr. Vora regarding an accident is speculative. This history also contains statements from Petitioner which were not part of his trial testimony (e.g., he works on "uneven surfaces" and "has to walk through alleys which was concerning to him").

Dr. Vora testified regarding his history from Petitioner as follows: "He injured his foot on June 14, 2007. Sprained his foot and went to urgent care. **No specific injury during the day,** but he has to get in and out of his truck often as he works as a delivery vendor for candy and pop machines and constantly in and out of his truck. Also he works in the city. **There are uneven surfaces and he may have rolled his foot or ankle but does not specifically recall.** At the end of the day when he took --- at the end of the day when he took his shoe off, he noticed a lot of swelling and sought treatment at urgent care." (RX 2, pp. 15-16). This suggests Petitioner was unware of an injury until he removed his shoe and notice the swelling. Given every opportunity to present a specific accident history, or even an accident history consistent with his trial testimony, Petitioner did not do so.

Further, and very significant, the treating medical records from Loyola Gottlieb Memorial Hospital, dated June 14, 2017, (PX 10, pp. 36-39), are very revealing and instructive. On the ate of the injury, the "ED Notes" indicate that Petitioner presented this history: **"Pain in the left foot from ankle to the toes while driving and walking...No injury."** The notes regarding indications for x-ray further add, **"no known injury"** . Further notes (Nursing Note by Ruacho, Patricia) indicate **"Pt denies injury and reports it happened at work while walking."**

Further, Petitioner retuned to Loyola Gottlieb Memorial Hospital on June 20, 2017 and the ED Notes indicate the following history: "...with complaint of continued left foot pain after possible sprain **(states was just walking)**."

Also on June 20, the "ED History and Physical Note" by Dr. Raziuddin, indicates the following completely different history: "Patient is 54y male presenting with ankle injury. **The history is provided by the patient...Time since incident: 1 week ago. Injury: Yes. Mechanism of injury: Fall. Impact surface: Hard floor."**

Petitioner admitted on cross examination that he did not recall exactly what history he told the doctors who treated him, but that he was truthful (Tr. p. 44). When these various histories were read to him during cross examination, **Petitioner agreed admitted that these histories are accurate.** (Tr. pp. 44-48). Perhaps Petitioner did not realize the significance of this acknowledgment, but that was his testimony. Given multiple opportunities to dispute or challenge the accuracy of the histories in the records, Petitioner did not do so. This is significant.

Further, Petitioner also testified as follows regarding how the alleged accident occurred, after the medical record histories were read to him: "I was walking in the alley behind 200 West Monroe, walking up there. There are potholes there. **If I injured my foot during the day,** my shoes were really tight, I would never have felt it. **If I twisted my ankle really bad,** I would have felt it, **but I might have injured it during the day,** and the shoes being tight by the end of the day, they loosened up probably. And I started to get severe pain in my foot." (Tr. pp. 48-49). Further,

In summary, this testimony nonetheless raises several key issues: Given yet another opportunity to do so, **Petitioner plainly again did not testify he sustained an accident. He is unsure what, if anything, did happen.** To the contrary, his testimony actually suggests that his foot was injured over the course of the day due to him wearing a shoe that was **admittedly too tight.** Further, **Petitioner again plainly admits he does not remember injuring his foot.** (Tr. pp. 48-50). **Petitioner does not remember "stepping into a pothole or something like that."** (Tr. p. 50). **This testimony cannot support a finding of accident, under any theory.**

Further, the testimony of Respondent's witness Pecora is very significant and instructive, and actually corroborates Petitioner's testimony regarding what he told her after the alleged accident on June 14, 2017 and corroborates that he did not know how or why he was injured. Accordingly, the Arbitrator finds and concludes Pecora's testimony was very credible and hereby adopts it. Further, the Arbitrator emphasizes that Pecora's testimony was never rebutted (Petitioner offered no rebuttal testimony after Pecora's testimony at trial) and Petitioner's own testimony corroborates Pecora's testimony.

Pecora testified regarding the following accident history Petitioner presented to her – all of which went unrebutted and unchallenged: **"Initially the day of, he did not know what happened, as far as an accident of what may have happened to cause his foot to be swollen and hurt."** (Tr. p. 67). "Initially – my initial question was, "Oh, my gosh. What happened?' You know, when you have someone who comes in with a foot that is hurt, you know, initially you say, 'Oh, my gosh. What happened?' But he was not able – I don't know that he knew what happened. He just knew it was hurting him horribly…" (Tr. p. 68). Petitioner did not tell Pecora how he hurt his foot.

Finally, it is very significant to emphasize that Petitioner never testified that he advised/notified Pecora how (the "cause") he hurt his foot. While Petitioner, somewhat disinegenuously, testified that he did not remember telling Pecora that he did not know how it happened, he did agree that he just knew "I told her my foot was in pain, severe pain." (Tr. pp. 41-42). Therefore, Petitioner's testimony corroborates Pecora's in that

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Petitioner did not advise Pecora as to how he injured his foot, but only told her he was in severe pain. Petitioner further acknowledged that he is basing his claim on the fact that in felt pain in his foot while working. (TR. p. 42). That is not sufficient testimony to prove accident.

Based on the above, and after a review of the entire record, the Arbitrator finds and concludes that Petitioner failed to prove he sustained an accidental injury arising out of and in the course of his employment with Respondent on June 14, 2017.

Based on the Arbitrator's finding that Petitioner failed to prove accident, the disputed issue of causation is moot.

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

Based on the Arbitrator's finding that Petitioner failed to prove accident, the disputed issue of medical is moot.

REGARDING ISSUE (L): WHAT TEMPORARY BENEFITS ARE IN DISPUTE?
THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's finding that Petitioner failed to prove accident, the disputed issue of TTD benefits is moot.

Robert M. Harris

Robert M. Harris, Arbitrator

Dated: September 26, 2018

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dennis O. Boyd,

Petitioner,

vs. NO: 18 WC 38063

Schrey Systems Inc., Wright Construction,

20IWCC0145

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of Petitioner's permanent partial disability and being advised of the facts and law, 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 10, 2019, 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.

20IWCC0145

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $22,900.00. 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 2 - 2020
MP:yl
o 2/25/20
68

Marc Parker

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BOYD, DENNIS O
Employee/Petitioner

Case# **18WC038063**

SCHREY SYSTEMS INC WRIGHT CONSTRUCTION
Employer/Respondent

20IWCC0145

On 9/10/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.82% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5274 HASSAKIS & HASSAKIS PC
JAMES M RUPPERT
206 S MAIN ST STE 201 POB 706
MT VERNON, IL 62864

1167 WOMICK LAW FIRM CHTD
CASEY VAN WINKLE
501 RUSHING DR
HERRIN, IL 62948

20IWCC0145

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Dennis O. Boyd
Employee/Petitioner

v.

Schrey Systems, Inc. Wright Construction
Employer/Respondent

Case # **18** WC **38063**

Consolidated cases: **N/A**

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 **Michael Nowak**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **8/7/19**. By stipulation, the parties agree:

On the date of accident, **10/26/18**, 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 $**39,520.00**, and the average weekly wage was $**760.00**.

At the time of injury, Petitioner was **48** years of age, ***single*** with **1** dependent children.

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

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

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

ORDER

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 **$456.00**/week for a further period of **50** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **10 % loss of use of the person as a whole**.

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

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

Michael K. Nowak, Arbitrator

9/4/19
Date

ICArbDecN&E p.2

FINDINGS OF FACT

Petitioner, Dennis O. Boyd, was 48 years old when he sustained an undisputed accident that arose out of and in the course of his employment with Schrey Systems, Inc. on October 26, 2018. Petitioner was working on a Walmart in South Carolina when he fell off a ladder and landed in a hole behind him (Tr. 9). The hole was cut out of the concrete and had cables running through it (Tr. 9). Photographs of said hole are part of the record (PX 5). As a result of said fall, Petitioner struck his head on the concrete and sustained an injury to his brain (Tr. 10). Immediately after the injury, Petitioner was discovered by his co-workers in a concussed state. An ambulance was called, but Petitioner refused medical treatment due to his disorientation and confusion from the injury.

Petitioner presented to Fairfield Memorial Hospital for emergent care on October 29, 2018 after his child's pediatrician, Dr. Jones, (who was examining Petitioner's infant child) advised him that he needed such care (PX1, p. 3). His emergent care records reflect that Petitioner had a closed head injury and sustained a loss of consciousness for an unknown duration due to the injury (PX1, p. 3). Dr. Christopher W. Ballard noted bruising around Petitioner's right eye and a scabbed laceration to the back right side of his head and right cheek (PX1, p. 6-7). Dr. Ballard also noted complaints of confusion, headache, nausea, dizziness, sleeping more than usual, trouble concentrating and blood/drainage from Petitioner's right ear (PX1, p. 6). A CT scan of Petitioner's head showed a skull base fracture involving the far anteromedial mastoid extending into the posterior wall of the right temporomandibular joint as well as a hemorrhagic contusion of the right frontal lobe and left temporal lobe. (PX1, p. 10). Dr. Ballad's differential diagnosis was intracranial bleed with basilar skull fracture (PX1, p. 7). Given the nature of Petitioner's injury, Dr. Ballad recommended immediately transferring Petitioner to Deaconess Hospital in Evansville, Indiana (PX1, p. 7).

On October 29, 2018, Petitioner was transported to Deaconess Hospital and Dr. Mark R. Nunge initially examined Petitioner, noting complaints of right ear pain with drainage from his right ear as well as headache, bruising to the right lower eyelid and right tympanic membrane perforation (PX3, p. 10-11, 13). Dr. Nunge reviewed the CT scan and opined that it showed fluid in the left maxillary sinus and right sphenoid sinus, skull fracture on the floor of the right middle cranial fossa, hemorrhagic contusion of the inferolateral right frontal lobe and hemorrhagic contusion of the anterolateral superior left temporal lobe (PX3, p. 13). Dr. Nunge diagnosed intracranial hemorrhagic contusions, basilar skull fracture and persistent spinal fluid leak from Petitioner's right ear (PX3, p. 14). Dr. Nunge recommended admitting Petitioner for care with Dr. Dharmesh Patel (PX3, p. 14). Dr. Patel's examination findings and diagnoses were similar to Dr. Nunge's (PX3, p. 16-17). Dr. Patel recommended a neurosurgical consultation with Ms. Claire Stevenson, NP (PX3, p. 17-18).

On October 29, 2018, Ms. Stevenson noted right periorbital ecchymosis, dried fluid in the right external ear canal, a positive hemotympanum sign and a positive Battle's sign (PX3, p. 20). Based on her examination, Ms. Stevenson diagnosed a hemorrhagic contusion of the right frontal lobe and left temporal lobe and skull base fractures involving the far anteromedial mastoid extending into the posterior wall of the right temporomandibular joint (PX3, p. 21). Ms. Stevenson recommended following the Petitioner with a series of neurological checks (PX3, p. 21). Ms. Stevenson reexamined Petitioner on October 30, 2018 and noted that he did not have further right ear drainage overnight as his head was elevated (PX3, p. 30). Ms. Stevenson opined that Petitioner could be discharged but would require follow-up with Dr. David Eggers and repeat CT imaging

of his head in four (4) weeks (PX3, p. 30). Per Dr. Patel's discharge summary, he recommended that Petitioner not return to work until cleared by Dr. Eggers (PX3, 6).

Petitioner returned to Dr. Eggers' office on December 10, 2018 (PX4, p. 7). Mr. Andrew F. Venditti, PA-C, one of Dr. Eggers' colleagues, saw Petitioner that day (PX4, p. 7). Mr. Venditti obtained a new CT-scan of Petitioner's head, and opined that it was unremarkable (PX4, p.7). Mr. Venditti noted that Petitioner continued to complain of dizziness (PX4, p. 7). Mr. Venditti instructed Petitioner to remain off of work for a total of three (3) months, or through January 29, 2019 (PX4, p.7). Mr. Venditti otherwise opined that Petitioner could return for care as needed (PX4, p.7).

As a result of the accident, the Petitioner testified that he suffers from speech impediments (Tr. 11-12). He has trouble coming up with the right words to say and stutters (Tr. 11-12). This is embarrassing for him as he gets stuck trying to find the words to talk to someone and cannot have a normal conversation anymore (Tr. 14). Petitioner further stated that he has problems laying on his back since the accident (Tr. 11-12). He cannot lay on his back without getting dizzy and having headaches (Tr. 11-12). Petitioner stated that laying on a creeper underneath a car causes him to get dizzy and that he cannot sleep laying on his back at night without getting sick or feeling dizzy (Tr. 11-12, 15). He has had to adjust to sleeping on his side (Tr. 15). Petitioner also stated that he does not get on ladders as much as he used to as he is scared that he would get dizzy and fall off (Tr. 13). Finally, the Petitioner testified that his brain injury has caused him to be more forgetful and that he did not have any of the above symptoms before his work injury (Tr. 12-13). Petitioner returned to work and now works as a supervisor for West Construction (Tr. 9, 16). He has not returned to a doctor in hopes that his symptoms will improve over time (Tr. 16-17).

CONCLUSIONS

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 neither party submitted an impairment rating. 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 Petitioner was employed by Schrey Systems, Inc. in the construction field at the time of the accident and that he is now employed by West Construction as a supervisor. Petitioner stated that as a supervisor at West Construction he supervises construction crews (Tr. 9). The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 48 years old at the time of the accident. Because of Petitioner's age, it is reasonable to conclude that he will continue to experience pain and limitations for a significant portion of his life. His symptoms are likely to inhibit or prevent his ability to do his regular activities, enjoy life and function for a considerable amount of time. While Petitioner is not at the beginning of his work life, he is also not near retirement age and therefore must continue to work with his ailments. 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 testified as to his symptoms and limitations resulting from his brain injury on October 26, 2018 and that he did not have any of his symptoms before the fall. The Arbitrator finds that Petitioner's medical records corroborate this testimony. The Petitioner's medical records reflect that he sustained a skull fracture, brain bleed and spinal fluid leak, and his ongoing ailments are understandable in light of his injuries. The Arbitrator finds it significant that the medical records corroborate Petitioner's testimony of ongoing problems and that Petitioner did not have any of these problems before the accident. 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 10% loss of use of the person as a whole pursuant to §8(d)2 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

ROBERT THOMAS,

Petitioner,

vs. NO: 18 WC 034458

KEYSTONE STEEL & WIRE CO.,

Respondent.

20IWCC0146

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, 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 July 15, 2019, 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)(2) of the Act, no bond for removal of this cause to the Circuit Court by Respondent as the Commission did not render an award for payment of money. The party

commencing 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 3 - 2020
KAD/mav
O: 01/07/2020
42

Kathryn A. Doerries

Maria E. Portela

DISSENT

I believe that there was more than enough evidence in the record to support Petitioner's claimed accident on 9/9/18, and that the Arbitrator erred in denying compensation based on what I consider to be an overly circumspect and critical review of the record.

It should be noted that 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*, 207 Ill. 2d 193, 203, 797 N.E.2d 665, 671, 278 Ill. Dec. 70 (2003). It is also a well-settled principle that the Act is a remedial statute and should be liberally construed to effectuate its main purpose – providing financial protection for injured workers. *Beelman Trucking v. Illinois Workers' Compensation Commission*, 233 Ill.2d 364, 371 909 N.E.2d 818, 330 Ill.Dec. 796 (2009).

The record shows that Petitioner had worked for Respondent as a mill builder for 4 to 5 years, and that he had never had any abdominal complaints or issues requiring medical treatment prior to the incident. He noted that on the date of the alleged accident, Sunday 9/9/18, he was working in a different job, that of a trimmer. He stated that this job consisted of cutting the back ends of coils, pulling them off a hook line, and throwing them into a dumpster. He noted that it took a lot of effort to lift these items and that he worked 16 hours performing that job on the day in question, having averaged 70 hours every week. Petitioner testified that on the date of the accident he noticed a cramping in his belly a few hours into his shift, at about 8:00 or 9:00 a.m., that came and went and progressed into pain. He noted that he never felt that pain before. He also testified that he thought it might just be a pulled muscle and that it was something he would get through. He completed his shift, and even worked another shift, finishing work at 10:00 p.m. that night. The next morning, he noticed he was in quite a bit of pain when he reported to work at 6:00 a.m. He acknowledged telling a foreman at that time that he was sore and that he didn't know what was wrong with him, given that he still thought it might be a pulled muscle and that it would go away. He went back to his regular job, which does not involve as much physical labor, and eventually reported the injury and filled out an accident report on Friday 9/14/18, or only five (5) days after the incident. He noted that at that time he still wasn't sure what was the matter with him, or how it had happened exactly; only that it started hurting when he was trimming the coils.

He also indicated that he did not know that he had a hernia at the time he filled out this report and that he thought he had a pulled muscle. Petitioner sought medical treatment at that time, underwent hernia repair surgery on 10/2/18 and eventually returned to full duty work on 10/14/18.

The Arbitrator denied compensation based on what she termed "a number of inconsistencies" that caused her to "place little evidentiary weight upon Petitioner's testimony in this case." (Arb.Dec.[Addendum], p.9). These so-called "inconsistencies" included the fact that Petitioner acknowledged "... he was familiar with workers' compensation as he had had three prior claims" and the fact that he was "aware of the plant rule to report all accidental injuries or conditions immediately and to complete an incident report." (Id., p.9). How having filed previous workers' compensation claims and knowing the accident reporting policy of your employer necessarily calls into question one's veracity is beyond me. Petitioner suffered a hernia. It was not beyond the realm of possibility that as a layperson this diagnosis was not immediately known to him, especially since he had never suffered any abdominal injuries in the past. It was also not unreasonable for him to want to wait and see if the problem would go away. And when it failed to improve, he reported the incident and filled out an injury report five (5) days after the incident, a delay which was not, by any stretch of the imagination, unreasonable under the circumstances.

The Arbitrator also found it "difficult to understand" how Petitioner could have finished his shift and then gone on to work an additional shift until 10:00 p.m. that night. The answer is simple – he didn't think the injury was that serious, hoping it was just a muscle strain that would go away, and that he simply wanted to try to work through it. An admirable trait, if you ask me, and not evidence of the dubiousness of Petitioner's claim.

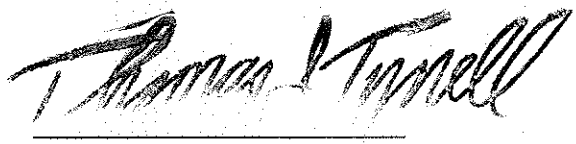
Furthermore, the Arbitrator found it significant that "... Petitioner offered no opinion from the treating doctor that a causal relationship existed between the alleged work activity of September 9, 2018 and the hernia condition." (Id., p.10). This, of course, is not a prerequisite to compensation. Indeed, under a chain of events theory of recovery, the case would be held compensable based on the sequence of events, the lack of symptoms prior to the accident and the manifestation of symptoms immediately following the accident. See *Steak 'N Shake v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150500WC (3rd Dist. filed 11/17/16); citing *Sisbro v. Industrial Commission*, 207 Ill.2d 193, 207-208; *United Coal Mining Co. v. Industrial Commission*, 318 Ill.App.3d 170, 175 (2000).

Here, the evidence clearly shows that Petitioner had never suffered a hernia prior to the date of the accident and that he was working a heavier than usual job when he noticed the onset of first cramping and then abdominal pain. The evidence also shows that he continued working and eventually sought medical treatment, underwent surgery and returned to full duty work in less time than the Act allows for even the giving of notice. The fact that he continued to work, and did not know the full extent of his injury at the very moment it occurred does not detract from the fact that there is no evidence to suggest that he was injured in any other way. And if we are indeed charged with the task of liberally construing the Act in order to effectuate its main purpose – that of providing financial protection to workers injured on the job -- then we should not be going out of our way to deny compensation based on perceived "inconsistencies."

20IWCC0146

As a result, I would reverse the Arbitrator's decision and find that Petitioner proved by a preponderance of the credible evidence that he sustained accidental injuries arising out of and in the course of his employment on 9/9/18, that his injury was causally related to said accident based upon a chain of events theory of recovery, and that he would be entitled to benefits accordingly.

Therefore, I respectfully dissent from the majority opinion.



Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

THOMAS, ROBERT
Employee/Petitioner

Case# **18WC034458**

KEYSTONE STEEL & WIRE CO
Employer/Respondent

20IWCC0146

On 7/15/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.07% 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:

5328 LAW OFFICE OF DAMON YOUNG
2708 N KNOXVILLE AVE
PEORIA, IL 61604

0507 RUSIN & MACIOROWSKI LTD
JOHN MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

20IWCC0146

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Robert Thomas
Employee/Petitioner

v.

Keystone Steel & Wire Co.
Employer/Respondent

Case # **18** WC **34458**

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 **Peoria**, on **May 14, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 9, 2018,** Respondent ***was*** operating under and subject 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.

Per the stipulation of the parties, in the year preceding the injury Petitioner earned **$178,457.38**; the average weekly wage was **$3,717.86**.

On the date of accident, Petitioner was **48** 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 **$650.00** in non-occupational indemnity disability benefits, for a total credit of **$650.00.**

Respondent is entitled to a credit for medical bills paid in the amount of **$ALL AMOUNTS PAID** through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent and, as such, all benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$650.00** in non-occupational indemnity disability benefits, for a total credit of **$650.00.**

Respondent is entitled to a credit for medical bills paid in the amount of **$ALL AMOUNTS PAID** through its group medical plan for which credit may be allowed 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. Gore-Sullivan
Signature of Arbitrator

7/11/19
Date

JUL 15 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Robert Thomas
Employee/Petitioner

Case # **18** WC **34458**

v.

Consolidated cases: **N/A**

Keystone Steel & Wire Co.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he was employed by Respondent as a metal builder and that he had done this job for 4-5 years. He testified that the date of accident, *i.e.*, September 9, 2018, was that of a Sunday and that he was not doing his usual job but rather was doing the trimmer job, which consisted of cutting the back ends of coils, pulling them off a hook line, and throwing them into a dumpster. He testified that it took a lot of effort to lift the items. He further testified that he worked 16 hours on the date of the accident and that, on average, he worked 70-72 hours every week.

Petitioner testified that on the date of the accident, he was at the trimmer's station and that a couple of hours into his shift he had cramping in his belly that then went to a little bit of pain. He testified that the pain "went in and out a little bit." He testified that the rods were circular coil that were ¼ inch around and that he cut the back end off. He testified that they had to cut off about 20 rings that day because it was a trial, and that he had to pull them off and throw them into a dumpster. He testified that the height that he was grabbing at was slightly above his waist and that the hook line was even with his chest. He further testified that the dumpster was at chest-level. Petitioner testified that when he was doing that job duty he felt pain in his abdomen, that it felt like a cramp, and that it then was a pain. He testified that it felt like there was a knot right at his belly button, and that he had not felt that type of pain before.

When asked how long the pain lasted that day, Petitioner responded that it went in and out and that it was not like he could not work, and that he thought he pulled a muscle. He testified that at the time, he thought would be okay. He testified that he continued throughout that shift, that his shift ended at 10 p.m., and that the incident happened that morning between 8 and 9 a.m. When asked what he did that night, Petitioner responded that he thought it would be okay and that he had eight hours in between his shifts. He testified that he went to do another job at 6 a.m. the next morning, and that when he got there the next morning he was in quite a bit of pain.

Petitioner testified that when he reported to work the next morning, he went back to his regular job duties that day. He testified that he was changing shocks on rolls with a crane and was not doing a lot of physical work like he had done on Sunday. He testified that he turned in the injury on Friday and filled out an accident report. When asked whether he had told anyone prior to that of the accident, Petitioner responded that he did not tell anyone that he thought he got hurt and that he said he was just hurting.

Petitioner testified that on September 14, 2018, he reported to his employer that he had injured himself and prepared a report. When asked why in the report he said that he thought it was trimming rods

at the trimming station, Petitioner responded that he was not sure what was the matter with him and that he just knew that it hurt. He testified that as he sat in the arbitration hearing, he knew that he injured himself while trimming because that was when it started hurting.

Petitioner testified that he reported the accident on Friday and was seen at Keystone Medical, but that Dr. Pena was not there so he was sent to OSF Occupational Health who sent him to the emergency room. He testified that "Rusty" told him to see the doctor of his choice, and that he sent him a prescription card that listed it as a worker's compensation case. He testified that he later received a letter stating that his case had been denied.

Petitioner testified that when he was seen by Occupational Health, he stated that he felt pain in his abdomen while lifting rods at work. He testified that he still did not know at that point that he had a hernia. He testified that when he was sent to the OSF emergency room, he had a CT scan and that at that point he was told he had a hernia. He testified that he was instructed to follow-up with a surgeon. He testified that he underwent a hernia repair with mesh by Dr. Tanck and that he was released and went back to work on October 14, 2018, having missed approximately two weeks of work. He testified that he was not paid temporary total disability benefits, and that he believed that he still had outstanding medical bills.

Petitioner testified that on the date of the accident when he was lifting, he felt that it was strenuous. He testified that while he was doing this strenuous work, he started to develop cramping-like pain in his abdomen. He testified that the cramping pain never went away, but that there were times when it hurt really bad. He further testified that there were times that the pain was more extreme. Petitioner testified that since he had the surgery he had not had any pain or cramping, and that he was back to work full duty.

Petitioner testified that on the morning of September 9, 2018 prior to his shift starting, he had no abdominal problems at all. He denied having done anything at home after the accident that aggravated or caused any pain complaints in his abdomen.

On cross examination, Petitioner agreed that he was released to return to work full duty work effective October 15, 2018. He agreed that he went back to regular work and was working the same number of hours as he had in the past. He testified that he currently had no pain and denied taking any type of medications. He testified that he had not returned to the doctor and denied using an assistive device.

On cross examination, Petitioner agreed that he was familiar with worker's compensation and had had three prior claims. He agreed that when he was hired, he was given a safety book. He agreed that he was aware of Respondent's rule that he was to report any condition of ill-being that he believed was related to a work accident, but further testified that he did not realize that he was hurt at the time. He agreed that when he reported a work incident, the supervisor that he reported the accident to was obligated to fill out a report.

On cross examination, Petitioner agreed that made no report of the accident it to the supervisor on the date of the accident. He agreed that he knew on the Friday before the accident that he was going to be doing the trimmer job on Sunday and that he had done the trimmer job before. He agreed that the rings that he was trimming off weighed weigh about 3 pounds each. He agreed that he completed his tasks that day until 2:00 p.m. and that he made no complaint to Tom Gladson that he was feeling pain in his abdomen. He agreed that after completing his shift at 2, he then went and worked another shift from 2 p.m. to 10 p.m. doing the same job and made no complaints to either Tom Gladson or Steve Harms.

On cross examination, Petitioner agreed that he came back to work the next day at 6 a.m. and told Mr. Jankenson that he was sore. He testified that Mr. Jankenson asked him what the matter was and that he said he did not know. He agreed that Mr. Jankenson did not complete an accident report that he was

aware of. He testified that he worked the following Tuesday and Wednesday as well, but that he did not know how many hours he worked those days but that he worked the mill building job.

On cross examination, Petitioner agreed that he worked on Thursday, September 13th. He agreed that Don Harmison wanted him to do a water box change. He testified that he did not know the weight of a water box. He agreed recalling telling Don Harmison that he did not want to sound like a sissy, but that his stomach had been hurting for the last few days. When asked whether he told Don Harmison that he woke up one day sore and that he did not know what it was from, Petitioner denied this and stated that he told him he had been sore all week but that he did not know what it was from. He agreed that when he filled out the incident report the next day, he assumed that the trimming was what had caused it.

On redirect, Petitioner agreed that when he was doing the trimming job on September 9th, that was when the pain started.

On further cross examination, Petitioner agreed that he did not tell Don Harmison that his pain started while he was lifting rods on September 9th.

On further redirect, Petitioner testified that he did not tell Don Harmison that his pain started while he was lifting rods on September 9th because everyone that was working around him all week knew that something was wrong with him.

Russell Hewit was called as a witness by Respondent at the time of arbitration. Mr. Hewit testified that he was employed by CCMSI, that his position was that of a claims adjuster, and that he was assigned to Respondent's plant and was based on-site.

Mr. Hewit testified that he received the incident report relative to Petitioner. He denied ever having told Petitioner that his claim was accepted. He testified that the on-site medical clinic issued the prescription cards to employees, and that it was not a determination as to whether the claim was accepted or denied.

Mr. Hewit testified that as part of the investigation, he reviewed statements from various individuals. He testified that based on the investigation that was performed, he issued a letter to Petitioner dated September 19, 2018 that stated that the case was denied.

On cross examination, Mr. Hewit testified that prior to issuing a denial, he reviewed medical records from Respondent's clinic. He testified that as he sat at arbitration, he did not know what the medical records stated. He testified that he interviewed Petitioner as to how he injured himself and that he stated that he was uncertain as to how the injury occurred, but that he thought it related to his work cutting ends off of coil. He testified that he prepared the denial letter, which was admitted into evidence as Respondent's Exhibit 7.

On cross examination, Mr. Hewit testified that he did not know why Petitioner wanted to reduce the ring load he was working on.

Thomas Gladson was called as a witness by Respondent at the time of arbitration. Mr. Gladson testified that on September 9, 2018, his position was that of a supervisor foreman in the lower reform area of the rod mill. He testified that he was familiar with Petitioner. He testified that the rule at Respondent for reporting conditions or incidents involving work by employees was that if you thought you had been hurt or injured at work, you were to report it immediately to your supervisor. He testified that this rule was advised to the employees in their introduction, that it was talked about in safety meetings, and that there were postings at the facility as well.

Mr. Gladson testified that Petitioner got the job on September 9th by his seniority in the bidding process. He testified that Petitioner's shift started that day at 6 a.m. and that it ended at 2 p.m. He testified

that he was present during that period of time. He testified that he had a conversation with Petitioner on that date relative to his work assignment at approximately 11:45 a.m. at Petitioner's trimmer station. He testified that they were directed by QA that they had a trial and that they needed to trim some extra rings off at that point in time. He testified that they were working on the "219" small diameter rods, and that they were the smallest rods they worked on. He testified that the rings they needed to trim off the 219 rods were on a coil that was on a hook that was run around the area by a conveyor system. He testified that to trim the rings off the 219 rods, they had to take the rings they were going to trim, grab them in their hand, and put them into a jaw cutter that cut the bottoms off so that they could pull them up over the hook and discard them in a hopper. He testified that a group of 3-5 rings weighed 2-5 pounds, and that for 20 rings the weight range was that of 8-20 pounds. He testified that Petitioner stated that for him to trim 20 rings off the back end it was too much for him, and that Petitioner said if he made him do it, he would just go to medical. He testified that Petitioner did not make any complaints to him at that time that he had experienced any type of pain in his abdomen earlier that day between 8 and 9 a.m. He testified that when he had this conversation with Petitioner, he showed no signs of discomfort. He further testified that he had no knowledge from any supervisor or co-employee that Petitioner was in discomfort or had sustained any type of injury.

Mr. Gladson testified that he gave Petitioner a manageable option that instead of doing all 20 at once, he could do 10 rings and then 10 more. He testified that 10 rings would have weighed anywhere between 4 and 10 pounds in total. He testified that the job did not take 5 or 6 individuals to perform. He testified that he observed Petitioner throughout the remainder of the day through the end of his shift, that he showed no signs of discomfort, and that there were no signs of an incident having occurred. He further testified that subsequent to his surgery Petitioner had performed at the same level as previously, and that he did not notice anything unusual about his performance.

Mr. Gladson testified that as part of the investigation into Petitioner's claim, he completed his statement of September 15, 2018. He testified that he was notified that Petitioner had gone to medical on September 14th, claiming that he had hurt himself on Sunday during the shift that he himself had worked. He testified that he had no knowledge from any source on September 9th that Petitioner was hurt from doing any job task.

On cross examination, Mr. Gladson testified that he did not directly watch Petitioner work from 6 a.m. until 11:40 a.m. when they talked, but that he did rounds and had to check on all his employees. He testified that his rounds consisted of walking no more than a ¼ mile in the reform area where he was a supervisor. He testified that he had office work to do as well, and that if he was sitting in his office he could bring up his employees on camera and watch them even if he was not out on the floor.

On cross examination, Mr. Gladson testified that Petitioner stated that he would go to medical if he made him trim all 20 rings off at one time. He testified that he told Petitioner that he would trim them off and that he gave him a manageable option of trimming 10 rings at a time instead of doing all 20 if 20 was too much. He testified that he did not ask Petitioner if he was injured at that point. He agreed that Petitioner and his co-workers did manual labor and that it took exertion to do it. He further testified that he had had individuals report muscle cramps or soreness in their shoulders to him.

On cross examination, Mr. Gladson testified that other than filling out an incident report as to what had happened between he and Petitioner, he did no other investigation. He testified that he completed his incident statement by e-mail and that he was asked to do so by his supervisor.

On redirect, Mr. Gladson testified that when Petitioner asked not to trim 20 rods, he did not say he was experiencing any pain from a physical condition at that time. He testified that Petitioner did not show any physical signs of discomfort. He testified that he did not consider it a heavy-exertion job or task that Petitioner was doing, and further testified that it was just a busy job.

On further cross examination, Mr. Gladson testified that Petitioner told him that he would go to medical if he made him trim the 20 rings off.

On further redirect, Mr. Gladson testified that he considered Petitioner's statement a threat.

Steven Harms was called as a witness by Respondent at the time of arbitration. He testified that on the date of accident, he was employed by Respondent as a lower reform supervisor. He testified that he was familiar with Petitioner and that he occasionally worked under his control. He testified that Petitioner was scheduled to work for him on the second shift on September 9, 2018 from 2 p.m. to 10 p.m.

Mr. Harms testified that on that date, Petitioner was assigned to perform rod trimmer tasks. He testified that he observed Petitioner perform those job tasks throughout the end of his shift, and that he noticed nothing unusual and that Petitioner made no complaints to him. He testified that Petitioner worked through to the end of his shift at 10 p.m.

Mr. Harms testified that he made a statement as part of the investigation in this case and that it was contained in Respondent's Exhibit 9. Mr. Harms denied having had any knowledge as of September 9, 2018 from any source that Petitioner was not feeling well or had injured himself while performing his job activities.

On cross examination, Mr. Harms testified that he kept an eye on all employees during the shift. He agreed that he walked around the ¼ mile stretch to watch the employees. He agreed that he did not watch the work that every employee did every moment of their shift.

On redirect, Mr. Harms testified that he had a camera in his office that showed each work station. He testified that at no time did Petitioner appear to be in pain or have difficulty perform his job tasks.

On further cross examination when asked how often he would watch the camera during an 8-hour shift, Mr. Harms responded that he always pulled it up while he was doing paperwork and that he was watching at least 30 minutes of his shift if he was not out doing his rounds.

Don Harmison was called as a witness by Respondent at the time of arbitration. He testified that on September 9, 2018, he was a rod mill foreman. He testified that he was familiar with Petitioner and that his position was that of a mill builder. He testified that he would occasionally supervise Petitioner and that he did so a few days a week.

Mr. Harmison testified that on Thursday, September 13th he had a conversation with Petitioner in his office. He testified that prior to this conversation, he had assigned Petitioner the job of changing water boxes. He testified that a water box weighed 30-40 pounds. When asked what Petitioner stated to him on September 13th during their conversation, Mr. Harmison testified that Petitioner said that he did not want to sound like a sissy, but that his stomach had been bothering him the last few days and that he was not sure if could do that work. He testified that Petitioner stated that he was not sure why his stomach was bothering him. Mr. Harmison further testified that Petitioner stated that the other day he woke up sore, that he took Advil and it went away but that it was bothering him again. He testified that he asked Petitioner if he wanted to go to first aid, that he said he did not want to miss work, and that he would make a doctor's appointment. He testified that he gave Petitioner a different assignment.

Mr. Harmison testified that he remembered the conversation and denied at any time during this conversation that Petitioner told him that the pain he was experiencing was due to some work activity. He further denied that Petitioner told him that it was due to trimming rods on September 9th. He testified that if Petitioner had told him that it was work-related, he would have insisted that he go to Medical. He testified that as foreman of the rod mill, he would be aware of all incident reports in the mill within a few

days after the incident occurred. He testified that if another supervisor had knowledge of Petitioner being hurt, they would have been obligated to fill out an incident report. He testified that he had no knowledge of any other management or supervisory employee having knowledge of Petitioner having a work incident prior to his completing the incident report on September 14, 2018 at Medical.

Mr. Harmison testified that he was familiar with trimming rings off 219's and that a single ring did not even weigh one pound. He testified that he did not consider the assignment of that job to be a strenuous one. He testified that Petitioner was off and returned to his regular work after surgery, that he had supervised him, and that he was still working the same hours and had had no change in output. He testified that Petitioner has never voiced any physical complaints to him.

On cross examination, Mr. Harmison testified that he did not recall whether he worked with Petitioner on September 9, 2018. He testified that he was not in charge of the ring area. He testified that he did not work the ring area on that date. He denied having talked to Petitioner about his condition outside of the conversation he testified to on direct. He testified that he did not discuss Petitioner's abdomen issues with him on September 14th. He denied that Petitioner reported a work injury to him. He testified that he did not know to whom Petitioner reported the work injury on September 14, 2018.

On cross examination, Mr. Harmison testified that his supervisor asked him to make a statement. He testified that he asked Petitioner why his stomach was bothering him. He agreed that Petitioner stated that he was not sure. He denied having asked Petitioner if it happened at work.

On redirect, Mr. Harmison agreed that Petitioner did not say that his condition was due to any work episode. He agreed that Petitioner told him that he woke up sore when he felt the pain.

On rebuttal, Petitioner testified that he did not tell Mr. Harms of any abdomen issues on September 9, 2018 because he did not know what he did and thought it was just cramping. He testified that he tried to work through it. He agreed that he heard Mr. Gladson's testimony about their conversation about him going to medical. He denied threatening Mr. Gladson to get out of work, and testified that he was hurting at the time and thought it would make it worse.

On rebuttal when asked why he stated to Mr. Harmison that he did not know why his stomach hurt, Petitioner responded that he did not know what his medical condition was, that he just knew it was hurting, and that he was in pain. He testified that he did not turn in the accident report until September 14, 2018 because he thought it was an ache or pain that would go away.

On cross examination during rebuttal, Petitioner agreed that when he told Mr. Gladson that he would go to the medical department if he made him do the 20 rings, he did not tell him that he was in pain. He agreed that he did not tell Mr. Harmison that his pain was from work.

The Application for Adjustment of Claim was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Application alleged that the date of accident was that of September 9, 2018 and that the accident occurred while lifting. (PX1).

The Keystone Steel & Wire Report of Injury or Illness was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The report reflects that Petitioner identified a date of incident of September 9, 2018 during the first shift and that the date the incident was reported was that of September 14, 2018 to Medical. It was noted that the incident occurred on a Sunday, that the Department was that of rod mill, that the supervisor was that of John Gooman, and that the specific job was that of a mill builder. When asked to list the specific machine/tool/chemical/equipment causing the injury, Petitioner indicated that he thought trimming rods at the trimming station. It was noted that the part of the body injured was that of the belly. It was noted that Petitioner was sent to OSF Occupational Health. (PX2).

The medical records of OSF Occupational Health were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on September 14, 2018, at which time it was noted that he was seen for abdominal pain/bulge following lifting rods at work. The injury dated was noted to be that of September 14, 2018. It was noted that on Sunday Petitioner was lifting rods (unknown weight), a job he normally did not perform, and that he noticed some abdominal pain with a bulge just above the umbilicus. It was noted that throughout the week the pain worsened and spread throughout the abdomen, that Petitioner did not have any nausea, vomiting, chills or fever, that he could pass stool without difficulty but that straining intensified the pain, and that he denied having a prior hernia. It was noted that Petitioner rated his current pain level at 9-10/10. The assessment was noted to be that of unspecific abdominal hernia without obstruction or gangrene. Petitioner was referred to the emergency room for further evaluation and treatment. (PX3).

The medical records of OSF St. Francis Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner underwent surgery by Dr. Tanck on October 2, 2018, which was that of an umbilical hernia repair with mesh for a pre- and post-operative diagnosis of umbilical hernia. (PX4).

The records of OSF St. Francis Medical Center reflect that Petitioner was seen in the emergency room on September 14, 2018, at which time it was noted that he was seen for abdominal pain. It was noted that Petitioner reported an episode of strenuous exertion on Sunday with subsequent pain in his periumbilical area, that he reported seeing a bulging just above his umbilicus measuring the size of a golf ball with intermittent pain that was described as sharp and non-radiating, and that he reported that the bulge was reducible but that the night before he had had significant pain that was 10/10. It was noted that the bulge was significantly smaller on that date by the patient and that he still had pain and decided to come for further evaluation It was noted that Petitioner was concerned about the possibility of a hernia but had not had one in the past, that he had also had no inguinal hernias, and that he denied any testicular pain or urinary symptoms. It was noted that there was a small mass measuring about 2 cm x 2 cm just above the umbilicus, that it was only appreciable when Petitioner was standing up, and that it was reducible. The diagnosis was noted to be that of umbilical hernia without obstruction and without gangrene. Petitioner underwent a CT of the abdomen and pelvis, which was interpreted as revealing a 3.5 x 2.5 cm fat-containing umbilical hernia. Petitioner was discharged and recommended to follow-up with Dr. Gerber for hernia repair. Petitioner was also recommended to avoid lifting over 10 pounds and to wear a binder for assistance when standing. (PX4).

The medical records of OSF Medical Group - Surgery were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that a History and Physical was performed on September 19, 2018, at which time it was noted that he stated that about a week and a half prior he started having abdominal pain, that at first it felt like a cramp but then it went away, and that the pain came back and was worse. It was noted that Ibuprofen did help with the pain and that Petitioner went to the emergency room on September 14th, that a CT scan was performed, and that he was diagnosed with an umbilical hernia. (PX5).

The Work Slip of Dr. Tanck dated October 12, 2018 was entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was allowed to return to work regular duty with no restrictions on October 15, 2018. (PX6).

Various Work Slips were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner was issued a work slip on September 24, 2018, which noted that he was undergoing surgery on October 2, 2018 and that he was to be evaluated in 1-2 weeks at the post-op appointment for return to work status. The work slip dated September 20, 2018 noted that Petitioner was seen for an office visit on that date. (PX7).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The Outstanding Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 9.

The Petition for Penalties was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The Petition alleged that Petitioner requested 19(k) and 19(l) penalties as to the refusal to pay medical and temporary total disability benefits in the case represented vexatious delay and that the suspension of payment of medical bills and benefits and requirement that Petitioner proceed with a hearing to prove entitlement to payment of medical bills and temporary total disability benefits was for the purpose of delay, as the uncontroverted facts presented no real controversy as to Petitioner's entitlement to payment of medical bills and temporary total disability benefits. (PX10).

The Case Docket – ICDW related to 96 WC 52527 was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Case Docket – ICDW related to 00 WC 10417 was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The Case Docket – ICDW related to 13 WC 4266 was entered into evidence at the time of arbitration as Respondent's Exhibit 3.

The Keystone Steel & Wire Report of Injury or Illness was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The record was duplicative of that as contained in Petitioner's Exhibit 2. (RX4; PX2).

The medical records of OSF HealthCare dated September 14, 2018 were entered into evidence at the time of arbitration as Respondent's Exhibit 5. The records reflect that Petitioner was issued a letter from the emergency room physician which noted that he had an umbilical hernia, that he needed to see a surgeon for repair, and that he could work until then as long as no vomiting or fever was present. (RX5).

The OSF CT report of September 14, 2018 was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The record was duplicative of that as contained in Petitioner's Exhibit 4. (RX6; PX4).

The September 19, 2018 Carrier Letter of Denial from Rusty Hewit was entered into evidence at the time of arbitration as Respondent's Exhibit 7. The letter noted that the claims consultant did not believe that any work-related injury occurred on September 9, 2018. (RX7).

The Operative Report and Records of OSF St. Francis Medical Center were entered into evidence at the time of arbitration as Respondent's Exhibit 8. The records were duplicative of those as contained in Petitioner's Exhibit 4. (RX8; PX4).

Various Witness Statements were entered into evidence at the time of arbitration as Respondent's Exhibit 9. The statement of Don Harmison noted that Petitioner approached him on Thursday, second shift early in the shift, and that they had a water box change coming up. It was noted that Petitioner stated that he "Didn't want to sound like a sissy" but that his stomach had been bothering him the last few days and was not sure why, that he was unsure about lifting the boxes and that he said the "other day" he woke up sore and took some Advil and it went away, but that it was bothering him on that date. It was noted that Mr. Harmison asked Petitioner if he wanted to go to first aid but that he said he did not want to miss any work, and that maybe he would make a doctor's appointment. It was also noted that Mr. Harmison gave Petitioner a different assignment and never heard anymore from him. (RX9).

The statement of Steve Harms noted that Petitioner was scheduled for second shift on Sunday, September 9, 2018 as a rod trimmer and that at no point during the shift did he come to him with any health concerns. The statement of Tom Gladson noted that they were trimming regular hot rings on first shift and had an extra trimmer at the "woody" and that at 11:40 a.m., and they started a trial of 77 coils that QA

wanted 20 rings off the back and the front trimmed off. It was noted that at 11:45 Mr. Gladson noticed Petitioner was pulling back 20 rings back on the back end and sending them to the woody to be taken off, that at that time he went to Petitioner and told him that they needed to trim those off at the trimmer station or were going to get backed up, and that Petitioner said that he was not going to trim 20 rings off and that it was too much to trim at the trimmer station. It was noted that Mr. Gladson told Petitioner that he would trim them and that if 20 rings was too much, then he was to make 2 cuts of 10 rings at a time which was very manageable. It was noted that Petitioner then told Mr. Gladson that if he made him trim that many rings off he would just go to medical and that Mr. Gladson told him again that he would trim the 20 rings at the trimmer station and walked away. It was noted that Rod Inspector Markell Clark did not think that was asking too much when Mr. Gladson asked him about the situation. It was also noted that Mr. Gladson did not hear back from Petitioner the rest of the day on needing to go to medical, and that he did trim the 20 rings off 10 at a time to get through the trial. (RX9).

CONCLUSIONS OF LAW

With respect to disputed issue (C), the Arbitrator finds that Petitioner has failed to prove that he sustained an accidental injury on September 9, 2018 that arose out of and in the course of his employment with Respondent.

In Illinois, it is well-settled that a party seeking an award under the Workers' Compensation Act must prove by direct and positive evidence, or by evidence from which the inference can be fairly and reasonably drawn, that the accidental injury arose out of and in the course of his employment. *Corn Products Refining Co. v. Industrial Commission*, 6 Ill. 2d 439, 442-443 (1955). The burden is upon the applicant to establish by a preponderance of competent evidence all of the essential elements of his right to compensation. *Id.* at 443.

The Arbitrator notes at the outset that there are a number of inconsistences which cause the Arbitrator to place little evidentiary weight upon Petitioner's testimony in this case. Not only did Petitioner acknowledge on cross examination that he was familiar with workers' compensation as he had had three prior claims, but he also acknowledged on cross examination that he was aware of the plant rule to report all accidental injuries or conditions immediately and to complete an incident report. Petitioner admitted, however, that at no time did he advise any of his supervisors – including Mr. Gladson, Mr. Harms and Mr. Harmison -- that he had experienced pain while performing a work activity on September 9th prior to his having filled out the incident report on September 14, 2018. In addition, Petitioner conceded that he never told any supervisor his condition was work-related and on September 14th filled out a report stating "I think" from trimming. (PX2). Petitioner also conceded on cross examination that he assumed that this was the activity that caused it, as he could not think of any other activity that would have resulted in the condition.

Furthermore, the Arbitrator finds it difficult to understand how despite experiencing pain between 8 and 9 a.m. on September 9th in a job that he himself described as strenuous, Petitioner apparently completed that shift through 2 p.m. and then worked an additional shift from 2-10 p.m. without reporting any incident to his supervisor or seeking any medical care whatsoever. The Arbitrator also notes that Petitioner told Don Harmison that his stomach had been bothering him the last few days and that he was not sure why. Mr. Harmison's statement reflects that Petitioner stated that the other day he woke up sore and took some Advil and that it went away, but that it had been bothering him on that date. (RX9). The Arbitrator believes that this would arguably have been an opportunity for Petitioner to indicate to Mr. Harmison that his condition was work-related and due to his job activities on September 9th, and yet

Petitioner failed to do so. Furthermore, Petitioner testified on redirect that that he did not tell Don Harmison that his pain started while he was lifting rods on September 9th because everyone that was working around him all week knew that something was wrong with him. This testimony, however, was not supported in any of the evidence submitted at the time of arbitration. In fact, this assertion was directly contradicted by the testimony of Tom Gladson and Steve Harms.

With respect to the medical records that were entered into evidence at the time of arbitration, the Arbitrator notes that Petitioner offered no opinion from the treating doctor that a causal relationship existed between the alleged work activity of September 9, 2018 and the hernia condition. In addition, in looking at the History and Physical dated September 19, 2018 as contained in the OSF Medical Group - Surgery records, it was noted that noted that Petitioner stated that about a week and a half prior he started having abdominal pain, that at first it felt like a cramp but then it went away, and that the pain came back and was worse. It was noted that Ibuprofen did help with the pain and that Petitioner went to the emergency room on September 14th, that a CT scan was performed, and that he was diagnosed with an umbilical hernia. The Arbitrator notes that no mention was made of either the date of September 9, 2018 nor that Petitioner's job-related lifting activities were involved in any way. (PX5).

Having reviewed and considered the entirety of the evidence in the case, the Arbitrator finds that Petitioner has failed to prove that he sustained an accidental injury on September 9, 2018 that arose out of and in the course of his employment with Respondent.

In light of the Arbitrator's findings with disputed issue (C), the Arbitrator makes no findings with respect to disputed issues (F), (J), (K), (L) and (M), as those issues are rendered moot. The claim is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BARBARA WELLER,

Petitioner,

vs. NO: 13 WC 029466

CUNETTO'S AT THE GALAXY, ILLINOIS STATE TREASURER, and INJURED WORKERS' BENEFIT FUND,

Respondents.

20IWCC0147

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent Injured Workers' Benefit Fund herein and notice given to all parties, the Commission, after considering the issues of accident, benefit rates, wage calculations, employer-employee relationship, 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 4, 2019, 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.

20IWCC0147

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 3 - 2020
KAD/mav
O: 02/04/2020
42

Kathryn A. Doerries

Maria E. Portela

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WELLER, BARBARA
Employee/Petitioner

Case# **13WC029466**

CUNETTO'S AT THE GALAXY ILLINOIS STATE TREASURER AND IWBF
Employer/Respondent

20IWCC0147

On 6/4/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.25% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

6175 UNSELL SCHATTNIK & PHILLIPS PC
BRADLEY YOUNG
3 S 6TH ST
WOOD RIVER, IL 62095

0000 CUNETTO'S AT THE GALAXY
305 E MAIN
ALHAMBRA, IL 62001

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

STATE OF ILLINOIS

COUNTY OF ST. CLAIR

☒ Injured 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

Barbara Weller,
Employee/Petitioner

Case # **13** WC **29466**

v.

Consolidated cases:

Cunetto's at the Galaxy, Illinois State Treasurer, and IWBF,
Employer/Respondent

20IWCC0147

An *Application for Adjustment 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 Harris**, Arbitrator of the Commission, in the city of **Collinsville**, on **April 30, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. ☒ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of 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 **Illinois Worker's Benefit Fund**

FINDINGS

On **February 2, 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 **$18,200**; the average weekly wage was **$350.00**.

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $66,733.42, as provided in Section 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $286.00 /week for 7-4/7 weeks, commencing 02/02/2013 through 03/27/2013, as provided in Section 8(a) of the Act.

Petitioner has proven she sustained permanent partial disability to the extent of 15% of a person as a whole (or 75 weeks) pursuant to Section 8(d)2 for the injuries sustained to her left shoulder.

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.

Robert M. Harris

Signature of Arbitrator Robert M. Harris

June 3, 2019
Date

JUN 4 - 2019

MEMORANDUM OF DECISION OF ARBITRATOR
Statement of Facts

Petitioner Barbara Boutana (formerly known as Barbara Weller and Barbara Burcham) filed an Application of Adjustment of Claims which alleged she sustained an accidental injury arising out of her course of employment at Respondent Cunetto's at the Galaxy, a bar and restaurant in Alhambra, Illinois. This claimed injury occurred on February 2, 2013. According to the application, Petitioner suffered serious and permanent injury to her left shoulder. As Respondent, Cunetto's at the Galaxy did not have Workers' Compensation insurance, the Illinois Workers' Benefit Fund was made a part to this claim. This claim seeks payment of unpaid TTD, payment the unpaid cost of reasonable and necessary medical bills, and for an award of Partial Permanent Disability.

At the time of the claimed accidental injury on February 2, 2013, Petitioner was married and Petitioner did have one (1) dependent child under the age of 18. Petitioner was 43 years old at the time of the accident.

Petitioner began working for Mike Cunetto, the owner and operator of Cunetto's at the Galaxy, at another restaurant in Greenville, Illinois around 2011 or 2012 (P. 36). In 2012, Mike Cunetto opened Cunetto's at the Galaxy in Alhambra, Illinois. Mike Cunetto hired Petitioner to be a manager at Cunetto's at the Galaxy because he liked how well she had worked from him in the Greenville restaurant in 2012 (P. 36). As part of Petitioner's duties as manager she ordered supplies, hired staff, directed staff, cleaned, tended the bar, waitressed, and handled any other house operations at Cunetto's at the Galaxy (P. 14).

On February 2, 2013, Petitioner was working at Cunetto's at the Galaxy (P. 13). Petitioner was handling tasks behind the bar (P. 17). She had taken a customer's credit card in her right hand and picked up dirty dishes with her left hand (P. 17). Petitioner was walking from the bar to the kitchen to drop of the dirty dishes and to use the credit card machine located in the back to process the customer's payment (P. 17). The kitchen is separated from the rest of the front of the bar area by swing saloon-style doors. As Petitioner, walked through the doors, her feet hit a wet and slippery patch of floor and she slipped (P. 17). Mike Cunetto had cooked pasta and had used the sink to pour out the water from the pasta (P. 17-18). Some of the water fell to the floor where it remained until Petitioner slipped on it. Petitioner had slipped on a patch of water of the kitchen

floor just past the saloon-style doors (P. 17-18). Mike Cunetto was at the scene and witnessed the accident (P. 21). He was aware Petitioner had been injured and called the ambulance to come to the scene to transport Petitioner to the hospital (P. 21).

When Petitioner fell back, she hit her left shoulder and felt immediate pain (P. 20). Petitioner's left shoulder began to immediately swell and "bloom" (P. 30). Mike Cunetto called 9-1-1 and an ambulance arrived and transported Petitioner to St. Joseph's Hospital in Highland, Illinois. (P. 21; Petitioner's Exhibit 1) At St. Joseph's, Petitioner received X-rays of her left shoulder (Petitioner's Exhibit 2). The X-rays showed an impacted fracture to the left humeral neck with extension into the humeral head in Petitioner's left shoulder. The on-call orthopedic doctor recommended Petitioner be sent for immediate orthopedic consultation. Petitioner was transferred by ambulance (Petitioner's Exhibit 3) to the emergency department at Saint Louis University Hospital (SLU). At SLU, Petitioner received a CT scan of her left shoulder. (Petitioner's Exhibit 4). The scan found a four-part proximal humeral fracture in Petitioner's left shoulder involving the surgical neck, greater tuberosity and lesser tuberosity. Petitioner required surgery to repair and stabilize the fractured left shoulder. Petitioner was taken into surgery at SLU. A number of surgical screws and a plate were implanted into Petitioner's left shoulder to repair the fracture of the left proximal humerus. Petitioner was admitted to the hospital and was discharged on February 6, 2013.

On February 27, 2013, Petitioner followed up with Dr. Boudreau of St. Louis University Department of Orthopaedics (Petitioner's Exhibit 5). Petitioner's humeral head was aligned with the glenoid. The hardware implanted during the surgery was also intact. Petitioner was doing well and pain was decreased. She was given exercises to complete daily. Petitioner was not bear weight, do overhead work or lift with the left shoulder until released by an orthopedic.

On August 21, 2013, Petitioner further followed up with Dr. Bourdreau. He found that Petitioner's hardware and osseous alignment had not changed. Petitioner had signs of healing (Petitioner's Exhibit 6).

On the last visit on October 9, 2013, Petitioner was released to return to full weightbearing and was cleared to resume her weightlifting training (Petitioner's Exhibit 6). She was unable to attend the recommended physical therapy due to a lack of workers' compensation insurance coverage (Petitioners Exhibit 6).

Petitioner could not afford any further medical treatment or physical therapy (P. 28). The bills for Petitioner's medical treatment are still unpaid. Petitioner currently has $66,733.42 in unpaid medical (Petitioner's Exhibits 7 – 16).

Petitioner was unable to work due to her shoulder injury from February 2, 2013 through March 27, 2013 (P. 23 & 32). Petitioner returned to work quickly due to the need for income (P. 24). Petitioner did not receive any pay for the time she was injured and there was no worker's compensation insurance coverage (P. 24). Petitioner had to return to work in order to earn money. She returned to work in the restaurant business. She was still recovering from her shoulder surgery. She worked one-handed doing as much as she could with her right hand will her left arm and shoulder were still in a sling (P. 33).

Petitioner testified she continues to have issues related to her shoulder injury of February 2013. The screws and plate that were implanted in Petitioner's left shoulder are permanent and remain implanted (Petitioner's Exhibit 4). Petitioner still feels her left shoulder is weaker than her right shoulder (P. 26). Petitioner still feels pain in the shoulder when reaching up and when the weather is rainy (P. 26). She was not able to restart her exercise routine (P. 27). The shoulder injury has also affected Petitioner's ability to work. Petitioner has had to turn down jobs that involve lifting 50 to 70 pounds repetitiously (P. 27).

Petitioner testified, on February 2, 2013, she was paid an hourly wage of $10.00 and worked 35 hours per week (P. 15). Petitioner's average weekly wage were therefore approximately $350.00 (P. 15). Petitioner attempted to obtain IRS tax transcripts of her tax returns for 2013. However, the transcripts were not available due to the length of time that had passed (Petitioner's Exhibit 18). Petitioner was able to obtain copies of a small number of checks issued by Cunetto's at the Galaxy to Petitioner (Petitioner's Exhibit 19). One check dated 12-19-12 shows a payment of $300 for a $150 Christmas Bonus and $150 cash advance to Petitioner. After Petitioner's injury on Feb 2, 2013, there were three checks of $300 made payable to Petitioner's landlord to directly cover Petitioner's rent (Petitioner's Exhibit 19).

An investigation into the status of Cunetto's at the Galaxy's worker's compensation insurance. A search of the online insurance database revealed no result for Cunetto's at the Galaxy or Mike Cunetto (Petitioner's Exhibit 20). An NCCI search was completed and the investigator has provided an affidavit that Cunetto's at the Galaxy and Mike Cunetto did not

have worker's compensation insurance at the time of the accident (Petitioner's Exhibit 21). As such, the Illinois Workers' Benefit Fund has been made a Respondent in this matter.

CONCLUSIONS OF LAW

The Arbitrator notes there is no dispute Petitioner sustained an accidental injury that arose out of and in the course of employment on February 2, 2013. Further, Petitioner testified she slipped and was injured on February 2, 2013. Petitioner's medical records also consistently show Petitioner suffered a slip and fall injury on February 2, 2013.

In regard to contested issue (A): Was Respondent operating under and subject to the Illinois Worker's of Occupational Disease Act? The Arbitrator finds and concludes as follows:

The Arbitrator finds and concludes Respondent was operating under and subject to the Illinois Worker's Compensation or Occupational Diseases Act. In support of this conclusion the Arbitrator notes the following:

Petitioner testified she was employed by Cunetto's at the Galaxy in Alhambra, Illinois, on February 2, 2013 as a manager. Respondent Cunetto's at the Galaxy was operating a bar and restaurant business in Illinois. As such, Respondent Cunetto's at the Galaxy was operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act.

In regard to contested issue (B): Was there an employee-employer relationship? The Arbitrator finds and concludes as follows:

There was an employee-employer relationship between Petitioner and Respondent on February 3, 2013. In support of this conclusion the Arbitrator notes the following:

Petitioner testified she was hired as a manager of the Cunetto's at the Galaxy restaurant in 2012 (P. 15). Petitioner testified she was working as a manager for Cunetto's at the Galaxy on February 3, 2013, when Petitioner was injured (P. 13). Petitioner also provided one check made out to her for a Christmas bonus and cash advance from Cuntetto's at the Galaxy (Petitioner's Exhibit 19).

Regarding contested issue (E): Was timely notice of the accident given to Respondent? Tthe Arbitrator makes the following conclusions of law:

The Arbitrator finds Respondent was given timely notice of the accident. In support of this conclusion the Arbitrator notes the following:

Petitioner testified that Respondent Cunetto's at the Galaxy is owned and operated by Mike Cunetto. Petitioner further testified Mike Cunetto spilled water he had used to cook pasta and that Petitioner slipped on that water causing her injury. Petitioner further testified that Mike Cunetto witnesses Petitioner's slip and fall and help attend to her injuries by calling 9-1-1 to have an ambulance respond to care for Petitioner's injuries and take her to the hospital for treatment of her injuries. As such, Respondent was given timely notice that Petitioner had been injured in an accident at work.

Regarding contested issue (F): Is Petitioner's current condition of ill-being causally related to the injury? The Arbitrator finds and concludes as follows:

The Arbitrator finds and concludes that Petitioner's current condition of ill-being is causally related to the accident of February 2, 2013. In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony and medical records indicate Petitioner was injured on February 2, 2013. Petitioner's medical records indicate Petitioner received medical treatment due to injuries sustained in a slip and fall accident while at work on February 2, 2013, including left shoulder surgery involving the implantation of several metal screws and a metal plate to stabilize a fractured humerus suffered on February 2, 2013. Petitioner testified that her left shoulder still has issues including pain and weakness due to the surgery.

Regarding contested issue (G): What were Petitioner's earnings? The Arbitrator finds and concludes as follwos:

The Arbitrator finds that Petitioner's average weekly wage at the time of February 2, 2013, was a $350.00. In support of this conclusion the Arbitrator notes the following:

Petitioner testified that she was paid a wage of $10.00 per hour and that she worked roughly 35 hours per week. There was no evidence to challenge, let alone rebut, Petitioner's credible testimony.

As to the contested issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services? The Arbitrator finds and concludes as follows:

The Arbitrator finds and concludes all medical treatment provided to Petitioner was reasonable and necessary and Respondent is liable for payment of the medical bills incurred herewith. In support of this conclusion the Arbitrator notes the following:

Petitioner testified she received treatment at two hospitals to treat her injured shoulder following her accident. Petitioner testified she felt immediate pain in her left shoulder following her slip and fall. Petitioner testified she was taken to a local hospital in an ambulance. Petitioner testified she received x-rays and was told she shattered her shoulder. Petitioner was then taken to Saint Louis University Hospital for a consultation and Petitioner testified she received a surgery to repair her fractured shoulder.

Petitioner's medical records indicate Petitioner received a fracture to her proximal humerus at Petitioner's left shoulder. The records indicate she needed an immediate orthopedic consultation. This consultation was performed at the Saint Louis University Hospital. There it was determined due to the location and severity of the fracture to Petitioner's proximal humerus that surgical intervention was necessary to stabilize the fracture and protect the shoulder joint. Petitioner then had two follow-up visit's that recorded her progress in recovering from Petitioner's surgery. These records indicate all the surgery and subsequent follow up treatment were all necessary to treat Petitioner's fracture suffered as part of a slip and fall at work on February 2, 2013.

The Arbitrator notes there was no evidence offered to challenge, let alone rebut, this finding and conclusion.

As to contested issue (K): What temporary benefits are in dispute? The Arbitrator finds and concludes as follows:

The Arbitrator finds and concludes Petitioner is entitled to temporary total disability benefits for 7-4/7 weeks commencing on February 2, 2013 to March 27, 2013 with no credit being given as no benefits have been paid. In support of this conclusion the Arbitrator notes the following:

Petitioner's medical records indicate that following her injury and surgery on February 2, 2013, she was not to bear weight with her left shoulder. Petitioner testified she was off of work due to the surgery for about two months and agreed 7-4/7 weeks sounded like the correct amount of time. Petitioner testified that she returned to work March 27, 2013 and worked with her arm in a sling as Petitioner need to earn an income.

The Arbitrator notes there was no evidence offered to challenge, let alone rebut, this finding and conclusion.

As to contested issue (L) What is the Nature and Extent of the Injury, the Arbitrator makes the following findings and conclusions of law:

Petitioner has proven she sustained partial permanent disability to the extent of 15% of a person as a whole (or 75 weeks) pursuant to Section 8(d)2 for the injuries sustained to her left shoulder.

In support of this conclusion the Arbitrator notes the following:

In determining the level of permanent partial disability, the Commission shall base its determination on the following factors pursuant to Section 8.1(b): (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability; corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order." 820 ILCS 305/8.1b(b).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no AMA 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 Restaurant Manager 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, however, Petitioner testified she is unable to do repetitive heavy lifting and has pain issue when reaching up. Because of these ongoing issues, Petitioner's ability to perform work activities will be impacted, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 43 years old at the time of the accident. Because of the likelihood that Petitioner will continue to work for 20 to 30 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 Petitioner testified she has turned down job offers due to limits on her ability to lift heavy objects. Petitioner also has pain when reaching up. While no specific evidence was offered regarding future earnings capacity, because of the nature of Petitioner's injury and the fact she has bene rejected for jobs, the Arbitrator draws the inference there is a potential limitation and diminution on future earnings; the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner's medical records evidence Petitioner sustained fracture to the left humerus requiring an ORIF. She underwent left shoulder surgery involving the permanent implantation of screws and a plate into Petitioner's left shoulder and humerus. The hardware was permanently implanted into Petitioner's humerus. Petitioner testified her left arm is still weaker that her right arm, she suffers occasional pain in her left arm, and had to forego job opportunities due to her not being able to lift weights of 50 to 70 pounds repetitiously (P. 26-27). Because of the effects of implantation of permanent hardware into Petitioner's left shoulder and humerus, the Arbitrator therefore gives *greater* weight to this factor.

Based on the five factors enumerated above, the Arbitrator finds that Petitioner suffered an injury resulting in the 15% loss (75 weeks) of the person as a whole pursuant to Section 8(d)2 of the Act for injuries sustained to the left shoulder.

As to contested issue (O): Injured Workers' Benefit Fund, the Arbitrator finds and concludes as follows:

The evidence shows Respondent Employer Cunetto's at the Galaxy did not have worker's compensation insurance coverage for Petitioner's injury. There is no evidence offered to the contrary. Therefore, this award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act.

Robert M. Harris

Robert M. Harris, Arbitrator
Dated: June 3, 2019

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

NOLBERTA MORALES,

Petitioner,

vs. NO: 17 WC 009120

FILTRAN, LLC,

Respondent.

20IWCC0148

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 accident, 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. 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 Com.*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 5, 2018 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 $7,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

MAR 3 - 2020
DATED:
KAD/mav
O: 02/25/2020
42

Kathryn A. Doerries

Maria E. Portela

Marc Parker

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

MORALES, NOLBERTA
Employee/Petitioner

Case# **17WC009120**

FILTRAN LLC
Employer/Respondent

20IWCC0148

On 11/5/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1747 SEIDMAN MARGULIS & FAIRMAN LLP
NANCY J SHEPARD
20 S CLARK ST SUITE 700
CHICAGO, IL 60603

3998 ROSARIO CIBELLA
2561 DIVISION ST
SUITE 103
JOLIET, IL 60435

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)

Nolberta Morales
Employee/Petitioner

v.

Filtran Inc.
Employer/Respondent

Case # 17 WC 9120

Consolidated cases: _____

20IWCC0148

An *Application for Adjustment 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 **Sept. 11, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **03-07-17**, 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*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $**30,155.09**; the average weekly wage was $**534.03**.

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

Respondent shall be given a credit of $**4,017.00** for TTD, $ **0** for TPD, $ **0** for maintenance, and $ **0** for other benefits, for a total credit of $ **4,017.00** .

ORDER

The parties deferred the issue of medical bills so the Arbitrator makes no findings related to medical bills.

Respondent shall pay Petitioner temporary total disability benefits of $356.02/week for 21 4/7 weeks, commencing 03-09-17 to 06-03-17 and 06-28-17 to 08-28-17, as provided in Section 8(b) of the Act.

The Arbitrator awards prospective medical in the right shoulder arthroscopic surgery as recommended by Dr. Nam.

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

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

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

Signature of Arbitrator

11-04-18
Date

ICArbDec19(b)

NOV 5 - 2018

Nolberta Morales v. Filtran, Inc.
17 WC 9120

STATEMENT OF FACTS

Ms. Nolberta Morales, Petitioner, was employed with Filtran, Inc, Respondent, on March 7, 2017. She testified that she started working for Respondent on December 20, 2013. (T. 8). Petitioner testified that Respondent makes car filters. She was employed as a machine operator on an assembly line. (T. 10).

Petitioner testified that when she started working for Respondent she worked on the first shift, which is 7:00am to 3:00 pm. She was switched to third shift three months after starting her job, which is 11:00 pm to 7:00 am. (T. 10-11). Petitioner testified that she gets two breaks during her shift, one for ten minutes and a lunch break for twenty, for a total of thirty minutes. Petitioner testified that she would on occasion work overtime. Petitioner testified that she was working on third shift on the date of accident in question, March 7, 2017. (T. 28). She remained on third shift through her alleged accident and initially returned to third shift when released but then was switched to first shift again. (T. 49). Petitioner further testified that she currently works the first shift. (T. 28).

Petitioner testified that she has been assigned to one machine, number 812, when she worked on third shift. (T. 61). Machine 812 has four different positions. Petitioner identified these as the "filter" position, the "magnet" position, the "packing" position and "material handling." Petitioner testified that the material handling position was the most difficult. (T. 28-29). However, she testified she only worked that position when she was moved to first shift. The most difficult position when working third shift was the "filter" position. (T. 31). Petitioner testified that she was on the filter position more often than the others while working on third shift. (T. 14-15). On third shift, she would work on the filter

position on average four hours out of her shift. (T. 15). She testified that she would rotate between two positions: the filter and the magnet position on the third shift. She testified that she rotated every two hours for a total of four hours at each position. (T. 62).

The filter position involved "assembl[ing] the filter". (T. 14). Petitioner testified that in this position she would grab a plastic piece from a holder on her right-hand side above her shoulder level to place on top of the filter. (T.18-19). The plastic pieces are approximately 10 2/3 inches long and shaped like a kidney, although bigger than a kidney. The piece was less than a pound. (T. 20). Petitioner testified that she would grab one piece at a time and that they do sometimes get stuck at the sensor so she has to reach higher up to grab them. (T. 21-22). Petitioner testified that she would have to grab approximately five pieces per minute and that the third shift is faster than the first shift. (T. 22).

Petitioner submitted into evidence a photograph of her performing this activity from directly behind her. (Px. 8). This photograph depicts Petitioner reaching up with her right arm to reach the pieces. Her arm is outstretched and above shoulder level. Petitioner was standing on a platform in the picture. (T 56, Px. 8). Petitioner testified that the platform feet are adjustable by "inch or half an inch." (T. 57). She testified that she had the platform set to the height she uses while working in the photograph. (T. 103; Px. 8). She further testified that it was not possible to make it higher because of safety concerns as the feet are not stable higher. (T. 105-106).

Petitioner testified on cross examination that a friend named Alicia took this picture. Petitioner testified that it was taken on first shift because Alicia worked first shift but she did not remember what month the pictures were taken, (T. 53), but knew that it was after November of 2017 because that is when she was moved back to first shift. (T. 68).

The material handling position, which was the most difficult for Petitioner, required that Petitioner lift a skid lid approximately four to six times per shift. (T. 30). This skid lid weighed more than fifty pounds and she would have to lift it up to her nose. (T. 30).

Petitioner testified that on March 8, 2017 she went to the emergency room at Advocate Lutheran General Hospital. (T. 9, Px. 2). She testified that she went to the hospital because her right arm was hurting her. (T. 9). The hospital medical records indicate that Petitioner had complaints of right shoulder pain and swelling for the past two days. The history indicates that she works in a factory and was constantly raising her right arm. The doctor indicated that he felt it was chronic overuse injury exacerbated recently. He prescribed Naproxen and indicated an MRI might be necessary, if pain persisted. (Px.2). Petitioner testified that she reported her pain to Jeff, her supervisor with Respondent. (T. 9).

Petitioner testified that she followed up with her primary care physician at Advocate Medical Group in Logan Square. Petitioner gave a history of working overtime at the same machine, which required repetitive motions with her right arm. She then started having pain at the end of her shift. She gave no history of right shoulder pain in the past. Her doctor referred her to an orthopedic physician and to physical therapy. She was taken off work through March 19, 2017. She followed up with Advocate Medical Group on March 16, 2017. She had continued complaints of right shoulder pain. She was again referred to an orthopedic physician and an MRI was recommended. She was kept off work through April 2, 2017. (Px. 3).

Petitioner underwent the MRI on March 29, 2017. It demonstrated severe supraspinatus tendinopathy with 6x7 mm intrasubstance tear of the distal supraspinatus

tendon. (Px. 4). She began physical therapy at Athletico on March 31, 2017. (Px. 6). Petitioner followed up at Advocate Medical Group on April 3, 2017 with continued complaints of pain in her right shoulder. She was continued in physical therapy and kept off work through April 27, 2017. (Px. 3).

Petitioner saw Dr. Kevin Nam at Chicago Orthopaedics and Sports Medicine on April 6, 2017. Dr. Nam documents a history of right shoulder pain from loading plastic from a machine. He documented that she had no prior problems with her shoulder but that her job does require a lot of overhead movements quickly. He diagnosed a work injury with impingement syndrome and some AC joint pain. He kept her off work and recommended continued physical therapy. (Px. 5). Petitioner continued in physical therapy.

Petitioner followed up with Dr. Nam on June 8, 2017. She had continued complaints of pain with positive impingement signs on examination. Dr. Nam recommended and performed a cortisone injection. He also recommended continued physical therapy. He put Petitioner on light duty of no lifting greater than five pounds below shoulder level. (Px. 5). Petitioner testified that she did return to work with restrictions at that time.

Petitioner testified that she was involved in a motor vehicle accident on June 10, 2017. Petitioner testified that she injured her right knee and her stomach from the blow to the steering wheel. Petitioner testified that she did not suffer an injury to her right shoulder in this accident. (T. 38).

Petitioner followed up with Dr. Nam on June 19, 2017. She was still having pain and he recommended a second cortisone injection, which he performed that day. He recommended continued physical therapy and kept her on the same work restrictions.

Petitioner contacted Dr. Nam's office on June 28, 2017 to advise that her employer was not following the restrictions so Dr. Nam took her off work altogether. (Px. 5).

Petitioner returned to Dr. Nam on July 17, 2017. He recommended continued physical therapy and kept her off work. She continued physical therapy and followed up with Dr. Nam on July 31, 2017. She continued to have pain and he recommended a third cortisone injection. He advised that if she could not live with the pain than arthroscopy would be the last resort. He recommended continued physical therapy and put her back on work restrictions. (Px. 5).

Petitioner followed up with Dr. Nam on August 28, 2017. At that time, she was still having pain but was feeling pretty good and requested to go back to work full duty. Dr. Nam released her to return to work full duty at that time. Petitioner finished her physical therapy and returned to work. (Px. 5, Px. 6).

Petitioner returned to Dr. Nam on December 11, 2017. She testified that that she returned because the pain was not going away and she wanted the surgery he discussed. (T. 42). Dr. Nam documented that she had increase in her right shoulder pain after returning to work full duty for one month with no new injury. He recommended the surgery as she could not live the pain. (Px. 5).

Petitioner testified that initially when she returned to work she was still on third shift but not assigned to Machine 812. She was placed in a similar position on a different machine. She testified that this machine was much slower. (T. 43-44). Petitioner testified that she moved to first shift and on first shift she was back to working on Machine 812 for three days per week. She advised that she rotated between the four positions when on first shift. (T. 49; T. 63).

Petitioner testified that she had recently had a hand surgery. (T. 45). She testified that she felt that the hand was related to the shoulder injury because her arm was weak (T. 46) but she also advised that this was not why "we were here today." (T. 8).

Petitioner testified that prior to the hand surgery was she was working full duty. (T. 48). Petitioner testified that her shoulder has not gotten any better and she continues to have pain. She last followed up with Dr. Nam on March 19, 2018 and he continued to recommend surgery. She has not followed up since then because she is waiting for the surgery to be approved. (T. 50).

Petitioner testified on cross examination that she has a husband and two sons that she lives with. (T. 64-65). She walks in the park as a hobby. She will cook lunch for her family and will use the overhead cabinets on occasion. (T. 66). She does have a step stool if necessary. (T. 70).

Respondent submitted into evidence a surveillance video dated March 7, 2017 at 4:58 am. The video documents four minutes of time. It appears to document the entire Machine 812 with all four positions. Petitioner is in the video and appears to start at the filter position. She is facing forward with the machine in front of her, blocking portions of her body and activities. She is working for approximately one minute and then moves the platform she is standing on and another coworker takes her place at the filter position standing on the same platform without adjusting it. This coworker is clearly taller than Petitioner. For the remainder of the video, Petitioner works at the other position with her back to the camera. The video can be zoomed in and Petitioner can clearly be shown reaching to grab the plastic pieces but it is unclear as to the exact angle of the reach. The camera is clearly positioned well above the machine looking down at an angle. (Rx. 4).

Respondent's witness, Ms. Shelly DiFonzo, testified that the surveillance cameras were on the ceiling but she did not know the height of the ceiling. (T. 87). The video shows that the ceiling appears to be quite high as there are four shelves stacked with what appears to be boxes and stairs leading to what appears to be an office behind Machine 812 and the ceiling is higher than the office. (Rx. 4).

Ms. DiFonzo testified that Petitioner would not work only on Machine 812 and would have rotated to several different machines and would be assigned to a different machine every day. (T. 80). She testified that the positions at all the machines are similar but different. She testified that there were no machines at all that Petitioner could work on that would require her to work above shoulder height. (T. 81). She testified that the most she would work in any position was two hours. Ms. DiFonzo testified that her shift was 6:30 am until 5:00 pm. She, therefore, only worked during thirty minutes of the third shift. Ms. DiFonzo is not in charge of the schedule or machine assignments. She is not in charge of employee position rotations or how often an employee would rotate. Ms. DiFonzo testified that there was a report called the OEA report that would document the exact machine assignments for each employee but she did not bring a copy of it with her and, therefore, could not be certain what machine Petitioner actually worked on. (T. 90). Ms. DiFonzo testified that she could not "say, specifically" whether Petitioner rotated every two hours because "I'm not out there on third shift." (T. 90). She testified that it was possible that an employee's request not to be rotated would be accommodated. (T. 91).

Ms. DiFonzo testified that there are platforms for employees to stand on and that they can adjust four to six inches. (T. 84). The lowest setting was four inches and the highest setting was six inches with a difference of two inches. (T. 92). These platforms were

purchased in 2015 and that prior to 2015 there were no platforms to stand on. (T. 91). Petitioner indicated during testimony using her fingers that it was adjustable by about four inches. (T. 103-104)

Ms. DiFonzo testified that the speed of the machine never changes due to "lasers and sensors that are timed." (T. 96). She, then, testified that the employee utilizes a button to control "how many parts go through the machine at a time." (T. 98). She further testified that the more parts Filtran produces the more profitable it would be. (T. 99). Petitioner testified that she produced 3,000 pieces on two occasions during her third shift. On average, it was between 2,500 and 2,800 per shift. (T. 108). Petitioner testified that she did not receive a bonus for producing more but the supervisor would receive one for the quantities being done. (T. 109).

Dr. Ellis Nam testified via an evidence deposition at the request of Petitioner. He testified that he had come to treat Petitioner and that her first visit with him was on April 6, 2017. She had given a history of pain developing when she was lowering plastic in a machine on March 7, 2017. She advised Dr. Nam that she had not had any prior shoulder issues. He diagnosed her with impingement syndrome and AC joint pain. He advised at based on her examination and history he felt that her condition was related to her work activities. (Px. 7, pg. 8). He testified that he continued to treat her and made treatment recommendations as documented in his records. (Px 7, pg. 8-12, Px. 5). He advised that he had performed three cortisone injections and that she had improved slightly with those injections. (Px. 7, pg. 11). He released her to return to work full duty on August 28, 2017 per her request. He testified that he advised her to return to see him if she has any issues or problems. (Px. 7, pg. 12).

Dr. Nam testified that she did return to see him on December 11, 2017. He testified that her pain complaints had returned and that they were basically the same complaints she had had previously. (Px. 7, pg. 12). Her diagnosis had not changed and due the recurrent nature of the symptoms he recommended arthroscopic surgery. (Px 7, pg. 13). Dr. Nam last saw Petitioner on March 19, 2018. He testified that her symptoms had not changed and he would continue to recommend surgery.

Dr. Nam testified that he did draft a narrative report at Petitioner's request dated February 20, 2018. (Px. 7, pg. 6). The report documents that Dr. Nam felt the job activities as described by Petitioner are a well-known causative factor of impingement syndrome and that he felt that her condition is related to her work activities. (Px. 7, Dep Exh. 2).

Dr. Nam did watch the video admitted as Respondent's Exhibit 4. He testified that the video "didn't really look like she was really reaching overhead." but that "it was hard to really qualify exactly how she was reaching from that angle." (Px. 7, pg. 14). Dr. Nam also reviewed the picture admitted as Petitioner's Exhibit 8. He felt "that's consistent with one developing her condition." (px. 7, pg. 14-15). He testified that doing that activity numerous times where she is "raising her arm up" and "reaching forward ... [which] puts more stress on the shoulder joint" is a reasonable way to develop impingement syndrome. He testified that when he indicates overhead he means "at shoulder level or higher." (Px 7, pg. 16). He testified that it was his opinion that "her need for surgery is a result of her right shoulder condition that she developed from her work activities." (Px. 7, pg. 17).

On cross-examination, Dr. Nam testified that impingement syndrome is on the spectrum of rotator cuff problems and that rotator cuff problems can be caused as a person ages. (Px. 7, pg. 22-23). He then testified that "usually impingement syndrome is going to

occur with somebody that does overhead activities. So if someone is pretty sedentary, they don't reach overhead on a frequent basis. I would find it somewhat unusual for them to develop impingement syndrome." (Px. 7, pg. 23-24). Dr. Nam testified that "it's possible" that Petitioner could develop this whether or not she had this job but clarified that "I do remember what she looks like, and ... she doesn't seem like a very otherwise active individual who goes around playing volleyball and activities such as that." (Px. 7, pg. 24-25). He advised that he thinks "her job activities is [sic] more likely to have caused that." (Px. 7, pg. 27).

Petitioner saw Dr. Michael Cohen on May 11, 2017 at the request of Respondent pursuant to Section 12 of the Act. (Rx. 2). Petitioner testified that she told Dr. Cohen about her job duties. Following this visit, she continued in physical therapy. (T. 36). Petitioner saw Dr. Cohen again on September 6, 2017 for a second IME. (Rx. 3).

Dr. Michael Cohen testified via evidence deposition on June 27, 2018 at the Respondent's request. Dr. Cohen testified that he conducted an independent medical examination on May 11, 2017. He indicated that he drafted a report following that examination. He testified that his report documents all of his findings and the "summary of the things [he] found most relevant." (Rx. 1, pg. 8). He indicated that Petitioner gave a history of pain in her right shoulder and that she attributed that to reaching for parts with an outstretched arm at forty-five degrees above shoulder height. (Rx. 1 pg. 9). He testified that Petitioner demonstrated for him exactly what position her arm was in to work the machine for this IME. (Rx 1, pg. 20). Dr. Cohen diagnosed Petitioner with impingement syndrome. He felt based on the Petitioner's description of what she did there was causal relationship between this condition and her employment activities. He felt that she could

return to work with a ten pound lifting limitation and no use of the right arm at or above shoulder height.

Dr. Cohen testified that he saw Petitioner for a second IME on September 6, 2017. (Rx. 1, pg. 13). Dr. Cohen testified, that at the time of the exam, he had reviewed a video provided by the Respondent. He testified that he did not see any significant overhead activity in the video. (Rx. 1, pg. 14). He felt as of September 6, 2017 that Petitioner had a normal exam and could return to work full duty. Dr. Cohen had not seen her since September 6, 2017. (Rx., 1, pg. 19).

Dr. Cohen testified that impingement syndrome can be caused idiopathically, every day activities such as cleaning windows, painting, or cleaning upper cabinets or actual trauma. (Rx. 1, pg. 12). Dr. Cohen testified that if zero degrees is your arm straight at your side and 180 is your arm straight up in the air, impingement syndrome could be caused by reaching out at 90 degrees or above. (Rx 1, pg. 26). Dr. Cohen watched the video again at the deposition at Respondent's request. He testified that watching the video again did not change his mind . He felt that the angle of the camera from the ceiling could alter the measurement of her arm angle of one to two degrees but not for the general measurement that he was looking at. He testified that he felt the video depicted Petitioner's arm to be 60 to 80 degrees, which he felt was "pretty unlikely" to aggravate impingement syndrome. (Rx. 1 pg. 38).

Dr. Cohen testified that he reviewed the picture that was admitted as Petitioner Deposition Ex. 8 and felt that it was not consistent with the video. (Rx 1, pg. 17). He testified that "if" the angle of the camera was "really steep" it could alter his opinion of her

arm height. (Rx. ?, pg. 24). He indicated that if the picture was an accurate depiction of her job duties that it could cause impingement symptoms. (Rx. 1, pg. 28)

CONCLUSIONS OF LAW

The Arbitrator finds that the Petitioner testified credibly during her hearing regarding her injury, work activities, treatment, and current condition.

In regards to (C) and (F), "Did an Accident occur that arose out of and in the course of Petitioner's employment by Respondent?" and "Is Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator finds:

The Arbitrator finds that Petitioner did suffer a repetitive injury to her right shoulder as a result of her work activities for Respondent and this injury led to the need for treatment including cortisone injections, physical therapy and the recommendation of future surgery.

The Arbitrator notes that at its core the issue in this case is whether Petitioner performed repetitive "overhead" work. Both experts, Dr. Nam and Dr. Cohen, testified that if Petitioner performed overhead work as she described it that would be a likely cause of her impingement syndrome and that overhead activities is a common cause of impingement symptoms. Dr. Nam also testified that reaching out increases the pressure on the shoulder joint. The Arbitrator notes that overhead work as used here is anything at or higher than shoulder level.

The Arbitrator further notes that the Petitioner has been consistent in all of her histories to each provider regarding the pain in her right shoulder and its development. She has been consistent in all of descriptions of her work to each of the physicians and providers she saw. This history of her job duties was also consistent with her testimony at trial.

The evidence that Respondent relies on to argue that Petitioner's condition is not related is the video admitted as Respondent's Exhibit 4. This video shows Petitioner working for only one minute at the filter position in question. Both doctors acknowledged that it did not appear to be remarkably overhead activity. However, Dr. Nam acknowledged that the angle of the camera made it hard to tell exactly and Dr. Cohen acknowledged that the angle of the camera could affect the appearance of the angle of Petitioner's arm but opined that he did not think it did in this case even though he was not aware of the angle of the camera. The Arbitrator finds that the video is deceptive in its appearance as it is set up far away from the Petitioner, it is high up on the ceiling and it is hard to tell the exact angle of the Petitioner's arm. It is impossible to determine the extent of reach that Petitioner due to the machine being in front of her and blocking some of her activities. These facts are not changed by the fact that the video can be zoomed in as that does not change the angle of the camera.

The Arbitrator finds that the picture admitted as Petitioner's Exhibit 8 shows a better angle to assess Petitioner's arm. He acknowledges that it is a still photograph and not a moving video but feels that the set up of the machine taken with the Petitioner's height show that the possibility of Petitioner not reaching at the very least shoulder height would be extremely small. The repetitiveness of the activity is really in question.

Much was made of the platform that Petitioner was standing on but Petitioner credibly testified that the platform as shown in Petitioner Exhibit 8 was the height that she used it while working and there was no evidence that it was not. Further, while the platform was adjustable there was no evidence presented that Petitioner did not have it adjusted to the highest setting possible while working.

Dr. Nam opined that he would not expect to find impingement syndrome in someone Petitioner's age without some repetitive overhead activity. Dr. Cohen indicated that everyday activity such as painting or window cleaning could cause it. However, there is no evidence presented in any way that indicates Petitioner performed any type of consistent overhead work outside of her work activities.

Therefore, the Arbitrator finds that Petitioner's condition as it relates to her right shoulder is causally related to her repetitive job activities and she did suffer an injury that arose out of and in the course of her employment. For clarification purposes, Petitioner testified that she had right hand surgery and that it was related to her shoulder being weak but not the subject of the trial. The Arbitrator does not find any evidence in the records that Petitioner right hand surgery has any relationship with the topic of the trial and makes no award or findings as it relates to the right hand.

In regards to (K), "What temporary benefits are in dispute? TTD?", the Arbitrator finds:

The Arbitrator finds that Petitioner is entitled to TTD benefits from March 9, 2017 through June 3, 2017 and June 28, 2017 through August 28, 2017 for a total of 21 4/7 weeks. These periods of time off are documented in the record as being related to her right shoulder. The Respondent would get a credit for $4017.94 in TTD payments previously made.

In regards to (K), "Is Petitioner entitled to any prospective medical care?", the Arbitrator finds:

The Arbitrator finds that as there is a causal relationship between Petitioner's right shoulder condition and her work activities that the surgery as recommended by Dr. Nam is

necessary, reasonable and related. Therefore, the Arbitrator awards the prospective medical sought by Petitioner.

STATE OF ILLINOIS)
) SS.
COUNTY OF DU PAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Comella,

Petitioner,

20IWCC0149

vs.

NO: 17 WC 035505

Speedway, LLC,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of the 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 6, 2019 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.

20IWCC0149

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $8,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED:
O022520 MAR 4 - 2020
MEP/ypv
049

Maria E. Portela

Kathryn Doerries

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

COMELLA, MICHAEL
Employee/Petitioner

Case# **17WC035505**

SPEEDWAY LLC
Employer/Respondent

20IWCC0149

On 8/6/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.95% 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:

0222 GOLDBERG WEISMAN & CAIRO LTD
JOEL J BLOCK
ONE E WACKER DR SUITE 3800
CHICAGO, IL 60601

2461 NYHAN BAMBRICK KINZIE & LOWRY
MARK MATRANGA
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

20IWCC0149

STATE OF ILLINOIS)
)SS.
COUNTY OF DU PAGE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

Michael Comella
Employee/Petitioner
v.
Speedway, LLC
Employer/Respondent

Case # **17** WC **35505**

An *Application for Adjustment 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 **Wheaton**, on **February 19, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of 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. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. **X** What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **November 3, 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 **$42,206.14**; the average weekly wage was **$794.45**

On the date of accident, Petitioner was **27** years of age, ***married*** with **0** dependent children.

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

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

To date, Respondent has paid **$5,726.17** 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 **$8,095.77** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$8,095.77**

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

ORDER

Medical benefits

Respondent has agreed to pay medical bills totaling **$6,769.63** subject to the fee schedule and pursuant to §8 and §8.2 of the Act, with credit to be given for payments already made.

Temporary Disability

Respondent has paid **TTD** from **November 4, 2016 to January 29, 2017** and **May 16, 2017 to June 4, 2017**, which is **15-2/7 weeks** at **$529.33 per week.**

Permanent Disability

Respondent shall pay petitioner the sum of **$476.67 per week** for a period of **15.05 weeks,** under the provisions of **§ 8 (e) 2** of the Act, as the injuries sustained caused **35% loss of use of petitioner's right index finger**

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

July 29, 2019

Date

20IWCC0149

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Comella	)
Petitioner,	)
vs.	) **No. 17 WC 35505**
Speedway, LLC	)
Respondent.	)

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in Wheaton on February 19, 2019. The parties agree that on November 3, 2016, 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. They agree that petitioner's right index finger condition was caused by the work accident. They agree petitioner gave respondent notice of the accident within the time limits stated in the Act. They agree petitioner earned $42,106.14 in the year pre-dating the accident; and petitioner's average weekly wage, as calculated pursuant to §10, was $794.45.

At issue in this hearing is as follows:

1. Whether respondent is liable for unpaid medical bills.
2. The nature and extent of petitioner's injury.

FINDING OF FACTS

Petitioner, now age 30, was employed by respondent as a maintenance technician. His duties included maintenance on various types of equipment at 11 of respondent's different locations. This job requires extensive use of his hands.

On November 3, 2016 petitioner attended a company meeting which included 'team building' activities. During one of these activities, a go-cart race, petitioner injured his right index finger when he braked to avoid striking the vehicle in front of him; the vehicle behind petitioner's crashed into his vehicle, causing the injury. He suffered a crushing injury to his right index finger when he caught it between the other vehicle and the steering wheel of his vehicle.

He presented at the Adventist Glen Oaks Hospital Emergency Room on the date of the accident. He was diagnosed as having a fracture dislocation of the middle phalanx involving the proximal interphalangeal joint of the right index finger. He was treated and released and referred to Dr. Patari for further treatment.

Petitioner first saw Dr. Patari on November 9, 2016, at which time Dr. Patari performed surgical irrigation and debridement of an open fracture of the middle phalanx articular surface involving the PIP joint with internal fixation. The pre and post-operative diagnosis was open right index middle phalanx PIP joint articular fracture. (PX 2) Dr. Patari issued restrictions on November 17, 2016, of no use of the right hand and no lifting/carrying or pushing/pulling. These restrictions were modified on December 12, 2016, to no forceful gripping with the right hand and to use a splint at work. (PX 3).

Petitioner remained off work following surgery and was released on January 2, 2017, to return to full duty effective February 13, 2017. Dr. Patari stated Petitioner was not yet at maximum medical improvement which he estimated he would reach on June 1, 2017. In the interim, the doctor revised Petitioner's work status on January 23, 2017, when he released Petitioner to return to work, full-duty, starting January 26, 2017. Per the stipulation of the parties, Petitioner returned to work after January 29, 2017. (Arb. Ex. 1).

When Petitioner followed up with Dr. Patari after returning to work, the doctor noted a post-operative contracture for which he was recommending another procedure. Surgery was performed on May 16, 2017, which was, according to the operative reported a tenolysis of the extensor tendon proximally and distally through the distal interphalangeal joint and that two screws in the middle phalanx of the finger were removed. The doctor also performed a manipulation and flexion of both PIP and DIP joints. He achieved up to 80 degrees' flexion of the distal interphalangeal phalanx and from 30 to 90 degrees' flexion of the proximal interphalangeal phalanx. He noted that Petitioner could touch the tip of the index finger to the palm. (PX 2).

Petitioner remained off work from May 16, 2017 and returned to work per Dr. Patari's orders on June 5, 2017. On follow up on June 14, 2017, Dr. Patari advised him to continue working full duty and follow up in a month. On July 13, 2017, Dr. Patari released Petitioner from care and stated that he would reach MMI in one month. (PX 3).

Petitioner testified that he currently performs full duty for respondent. His current work activities involve use of both hands. He testified that his motor skills have been affected by the injury. The injury affected his ability to target shoot; although he does continue to participate. He reported a loss of mobility of his right index finger and complained of nerve damage.

The Arbitrator observed the Petitioner's right index finger which appears to be in a fixed position with the right index finger locked in an extension deficit of approximately 45 degrees. Also, when petitioner makes a fist, the tip of the finger does touch the palm but remains in a permanently flexed position at approximately 50% total possible flexion.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

J. With respect to the issue regarding medical bills, the Arbitrator makes the following conclusions of law:

The Arbitrator finds the following bills were reasonable and necessary to treat petitioner of his work injury of November 3, 2016 and awards same pursuant to the fee schedule, §8 and §8.2 of the Act, with credit to be given for any payments already made:

$5,533.63 Adventist Glen Oak Hospital
$88.00 Suburban Radiologist
$1,148.00 Illinois Emergency Medical Specialist

L. In support of the Arbitrator's decision with regard to the nature and extent of injury, the Arbitrator finds the following:

As a result of the work accident of November 3, 2016, petitioner suffered a crushing injury to his right index finger petitioner which required two operative procedures and resulting in a loss of movement.

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 there was no AMA rating. Therefore, the Arbitrator cannot give any weight to this factor.

With regard to (ii) of §8.1b (b) the occupation of the injured employee, the Arbitrator notes petitioner's job as a maintenance mechanic requires use of both hands. 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 30 years of age, this gives petitioner a thirty-plus-year work-life expectancy. Therefore, the Arbitrator gives more weight to this factor.

With regard to (iv) of §8.1b (b) the employee's future earning capacity, the Arbitrator notes petitioner was able to return to his regular employment. There is no evidence the injury has reduced petitioner's earning capacity. Therefore, the Arbitrator gives no weight to this factor.

With regard to (v) of §8.1b (b) evidence of disability corroborated by the medical records, the Arbitrator notes the medical records confirm petitioner required two surgeries and continues to have numbness and contractures that requires a dynasplint. Therefore, the Arbitrator gives some weight to this factor.

Based upon the above factors, and the record taken as a whole, the Arbitrator finds petitioner sustained permanent partial disability to the extent of 35% loss of use of the right index finger under § 8 (e) 2 of the Act as a result of the work accident.

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

JERRY HAMBY,

Petitioner,

20IWCC0150

vs. NO: 18 WC 26370

UNITED CONTRACTORS MIDWEST,

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner tripped on a rock located on a gravel entrance to the Lowry Gravel Pit and injured his left ankle, right knee and right shoulder. On the issue of accident, Respondent conceded the "in the course of" prong but argued that Petitioner's injury did not "arise out of" his employment. The record contains a significant amount of testimony pertaining to a "neutral-risk" analysis such as whether the area was "open to the public," if Petitioner was holding anything in his hands at the time, whether he was wearing any equipment, etc. The Arbitrator ultimately found that Petitioner was exposed to "a risk particularly associated with Petitioner's job duties on the date of the accident" and that his accident arose out of his employment.

However, the Commission finds that a neutral risk analysis is unnecessary because Petitioner was injured due to a dangerous condition or defect on Respondent's premises.

Respondent's Labor Foreman, Todd Stephens, testified that the Lowry Gravel Pit is owned by Respondent. *T.60.* He testified that the area where Petitioner fell was "in the entrance. I consider it the gravel pit." *T.68.* Mr. Stephens also testified that he saw Petitioner fall. *T.64.* Afterwards, Mr. Stephens went over to the area to investigate and he saw a 3-inch diameter rock, which was "absolutely" big enough for someone to twist an ankle. *T.66.* There were other large rocks in the area similar to the one Petitioner tripped over. *T.68.* He described it as "just one big rock in the middle of a gravel pit that he tripped on." Id. Additionally, Mr. Stephens testified that he told Petitioner that the area he was in was a good spot for him to stage the water truck. *T.62.*

We find Petitioner was injured by a dangerous condition/defect (large 3-inch diameter rock) on property owned by Respondent. Respondent's focus on the area being "open" to the general public is misplaced because it is not "owned" by the public. In other words, thousands of people (general public) could pass through that area every day but if Petitioner, as an employee, injured himself due to a defect on Respondent's property, the risk is characterized as a risk incidental to the employment resulting in a compensable accident. Respondent owned the gravel pit and the logical inference is that it was responsible for the maintenance of the gravel entrance road as well. *See* Rx9 through Rx11 (photos). We find that, even though it was a gravel road (with small rocks throughout), the occasional large rock scattered here and there at the entrance to Respondent's gravel pit constitutes a dangerous condition or defect.

Based on the above, we affirm the outcome and awards in the Arbitrator's decision but modify the legal analysis and rationale used to find that Petitioner proved he sustained an accidental injury arising out of and in the course of his employment.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 18, 2018, is hereby affirmed and adopted with the changes in rationale noted above.

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.

20IWCC0150

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 $8,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 4 - 2020

Maria E. Portela

Thomas J. Tyrrell

Kathryn A. Doerries

SE/
O: 1/7/20
49

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

HAMBY, JERRY
Employee/Petitioner

Case# **18WC026370**

UNITED CONTRACTORS MIDWEST
Employer/Respondent

20IWCC0150

On 12/18/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.48% 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:

5847 LAW OFFICE OF DAVID HUNT LTD
245 N E PERRY AVE
PEORIA, IL 61603

1337 KNELL LAW LLC
CHARLES D KNELL
504 FAYETTE ST
PEORIA, IL 61603

20IWCC0150

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Jerry Hamby
Employee/Petitioner

v.

United Contractors Midwest
Employer/Respondent

Case # **18** WC **26370**

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 **Bloomington**, on **October 30, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **June 21, 2018**, Respondent *was* operating under and subject 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.

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$69,377.88**; the average weekly wage was **$1,334.19.**

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

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

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 medical bills paid in the amount of **$0** through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent shall authorize the treatment recommended by Dr. Johnson, including, but not limited to, the recommended post-operative physical therapy.

Respondent shall pay the reasonable and necessary medical services **as contained in Petitioner's Exhibit 7** as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses 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 **$889.46**/week for **8 4/7** weeks, **for the timeframe of September 1, 2018 through October 30, 2018,** as provided in Section 8(b) of the Act.

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

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

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

Melinda M. Pace Gillman
Signature of Arbitrator

12/14/18
Date

ICArbDec19(b)

DEC 18 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Jerry Hamby
Employee/Petitioner

Case # **18** WC **26370**

v.

Consolidated cases: **N/A**

United Contractors Midwest
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that on June 21, 2018, he was employed by Respondent and that his job duties included running a service/water truck for a paving crew working on the Manito Blacktop. He testified that when a machine ran out of water blacktopping, he would be called. He testified that on June 21, 2018, he was out of his truck and walked to a foreman's truck. He testified that he received a phone call indicating that water was needed by the crew performing work on the blacktop. He testified that as he was walking back to his service truck, he stepped on a rock, rolled his ankle and fell on his right shoulder. He testified that Petitioner's Exhibit 6 was a diagram showing the position of his truck, where he fell and where Todd Stephens' truck was located.

Petitioner testified that he did not see the rock that he stepped on. He testified that he fell when he was about half way between Todd Stephens' truck and the truck that he had been driving. He testified that he continued to work the rest of the day and that he went to Prompt Care the following day. He testified that he then went to Occupational Health and had an MRI on the right shoulder which was performed on July 27, 2018, and that he was referred to Dr. Johnson at Midwest Orthopedic Center. He testified that he had surgery on his right shoulder on October 4, 2018 at Proctor Hospital. He further testified that his employer provided him work within his restrictions through August 31, 2018, that he was completely off work as of September 1, 2018 and that he was still off work at the time of the arbitration hearing (*i.e.*, October 30, 2018).

Petitioner testified that his job was to get water to the crew that was doing the paving on the road. He testified that it was not always necessary or convenient to have the truck somewhere where he could be outside of it and still see the work that was going on, and that oftentimes he would stay inside the truck and listen to the phone. He testified that on June 21, 2018, there was a convenient parking spot for him to put the water truck.

On cross examination, Petitioner agreed that Respondent's Exhibit 11 was a photograph which depicted the entrance off the roadway of the Manito Blacktop and that the entrance was to a gravel pit called the Lowry Pit. Petitioner agreed that the gravel pit was accessed by companies who purchased gravel and that trucks would enter and exit the main entrance to the gravel pit, which had a Y-shaped mouth entrance. Petitioner agreed that anyone could pull in and turn around in the entrance area and that there was nothing prohibiting him, as an employee of Respondent, from entering the mouth of the entrance.

On cross examination, Petitioner agreed that his job was to provide water to the individuals that were working on the Manito Blacktop near the Lowry Pit. He agreed that he pulled into the entrance of the pit, made a U-turn, parked and walked toward Todd Stephens' truck. He agreed that he had nothing in his arms that bothered him or caused problems in his walking. He agreed that as he was walking there was nothing in his arms. He testified that he wears glasses but that they did not bother him on that date. He testified that he had no equipment from Respondent that caused him to fall. He agreed that as he was walking there was nothing obstructing his view as he walked towards his truck. Petitioner further agreed that he did not slip, that his boots did not cause him to fall and that his knee did not give out.

On cross examination, Petitioner agreed that he completed a portion of an incident reporting form which was entered into evidence at the time of arbitration as Respondent's Exhibit 12. He agreed that the report was prepared the day after the accident took place. He testified that when he fell, Todd Stephens was across the roadway. He further testified that Mr. Stephens never came and looked at the area where he fell, nor did he assist him back into his truck or talk to him about what he fell on.

Todd Stephens was called as a witness at the time of arbitration. Mr. Stephens testified that he was a laborer foreman on June 21, 2018. He testified that he was working on paving the Manito Blacktop and that they were paving over a milled surface. He testified that Petitioner was working on June 21, 2018 and that his job was that of a service truck driver. He testified that he was not Petitioner's foreman on that date and that he was in traffic control and dealt with the flaggers.

Mr. Stephens was shown Petitioner's Exhibit 6, which was a map prepared by Petitioner. He testified that the diagram was that of an area known as the Lowry Gravel Pit. He testified that the pit was open to the public. He testified that at no time was he across the Manito Blacktop as portrayed in Petitioner's Exhibit 6. He testified that he was standing by his truck when Petitioner walked away. He testified that he saw Petitioner fall. After reviewing Respondent's Exhibit 11 he testified his truck was over by the white sign as portrayed in Respondent's Exhibit 11, and that Petitioner's truck was over on the left side of the photograph next to the grassy area.

Mr. Stephens testified that after he saw Petitioner fall, he did not go and try and help him. He testified that he went over to the area where Petitioner fell and that he found a rock that was about 3 inches in diameter. He testified there were other rocks in the area as well and that there were other rocks of a variety like the one Petitioner twisted his ankle on. He testified that it was in the entrance area to the gravel pit.

Mr. Stephens testified that Petitioner did not have anything in his arms as he was walking away. He testified that there were no trucks coming into the gravel pit area that caused Petitioner to lurch one way or another or to jump out of the way. He testified that the area and entryway into the gravel pit was gravel and that were no marked parking spots. He testified that the mouth of the entrance to the gravel pit was anywhere from 80-100 feet in width.

Roger Shaw was called as a witness at the time of arbitration. He testified that he is a friend of Petitioner's and that he has been to the Lowry Gravel Pit five or six times over the past three or four years. He testified that he last went to the Lowry Pit around the 4th of September of the Labor Day weekend in 2018. He testified that he entered the pit in order to purchase some sand for a sandbox. He testified that he drove his pick-up truck in, drove to the scale and told the woman in the booth that he needed some sand. He testified that the woman pointed him towards the sand pile, that he pulled off the scale, that he went down to where his pick-up truck was loaded and that he then went back to the scale and pulled up to the window. He testified that he paid the woman, that she gave him a receipt and that he then left, and that at no time did he ever have to exit his vehicle.

On cross examination, Mr. Shaw testified that the entrance to the gravel pit was approximately 80-100 feet wide. He testified that there was nothing in the entryway which would prevent someone from stopping and getting out of their vehicle. He testified that there were no signs saying not to park there or not to get out of the vehicle. He testified that he has known Petitioner for about 10 years. He testified that the trip that he made in September of 2018 was done to show Petitioner how it worked getting in and out of the pit without having to get out of a vehicle. He further testified that he had been to the pit before the September 4th visit.

On redirect, Mr. Shaw testified that he had been to the Lowry Pit multiple times before June 21, 2018 and that his experience on those visits was no different than what he testified to. He testified that he had gone to the pit before and that nothing had changed. He denied altering his testimony so as to intentionally aide Petitioner.

The medical records of OSF Center for Health dated June 22, 2018 were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner presented for left ankle pain and left shoulder pain status post a fall the day before at work. It was noted that Petitioner stated that he stepped on a rock and twisted his left ankle and fell and that he stated that he did not remember hitting his right arm or shoulder, but that he developed right shoulder pain last evening several hours after the fall. It was also noted that Petitioner stated that he had injured his left ankle before and was afraid he had re-injured it worse this time. The assessment was noted to be that of acute left ankle pain and acute pain of the right shoulder. Petitioner was ordered to undergo x-rays of the left ankle and right shoulder, which were interpreted as negative for acute abnormalities. Petitioner was instructed to rest, use ice, take medication, elevate when possible and follow-up with his primary care physician or Orthopedics within one week. (PX1).

The medical records of OSF Center for Occupational Health were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen on July 13, 2018, at which time it was noted that he related that last month he rolled his left ankle and fell to the ground onto the right shoulder. It was noted that ever since Petitioner had had right shoulder pain and difficulty sleeping due to pain, that he related decreased motion and strength and that he worked as a truck driver and had been managing his pain with over-the-counter medications and accommodating himself with the other arm, if needed. It was noted that Petitioner went to Prompt Care and that imaging was negative for fracture, and that there was no prior history of right shoulder problems and no complaints of left ankle problems regarding baseline. It was noted that Petitioner related that he had chronic problems with the left ankle due to past injuries and that there was always some baseline discomfort. The diagnosis was noted to be that of strain of muscle/tendon of the rotator cuff of the right shoulder. Petitioner was issued work restrictions and was ordered to undergo an MRI of the right shoulder. (PX2).

The records of OSF Center for Occupational Health reflect that Petitioner was seen on July 30, 2018, at which time it was noted that the MRI of the right shoulder showed a partial tear of the supraspinatus and that he was still symptomatic. Petitioner was issued work restrictions and was referred to an Orthopedist. (PX2).

The MRI Interpretive Report dated July 27, 2018 was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that the films were interpreted as revealing (1) supraspinatus tendinopathy with high-grade partial-thickness, partial width tear involving the distal insertional fibers; no definite full-thickness component allowing for limitations from motion; (2) SLAP tear with small 3 mm paralabral cyst; (3) mild degenerative arthritis right acromioclavicular joint with lateral downsloping of the acromion; recommend correlation for symptoms of impingement; (4) subacromial/subdeltoid bursitis. (PX3).

The medical records of Midwest Orthopaedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on October 8, 2018, at which time it was noted that he was four days status post right shoulder arthroscopy, subacromial decompression, distal clavicle excision and rotator cuff repair, that he stated that he was doing too well and that he attributed it to his pain medication due to the side effects. It was noted that Petitioner described his pain as soreness, that he was also having trouble sleeping and that he started therapy on that date. It was also noted that Petitioner was still improving, that he was reassured that his procedure went well and that he was informed to take off the sling intermittently to extend his elbow. Petitioner was provided with Norco. (PX4).

The records of Midwest Orthopaedics reflect that Petitioner was seen on September 28, 2018 for physical therapy. It was noted that Petitioner fell after rolling his ankle on a rock and that the injury happened on June 21, 2018. It was noted that Petitioner stated that he hit pretty hard on his right side when he fell and that he was scheduled for rotator cuff repair on October 4, 2018 with Dr. Johnson. At the time of the September 17, 2018 visit with Dr. Johnson, it was noted that Petitioner was seen for re-evaluation of right shoulder pain after a fall three months ago. It was noted that it hurt Petitioner mostly at night, that it affected his sleep, that any movements of his arm exacerbated his pain and that he stated that the pain had not improved much over time. It was noted that Petitioner drove a truck for a living and had been working light duty with decreased hours due to his pain, and that he had been doing his home exercises and taking NSAIDs for his pain but it still persisted. The assessment was noted to be that of a complete tear of the rotator cuff tendon. It was noted that since his pain had been persistent over three months and had not improved over time with NSAIDs and home exercises, Petitioner wished to proceed with right shoulder arthroscopy, subacromial decompression, distal clavicle excision and rotator cuff repair. (PX4).

The records of Midwest Orthopaedics reflect that Petitioner was seen on August 15, 2018, at which time it was noted that he had complaints of right shoulder pain, that he tripped and fell about six weeks ago and injured the shoulder and that he had immediate pain that had remained unchanged since the injury. It was noted that Petitioner had had an MRI but otherwise had not had any treatment, and that he had been working with a 5 lb. restriction but was having quite a bit of difficulty. It was noted that the MRI findings included supraspinatus tendinopathy with high-grade partial thickness tear involving the insertional fibers, SLAP tear with small 3 mm paralabral cyst, mild arthritis AC joint with downsloping of the acromion and subacromial/subdeltoid bursitis. The assessment was noted to be that of complete tear of rotator cuff tendon. It was noted that Petitioner wished to proceed with surgery. Petitioner was also issued work restrictions at that time. (PX4).

Pictures of Petitioner's Injury were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. A Map was entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 7.

The Response to 19(b) Petition was entered into evidence at the time of arbitration as Respondent's Exhibit 2.

The medical records of OSF Healthcare System dated on October 6, 2015 were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The records reflect that Petitioner was seen in the emergency room on that date, at which time it was noted that he was seen for evaluation of left ankle swelling and pain after stepping off a truck and rolling his left ankle on the edge of blacktop that occurred around 7 a.m. that morning. It was noted that Petitioner reported that he had a co-worker help him off and that he worked for 30 minutes before feeling that his boot was tight on his foot, and that he reported the pain was exacerbated by movement. The records reflect that Petitioner underwent x-rays of the left ankle on that date, which were interpreted as revealing no fracture or dislocation; lateral soft tissue swelling. The clinical impression was noted to be that of a sprain of the deltoid ligament of the left ankle. Petitioner was recommended to seek orthopedic follow-up. (RX3).

The medical records of OSF St. Francis Medical Center – Peoria Occupational Health were entered into evidence at the time of arbitration as Respondent's Exhibit 4. The records reflect that Petitioner was seen on November 5, 2015, at which time it was noted that he was seen in follow-up of a left ankle sprain. It was noted that Petitioner was doing well, that he had no current symptoms and that he had been wearing a pull-up elastic ankle brace for extra support while he was doing his regular duties and tolerating things well. The assessment was noted to be that of left ankle sprain. It was noted that Petitioner had healed very well, that he had a normal functional exam and that he was released from further follow-up. It was also noted that Petitioner was to continue to work without restrictions. (RX4).

The records of OSF St. Francis Medical Center – Peoria Occupational Health reflect that Petitioner was seen on October 16, 2015, at which time it was noted that he was seen in follow-up for his 10-day-old left ankle inversion injury. It was noted that Petitioner related that he had no pain and requested that he be released to return to work, that he had not been accommodated with restrictions and that x-rays obtained earlier were negative for any fracture. It was noted that Petitioner was anxious to return to work. The assessment was noted to be that of left ankle sprain with persistent swelling but denial of pain. It was noted that some incentive to return to work may drive Petitioner to minimize his discomfort. It was noted that Dr. Pena agreed to release Petitioner to return to work at regular duty on October 17, 2015, but that he should be re-checked by an associate in two weeks. It was noted that Petitioner was recommended to use compression inside his boot for the next two weeks and to continue use of the Mobic every day, and that it was stressed to Petitioner that continually being on his feet and not having any support of his ankle might cause a chronic swelling which would be difficult to resolve. At the time of the October 14, 2015 visit, it was noted that Petitioner reported that his left ankle still had a lot of swelling and that he was having problems with the walking boot rubbing his ankle. It was noted that Dr. Moody was going to let Petitioner go without immobilization and that he thought the foot was too swollen to attempt steel-toed shoes. (RX4).

The records of OSF St. Francis Medical Center – Peoria Occupational Health reflect that Petitioner was seen on October 9, 2015, at which time it was noted that he worked as a truck driver for United Contractors Midwest, that on October 6, 2015 at approximately 7 a.m. he was climbing down from the side of a dump truck when he stepped with his left foot onto the edge of a large trunk [*sic*] of asphalt, which was unstable. It was noted that Petitioner's left ankle inverted and he fell to the ground, and that he had some immediate pain and swelling and was unable to bear weight. It was noted that Petitioner went to the OSF emergency room where x-rays were negative for any fracture and that he was given an ACE wrap and crutches. It was also noted that Petitioner reported some continued pain, that he reported the inability to bear weight and that he had taken the Norco which helped some. The assessment was noted to be that of a left ankle sprain. Petitioner was placed in a walking boot to help with comfort and for stability. It was noted that Petitioner was to continue the use of crutches to be non-weightbearing if he was able, but that he reported that he felt unsteady to do this. It was noted that Dr. Braun thought that the best thing to do was to let Petitioner's swelling go down and then re-evaluate him, and that he thought the swelling in the area was causing all of his pain. (RX4).

The medical records of OSF St. Francis Medical Center dated June 22, 2018 were entered into evidence at the time of arbitration as Respondent's Exhibit 5. The records were duplicative of those as contained in Petitioner's Exhibit 1. (RX5; PX1).

The medical records of OSF Center for Occupational Health dated July 13, 2018 were entered into evidence at the time of arbitration as Respondent's Exhibit 6. The records were duplicative of those as contained in Petitioner's Exhibit 2. (RX6; PX2).

The MRI Interpretive Report dated July 22, 2018 was entered into evidence at the time of arbitration as Respondent's Exhibit 7. The records were duplicative of those as contained in Petitioner's Exhibit 3. (RX7; PX3).

Various Photographs were entered into evidence at the time of arbitration as Respondent's Exhibits 8 through 11.

The Incident Reporting Form dated June 22, 2018 was entered into evidence at the time of arbitration as Respondent's Exhibit 12. It was noted that Petitioner indicated that he hurt his shoulder and rolled his ankle, that he was walking back to his truck and stepped on an object and that he fell to the ground, hitting his shoulder. (RX12).

CONCLUSIONS OF LAW

With respect to disputed issue (C) pertaining to accident, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of his employment with Respondent on June 21, 2018.

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.

At the outset, the Arbitrator notes that Respondent agrees that Petitioner was "in the course of" his employment when he stepped on a rock in the entrance to the Lowry Pit and that the main issue in dispute as it pertains to the issue of accident is whether the accident "arose out of" Petitioner's employment with Respondent.

In the case at hand, the Arbitrator notes that Petitioner testified that while returning to his vehicle in order to perform his job duties, he tripped over a rock and injured his right shoulder. Additionally,

testimony was proffered from one of Respondent's foremen, Todd Stephens, who testified that he actually witnessed Petitioner fall on the rock and that he investigated where Petitioner fell and found the rock in question, stating that it was large enough for an individual to step on, twist their ankle and fall. The Arbitrator finds and concludes that this was a risk particularly associated with Petitioner's job duties on the date of the accident at issue and therefore finds that Petitioner's accident did arise out of and in the course of his employment with Respondent.

The Arbitrator further notes that Respondent argued that the risk associated with this incident was a neutral risk given that the gravel pit where Petitioner's vehicle was parked was open to the general public. The Arbitrator finds this argument to be unpersuasive, however, as the only evidence put forth at the time of hearing as to whether the area was, in fact, open to the public was through the testimony of Roger Shaw. Mr. Shaw testified that he had been to the Lowry Pit as a member of the general public on multiple occasions, and that at no point during any of those various visits was he required to exit his vehicle for any reason. The Arbitrator infers from Mr. Shaw's testimony, then, that while the general public may be theoretically allowed to traverse the area in which Petitioner fell, from a practical standpoint regular foot traffic in the area in which Petitioner fell did not occur.

Having reviewed and considered the entirety of the evidence presented by both parties at the time of arbitration, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of his employment with Respondent on June 21, 2018.

With respect to disputed issue (J) pertaining to 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 June 21, 2018. As a result thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibit 7, 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. Johnson, including, but not limited to, the recommended post-operative physical therapy.

With respect to disputed issue (L) pertaining to temporary total disability benefits, the Arbitrator notes that Petitioner seeks temporary total disability benefits from September 1, 2018 through October 30, 2018. (AX1).

Petitioner testified that Respondent provided him work within his restrictions through August 31, 2018, that he was completely off work as of September 1, 2018 and that he was still off work at the time of the arbitration hearing (*i.e.*, October 30, 2018). In light of the Arbitrator's aforementioned conclusions, the Arbitrator finds that Respondent shall pay Petitioner temporary total disability benefits of $889.46/week for 8 4/7 weeks, for the timeframe of September 1, 2018 through October 30, 2018, as provided in Section 8(b) of the Act.

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

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROY MCGUIRE,

Petitioner,

20IWCC0151

vs.

NO: 17 WC 20693

MIDWEST POWER SOURCE, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

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

This case relates to Petitioner's accident on May 1, 2017. All findings of fact and conclusions of law related to Petitioner's alleged accident on January 17, 2017, are hereby stricken from this decision since that accident is addressed separately in case number 17 WC 20719.

We affirm the Arbitrator's finding that Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent on May 1, 2017, but explain our decision in greater detail. Petitioner testified that on May 1, 2017, he was pulling 100-pound "heads" into the dumpster and, when he was done, his body started tingling: toes, arms, everything from his neck down. *T.79.* He testified that he told Dale Lewis, the locomotive engine shop manager, who told him to see Amber Braundmeier, the office manager. *Id.*

This is supported by both Mr. Lewis and Ms. Braundmeier. Dale testified that, a couple hours into the day on May 1st, Petitioner told him "he couldn't do it anymore" but did not tell him about any incident or accident involving putting parts into the dumpster or details about what was causing his symptoms. *T.170-73.* Dale told Petitioner to talk to Amber about what was wrong and to do paperwork. *Id.*

Amber testified that she does remember talking to Petitioner in May 2017 about him hurting while at work and wanting to file a workers' compensation claim. *T.141.* Petitioner did not tell her

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about any accident or job duties that caused the onset of his symptoms but she filled out an accident report and gave Petitioner a copy. *T.152-53.* Interestingly, Respondent's attorney indicated that this form is not in evidence. *T.154.* Therefore, we make the reasonable inference that this document supports Petitioner's claim of a specific injury on May 1, 2017. We also note Amber signed a letter, on May 1, 2017, indicating that Petitioner was sent home after having told both her and Dale on that date about "not being able to perform job duties due to leg and shoulder and not being able to hold onto anything." *Rx6.*

Randy Throne, a mechanic at Respondent, also testified that when Petitioner came back from his carpal tunnel surgery in April 2017, he said he was better, did not complain about numbness and tingling in his body, and worked his regular job duties for three days. *T.186-87.* When Petitioner came to work on Monday, May 1, 2017, he was "normal, good; no complaints." *T.187.* Randy had asked Petitioner to "lay down the packs to be tore down and when I came back he was gone, like that's it." *Id.* We find that after Petitioner did what Randy asked him to do; Petitioner told Dale that he couldn't do it anymore. Petitioner then talked to Amber about his problems and desire to file a workers' compensation claim.

The Commission acknowledges, however, that there is some evidence which is inconsistent with Petitioner's claim of a specific injury on that date. First, when Petitioner saw Dr. Jain's nurse practitioner on May 5, 2017, it was for low back pain with numbness and tingling in his legs. Petitioner's wife was also present and a history was given of pain that started at home five months prior without any precipitating event or injury. However, it also states that "Aggravating factors contributing to the back pain may be job related repetitive lifting with back strain." *Px1.* An addendum dated May 9, 2017, indicates that, according to Petitioner, "this apparently has been ongoing at work and is a work-related issue." A separate visit note, also dated May 9, 2017, modifies the history and states, "[t]he event which precipitated this pain was job-related repetitive lifting. This occurred at work." This record also mentions ongoing neck pain that radiates to the arms, which had not been previously mentioned to the provider.

Another inconsistent record is from the emergency room at St. John's Hospital on May 9, 2017, which indicates Petitioner had started slurring his speech and developed weakness in his arms 3 to 4 weeks prior. There is no mention of any specific injury on May 1, 2017, while putting engine parts into a dumpster, and the history indicates Petitioner was having significant neurologic symptoms before the alleged date of accident.

We also note that Petitioner alleged that he sustained a work accident in January 2017, which we found he failed to prove in case number 17 WC 20719. None of the medical records prior to Petitioner's May 1, 2017 accident reflect any history of a work accident in January 2017. It is not until the visit with Dr. Jain's office on May 5, 2017, that Petitioner gave a history of pain that started five months prior.

The dilemma the Commission is faced with is whether it is possible to reconcile Petitioner's testimony, the medical records and his claim of a specific accident on May 1, 2017. None of the contemporaneous medical records reflect a specific accident on that date. Even Dr. Purvines' May 19, 2017 record refers only to an alleged incident in January and does not mention anything about an accident on May 1st. However, Respondent's Section 12 physician, Dr. Bernardi, testified that the herniation shown on Petitioner's May 11, 2017 MRI is so "massive" and was causing such a "profound narrowing of his spinal canal," that it was the type of thing that did not evolve over weeks or months but, rather, hours or days. *Rx7 at 19.* We find this would be consistent with an onset date of May 1, 2017. Although Dr. Bernardi believed that Petitioner sustained a non-work-related muscular low back

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strain, he admitted that numbness and tingling in the legs could be a manifestation of cervical pathology. *Rx7 at 63-64.* He also admitted that Petitioner's leg symptoms got better after his cervical fusion, which "does tend to argue that they were related to his neck." *Id. at 48-50.*

Dr. Bernardi testified he could not opine that Petitioner's condition was work-related because of the varied histories contained in the records and the fact that a herniation can be caused by anything. Regarding the varied histories, Dr. Bernardi's report indicates that a workers' compensation form was completed in Dr. Jain's office on May 17, 2017, indicating that Petitioner's injury occurred on May 1, 2017, while knocking pistons out of an engine using a sledgehammer. This is obviously not the same mechanism of injury that Petitioner testified happened on May 1, 2017. However, similar to the workers' compensation form that Amber Braundmeier completed on May 1, 2017, this workers' compensation form from Dr. Jain's office is not in evidence. The Arbitrator also noted that Dr. Bernardi referenced this May 17, 2017 form but "the Arbitrator is not able to locate any such document in the record." *Dec. at 5.*

We do not find Dr. Bernardini's causation opinion persuasive but we do find it persuasive regarding the acute and recent nature of Petitioner's cervical herniation, which we find to be consistent with an onset date of May 1, 2017, when Petitioner asked Amber to file a workers' compensation claim and he stopped working.

The Commission finds that the evidence shows, more likely than not, that Petitioner sustained a cervical injury at work on May 1, 2017. We note that Petitioner has not alleged a repetitive trauma cervical injury. However, the evidence in this case supports a finding of a specific cervical traumatic event in the context of a repetitive, heavy-duty job. We find that Petitioner did have a heavy-duty job, which involved hitting metal pistons with a sledgehammer and lifting heavy engine parts. Although the medical records indicate Petitioner may have had some degenerative cervical conditions and minor symptoms prior to May 1, 2017, we find that his work activities on that date caused a permanent aggravation of his cervical condition. In other words, even though Petitioner's cervical condition may have been gradually worsening over time, the inciting event which caused the "massive" herniation at C4-5 was the incident on May 1, 2017, when Petitioner was pushing heavy motor parts into a dumpster. Petitioner testified that after the May accident, he couldn't hold a fork, spoon, or cup and he "couldn't function right" because "my whole body was like shaky." *T.84-86.* We find Petitioner's testimony credible in that, after this, his condition markedly deteriorated. He was taken off work after this event and required emergent cervical fusion surgery, which he underwent with Dr. Purvines on June 1, 2017. *Px7.*

We also affirm the Arbitrator's finding that Petitioner's current cervical condition of ill-being remains causally related to this accident. Regarding the five factors in Section 8.1b(b) used to determine Petitioner's permanent partial disability, we affirm the Arbitrator's findings under factors (i) and (iv), which are given no weight.

For factor (ii), Petitioner's occupation, Dr. Purvines testified Petitioner was released to return to work full-duty as of August 24, 2017. *Px10 at 42-43.* However, Petitioner testified that when he tried to go back to his former job with Respondent he was told that they hired somebody else. *T.92.* Respondent never hired him back. *Id.* Instead, Petitioner now works at a job filling vending and soda machines, which is a lot easier on his neck. *T.96.* We find that, although Petitioner no longer has any work restrictions, he was never given the opportunity to see if his post-surgical neck condition would really be able to handle the repetitive, forceful pounding of pistons with a sledgehammer, which his previous job required. We give this factor significant weight.

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The Arbitrator gave factor (iii), Petitioner's age, "some" weight because he was 61 years old and "has diminished healing capacity and a low threshold for future injury." *Dec. at 12.* We find there is no evidence to support this statement and modify this factor to give it zero weight.

For factor (v), evidence of disability corroborated by the treating medical records, the Arbitrator focused on the extent of Petitioner's injuries and his pre-surgery complaints. However, those facts are not relevant to Petitioner's current, post-surgical level of disability. The evidence indicates Petitioner had a very successful outcome from his two-level cervical discectomy and fusion at C4-5 and C5-6. Petitioner testified that the surgery "worked" and solved the "shaking, the wobbliness and everything." *T.94.* "Everything went away" including the rubber band feeling around his abdomen and his "whole body was normal again." *T.94-95.* He no longer has any neck, leg or back problems. *T.95-96.* The only issue he has remaining is with his ring and pinky fingers related to his carpal tunnel syndrome. *Id.* However, Petitioner does have limited range of motion in the neck. *T.96.* We give this factor some weight.

Based on the above, we find Petitioner is entitled to permanent partial disability for the 25% loss of use of the person-as-a-whole under Section 8(d)2 of the Act.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $360.00 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 $324.00 per week for a period of 125 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 25% loss of use of the person-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $65,820.30, as set forth in Petitioner's Exhibit 9, 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 $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 4 - 2020

Maria Elena Portela
Maria E. Portela

Thomas J. Tyrrell

Kathryn A. Doerries
Kathryn A. Doerries

SE/
O: 1/7/20
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McGUIRE, ROY
Employee/Petitioner

Case# **17WC020693**

17WC020719

MIDWEST POWER SOURCE INC
Employer/Respondent

20IWCC0151

On 11/14/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2322 ROTH LAW OFFICES LLC
GEORGE ALBERS
2421 CORPORATE CENTRE DR #200
GRANITE CITY, IL 62040

0000 RUSIN & MACIOROWSKI LTD
R MARK COSIMINI
2506 GALEN DR SUITE 108
CHAMPAIGN, IL 61821

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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

Roy McGuire
Employee/Petitioner

v.

Midwest Power source, Inc.
Employer/Respondent

Case # **17** WC **20693**

Consolidated cases: **17 WC 20719**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Springfield**, on **5/23/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of 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 **5/1/17**, 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*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $**28,080.00**; the average weekly wage was $**540.00**.

On the date of accident, Petitioner was **61** years of age, ***married*** with **no** dependent children.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $**65,820.30**, as set forth in Petitioner's exhibit 9, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $**360.00**/week for **16 2/7** weeks, commencing **5/2/17** through **8/23/17**, 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 $**324.00**/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 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.

Michael K. Nowak, Arbitrator

10/11/18
Date

FINDINGS OF FACT

Petitioner was employed by Respondent Midwest Power Source, Inc. Prior to becoming Midwest, the company was known as Triple D Parts. That company was owned by Paula Lewis. Petitioner's wife, Carla, is the sister of Paula Lewis. Also employed by Triple D Parts were Paula's three children and the spouses of her two daughters. As of the dates in question in this case Paula's daughter, Amber Braundmeier was Respondent's office manager and her husband Zach Braundmeier was Petitioner's foreman. Also testifying, but no longer employed by Respondent was Paula's daughter Courtney Throne. Courtney's ex-husband Randy Throne was also employed by Respondent as a mechanic. Paula's son, Dale Lewis was Respondent's warehouse manager. Prior to the dates in question in this case Paula Lewis sold Triple D Parts to Jason who continued to operate the business as Midwest Power Source, Inc.

This case involves two claims which were consolidated for trial. The first involves an accident date of May 1, 2017, 17 WC 020693. The second involves an accident date of January 17, 2017, 17 WC 020719.

Petitioner has an eighth grade education which consisted of a special education curriculum. He cannot read or write very well. Since the eighth grade Petitioner has worked in various manual labor jobs. Petitioner testified his job duties for Respondent included tearing down and rebuilding locomotive engines, as well as cleaning parts.

One of Petitioner's job duties is to remove pistons from a cylinder-shaped liner which is also called a pack. Sometimes, the piston can simply be removed by hand, but sometimes, a sledgehammer is used to knock the piston loose.

Petitioner testified that on January 17, 2017, he was attempting to remove a piston from a pack. He indicated that generally the pack would be laid on its side on the floor and struck with the sledgehammer in what he described as a golf swing like motion. On that date, however he had been unable to move the piston with the pack lying horizontally so he had the pack standing up in a vertical position, and he used an overhead swing with a sledgehammer to strike the top of the piston. Petitioner indicated he immediately felt tingling in his neck all the way down to his toes.

Petitioner testified that Zach was in the vicinity when the incident occurred, and that Zach actually tried striking the piston a couple of times before discarding it. He further testified he told Zach about the symptoms he was feeling after striking the Piston while Zach was standing next to Randy. He then told Amber, the office manager, about the incident either January 17, 2017 or January 18, 2017. He further testified that Amber told him the owner of the company, Jason, would not allow it. Petitioner and his wife both credibly testified that he was the sole bread winner and that Mrs. McGuire suffers from a serious medical condition which requires them to maintain health insurance at their own expense. Consequently, Petitioner continued to work while suffering from symptoms. Although his speech is far from eloquent, the Arbitrator found the Petitioner's testimony, as well as that of his wife forthright and credible.

The first medical note admitted in evidence is dated January 27, 2017. Petitioner was evaluated by his primary care physician, Dr. Rajneesh Jain. (Px.1, Rx.1) Petitioner was noted to have diabetes and high cholesterol. The musculoskeletal exam was negative for significant arthralgias, back pain, and myalgias. The

neurological findings were negative for dizziness, headaches, paresthesias, and weakness. However, on exam, the neurologic testing revealed hypoesthesia in the bilateral median nerve distributions. Based upon the symptoms in the median nerve distributions, Dr. Jain diagnosed Petitioner with bilateral carpal tunnel syndrome. He referred Petitioner to a surgeon for the evaluation of the carpal tunnel syndrome. Dr. Jain's January 27, 2017 note does not make any mention of numbness from Petitioner's neck down to his toes and does not make any mention of Petitioner sustaining an injury at work.

On February 10, 2017, Petitioner was evaluated by Dr. Craig McKee who is a plastic surgeon. (Px.2, Rx.2) Dr. McKee diagnosed Petitioner with fairly severe bilateral carpal tunnel syndrome. He did not believe Petitioner was suffering from ulnar neuropathy. Petitioner indicated he had to acquire some sick time in order to be able to undergo surgery. Dr. McKee performed bilateral carpal tunnel releases March 14, 2017. (Px.2)

After a couple of follow-up visits, Dr. McKee evaluated Petitioner April 25, 2017. He noted Petitioner was complaining of tingling in all of his digits as well as complaining of stiffness in his hands. Petitioner was not experiencing any elbow pain, but Dr. McKee thought Petitioner may be suffering from cubital tunnel syndrome. Petitioner requested a full-duty release, and Dr. McKee granted the request discharging Petitioner from care without imposing any restrictions.

Petitioner was off work from March 14, 2017 through April 25, 2017, and he returned to work Wednesday, April 26, 2017. Petitioner's bilateral carpal tunnel syndrome is not part of this claim.

Petitioner testified that when he returned to work April 26, 2017, he was experiencing symptoms from his neck down.

Petitioner testified that on May 1, 2017, he used a forklift with a skid to move the heads/liners into a scrap bin. He testified he had to slide the heads off of a skid into a dumpster. Petitioner testified that while performing those job duties, he was hurting and was experiencing tingling in his neck down to his toes. He still felt like he had a rubber-band around his abdomen. He reported having a difficult time getting up from the ground and he was having problems with his whole body including his feet, neck, and arms.

Petitioner next sought medical treatment May 5, 2017. He was evaluated by Dr. Jain's nurse practitioner, Mara Knoche. (Px.1, Rx.3) Petitioner and his wife provided a history to Nurse Knoche of low back pain with numbness and tingling in his legs. Petitioner's primary discomfort was in the lower lumbar spine, and he indicated his symptoms radiated to the thighs. He described the symptoms as a constant pins and needles sensation. The note indicates this was an acute episode, but it also indicates the current episode of pain started five months earlier. Petitioner did not recall any precipitating event or injury. The note indicates it occurred at home. Aggravating factors contributing to the back pain were thought to possibly be job-related repetitive lifting with a back strain. On exam, hypoesthesia was noted in the bilateral L4 distribution. Petitioner was diagnosed with low back pain. X-rays taken of the low back revealed a mild anterolisthesis of L5 on S1 which was likely secondary to pars defects.

Petitioner returned to see Nurse Knoche May 9, 2017. Petitioner's symptoms were again most prominent in the lower lumbar spine, and they radiated to the thighs. The note indicates Petitioner reported the event which precipitated the pain was job-related repetitive lifting. Petitioner complained of neck pain which

was diffuse. He indicated the symptoms radiated to his arms and the symptoms consisted of a pins and needles sensation. Petitioner could not recall the time of initial onset. Nurse Knoche noted the symptoms were apparently ongoing, but they were not previously mentioned. On exam, positive neurological findings were identified including ataxia and weakness in both the arms and legs as well as numbness in the hand. Additionally, Petitioner was noted to be shuffling in a slowed and unsteady manner. Petitioner's reflexes were increased, and his speech pattern was thought to be pressured. Petitioner was referred to the St. John's Hospital emergency room.

The St. John's Hospital records were admitted in evidence as Petitioner's Exhibit 5 and Respondent's Exhibit 5. The chief complaint was listed as "stroke symptoms." The history indicates Petitioner had diffuse paresthesias and generalized malaise which started in January. Petitioner reported a sudden onset in January followed by constant symptoms since then. The symptoms included generalized weakness. On exam, Petitioner had a full range of motion with stability, muscle strength, and normal tone of his upper and lower extremities. A CT-scan of the head was performed, but it did not reveal any abnormalities.

On May 11, 2017, an MRI of the cervical spine was performed. It revealed severe cervical spondylosis with myelomalacia at C4-5 and C5-6.

Petitioner returned to see Dr. Jain May 12, 2017. Dr. Jain indicated Petitioner was sent to the emergency room for findings suspicious of cervical myelopathy with spastic quadriparesis, but Petitioner was evaluated for a stroke and was discharged. Dr. Jain referred Petitioner to Dr. Purvines for a consult.

The Arbitrator notes that the section 12 examination report of Dr. Bernardi references a May 17, 2017 workers' compensation form from Staunton Clinic, however the Arbitrator is not able to locate any such document in the record.

Petitioner saw Dr. Purvines May 19, 2017. (Px.7) The history indicates that about January 15, 2017, Petitioner had an incident at work while dismantling an engine. The history indicates Petitioner was hammering pistons out of an engine and had an abrupt onset of weakness and numbness in his extremities which persisted until the time of the visit with Dr. Purvines. Dr. Purvines noted a spastic gait and diffuse weakness in the upper extremities and the lower extremities. Dr. Purvines interpreted the MRI to show large central and right-sided herniated discs at C4-5 and C5-6 which were severely compressing the spinal cord. Dr. Purvines commented that the pathology likely occurred at the time of the work incident in January.

On June 1, 2017, Dr. Purvines performed surgery on Petitioner's neck. The procedures consisted of a discectomy, foraminotomy and fusion at the C4-5 and C5-6 levels.

Dr. Purvines post-operative note dated July 13, 2017 indicates Petitioner was doing quite well with substantially reduced or eliminated pain in his upper extremities and neck. On exam, Petitioner's strength and sensation in the bilateral upper extremities were thought to be normal, but Petitioner had decreased cervical range of motion. Dr. Purvines recommended a course of physical therapy to prepare Petitioner for his strenuous job. On August 23, 2017, Dr. Purvines allowed Petitioner to return to work in a full-duty capacity effective August 24, 2017.

Amber Braundmeier was called to testify. She denied speaking with Petitioner in January 2017 concerning any type of injury. She indicated that as the only person in the front office, all claims by injured workers go through her. The process is that a worker should report an injury to the supervisor, and then the supervisor will send the worker to Amber to complete the workers' compensation paperwork. The Arbitrator notes that the unrefuted testimony of Petitioner indicates he did tell his foreman, Zach about the incident.

Amber testified the first time she spoke with Petitioner about any type of physical complaint was on March 6, 2017 when Petitioner requested short-term disability forms for his unrelated carpal tunnel syndrome.

Dale Lewis also testified. He is the production supervisor for Respondent, and Amber's brother. He testified he had no knowledge of Petitioner injuring his neck in January 2017. He also testified he had no knowledge of Petitioner sustaining any type of injury as a result of using a sledgehammer. With respect to the job duties described by Petitioner, Mr. Lewis testified it would be improper for a worker to stand a liner on end so it was vertical and then strike the top of the liner with a sledgehammer. He explained that would not be useful in removing the piston, and it would render the liner useless.

Randy Throne also testified. He is a mechanic who performs many of the same job duties as Petitioner. He testified that they sometimes do stand the liners on end and strike them with a sledgehammer. Mr. Throne also testified he had no knowledge of Petitioner injuring his neck or any other body parts in January 2017.

Amber testified that when Petitioner returned to work April 26, 2017, he indicated he was a new man and gestured with his hands as though they were cured.

Randy testified Petitioner indicated he never felt better when he returned to work following the carpal tunnel surgeries. Randy also testified Petitioner performed his regular job duties from April 26, 2017 through April 28, 2017. Petitioner did not make any complaints of having any problems during that time period.

Randy testified that on May 1, 2017, he asked Petitioner to perform discard some cylinder heads. He indicated he did not see Petitioner after that time. Petitioner indicated that while pushing the heads off a pallet which was suspended by a fork lift into the dumpster he again experienced a jolt of pain like he had in January. He further indicated he walked over to Dale and Randy, told them about the incident and was referred to speak with Amber. Petitioner candidly admitted he did not tell them he had sustained a neck injury at that time because until the MRI was performed and he spoke with his doctor in mid May he had no idea the symptoms were coming from his neck.

Dale testified that on May 1, 2017, Petitioner came to him saying he could no longer perform his job duties. Dale immediately sent Petitioner to Amber to report his difficulties. Amber testified that when Petitioner came to her office May 1, 2017, he indicated that the workplace crippled him. She alleged Petitioner complained of problems with his leg and shoulder.

Amber allegedly documented the conversation between she and Petitioner. She testified she read the documentation to Petitioner which indicates Petitioner was not able to perform his job duties due to his leg and shoulder and not being able to hold on to anything. (Rx.6) She said Petitioner came in and told her he needed to file a workers' compensation claim. She also claimed she never spoke to Paula or Courtney on May 1, 2017.

Amber, Dale, and Randy each testified that Petitioner did not advise them of a new accident or new injury on May 1, 2017. The Arbitrator notes that there clearly was some communication regarding work related disability on that day. None of the witnesses indicated that they questioned Petitioner about his condition and its cause where after Petitioner denied a work accident.

Amber testified that she completed an accident report to be submitted to the workers' compensation insurance carrier, and she provided a copy to Petitioner. Petitioner denied ever receiving an accident report. Significantly, the Arbitrator notes no such report was offered into evidence. Further, Petitioner testified that Amber provided him a paper with telephone numbers for the workers' compensation carrier and Jason and told him to call Jason first.

The Arbitrator notes there were a number of inconsistencies in the testimony of Respondent's witnesses. By way of example, Amber testified that she was aware of an incident with a sledgehammer because Petitioner told dale and Randy about it, and presumably they told her. Dale, however denies knowing about a sledgehammer incident.

Courtney Throne was called by Petitioner as an adverse witness. Although at the time of Petitioner's injuries she no longer worked for Respondent, on May 1, 2017 she sent a text message to Mrs. McGuire warning that Petitioner was about to "fuck up" their lives and she should call mom (Paula Lewis) before Roy calls Jason. She vehemently denied speaking with anyone from Respondent on May 1, 2017 alleging instead that Petitioner was the one who told her he was claiming a work related accident. She had previously denied speaking with Petitioner since prior to his carpal tunnel surgeries in March of 2017. Ms. Throne was noted to be quite evasive in her answers and was simply not credible in her attempts to explain how she became aware of Petitioner's injury on May 1, 2017.

Petitioner testified that he first attempted to contact the workers' compensation insurance carrier, but got an answering machine so he then called Jason. Petitioner's wife testified that the call between Petitioner and Jason occurred at their home and she was listening to the conversation as the phone was set to speaker mode. Both agreed that Petitioner had told Jason of the accident which occurred on May 1, 2017. Petitioner was told Jason would not stand for him making a claim and that "I (Jason) gotta do what I gotta do, and you gotta do what you gotta do."

The Arbitrator notes that Jason was not called to testify.

At the request of Respondent, Petitioner was evaluated by Dr. Robert Bernardi on October 24, 2017. Both Dr. Purvines and Dr. Bernardi testified by way of evidence deposition.

Dr. Purvines testified by way of evidence deposition on September 12, 2017. (Px.10) Dr. Purvines first evaluated Petitioner May 19, 2017. Petitioner provided a history of hammering pistons out of an engine January 15, 2017 and having an abrupt onset of weakness and numbness in his extremities. (Px.10, pp.6-7) Petitioner also told Dr. Purvines that despite undergoing carpal tunnel surgery, he continued to have trouble with his arms and legs with difficulty walking and pain in his neck. Petitioner also told Dr. Purvines he was using a sledgehammer. (Px.10, p.7)

Dr. Purvines interpreted the MRI study from May 11, 2017 to show a large disc herniation at C4-5 which was severely compressing the spinal cord. He also identified a similar finding at C5-6 which was also severely compressing the spinal cord. (Px.10, p.10) Dr. Purvines rendered an opinion Petitioner's described job activities from January 2017 either caused or aggravated Petitioner's cervical condition. (Px.10, p.12)

Dr. Purvines performed surgery on Petitioner's neck consisting of a C4-5 and C5-6 anterior cervical discectomy and fusion. (Px.10, p.13)

Petitioner's attorney provided a history to Dr. Purvines of Petitioner moving heavy engine parts at about chest height and asked whether those job duties could cause or aggravate the cervical condition. Dr. Purvines testified Petitioner probably already had a problem in his neck and his spinal cord was continuing to give him trouble and he felt the symptoms. (Px.10, pp.14-16)

With respect to Petitioner's restrictions, Dr. Purvines acknowledged his work note dated August 23, 2017 indicating he allowed Petitioner to return to work in a full-duty capacity as of August 24, 2017. He further acknowledged that the full-duty release was rendered with the knowledge that Petitioner would be performing his regular job duties using a sledgehammer to pound on pistons. (Px.10, pp.42-43)

When asked about Petitioner's capabilities following the alleged incident from January 2017, Dr. Purvines testified Petitioner may not have been able to lift more than 5-10 pounds and may have had a difficult time lifting a bag of groceries. (Px.10, p.30)

Dr. Robert Bernardi testified on behalf of Respondent by way of evidence deposition on December 1, 2017. His testimony was based upon a section 12 examination he performed October 24, 2017. (Rx.7)

Following the October 24, 2017 IME, Dr. Bernardi prepared a 12-page report documenting a history provided by Petitioner, the medical records, diagnostic studies, Dr. Bernardi's exam of Petitioner, and Dr. Bernardi's opinions. The report was admitted in evidence at the time of Dr. Bernardi's deposition. (Rx.7, Dep. Ex.2)

Dr. Bernardi testified he was confident the disc herniation identified on the MRI study was not present in January 2017. He explained the disc herniation was huge, and there were signal changes on the MRI which suggested it was acute. He further opined that a disc herniation that large would cause rapidly evolving symptoms and not symptoms that would evolve over four or five months. (Rx.7, p.14)

Dr. Bernardi testified Petitioner made a remarkable recovery following the surgery performed by Dr. Purvines. He further testified that if Petitioner had severe cord compression for several months, he probably would not have done as well as he did in terms of his recovery. (Rx.7, p.16) Dr. Bernardi agreed with Dr. Purvines that Petitioner did not need any formal restrictions on his activities. (Rx.7, p.18)

Dr. Bernardi testified he could not conclude that Petitioner sustained an injury in mid-January 2017 involving his neck. He explained the disc herniation at C4-5 could not have been present for four months. He believed the disc herniation was present for a much shorter period of time. He further testified the spasticity with Petitioner's gait could not have gone unnoticed for several months without somebody picking up on it. (Rx.7, pp.22-23)

When asked about Dr. Purvines' opinion that Petitioner was suffering from pathology in January 2017, and the condition progressively got worse, Dr. Bernardi testified it was possible. However, he testified it was an unlikely scenario. He explained pressure on the spinal cord can cause hand symptoms. However, the symptoms would involve all of the fingers on both hands. It would not be dependent upon wrist posture or anything else, and it would not be intermittent. It would be constant. (Rx.7, pp.24-25)

Although he was of the opinion that the disc herniations revealed on the MRI study from May 11, 2017 were acute, Dr. Bernardi testified he could not conclude that Petitioner suffered from a work accident in May 2017. (Rx.7, pp.25-26)

At trial, Petitioner testified that following the surgery on his neck, the symptoms he had which included shaking, wobbliness, and everything including the rubber-band feeling around his abdomen went away. Petitioner testified his whole body was normal again. Petitioner also testified the only issues he still had as of the time of trial are with his little finger and ring finger. Petitioner believes it had something to do with his carpal tunnel. Petitioner did indicate that he could not move his head back too far. Petitioner testified his current job included filling vending machines and soda machines.

As indicated above Petitioner candidly acknowledged he did not know that he had injured his neck. He thought the problem was with his arms. He further acknowledged that although he complained of his symptoms following the accidents, he never told Amber or Dale from the employer that he had a problem with his neck. Additionally, when Petitioner spoke with Amber May 1, 2017, he did not know he was having a problem with his neck, so he could not have told her about a neck problem. He indicated that he had no idea the problems he was experiencing were emanating from the neck until after the MRI of May 11, 2017.

CONCLUSIONS

Although he was of the opinion that the disc herniations revealed on the MRI study from May 11, 2017 were acute, Dr. Bernardi testified he could not conclude that Petitioner suffered from a work accident in May 2017. He arrived at this conclusion based upon a number of factual determinations which are within the province of the Commission and with which the Arbitrator disagrees.

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

Issue (E): Was timely notice of the accident given to Respondent?

Petitioner credibly testified that on January 17, 2017 he sustained an injury while striking a piston with a sledgehammer. He further indicated that he told his foreman, Zach, that he had been injured and that Zach himself hit the piston a couple of times before throwing it into the trash. Petitioner was then directed to speak with Amber which he testified he did and was told that Jason would not allow a claim. Amber denied knowledge of Petitioner reporting an injury to her, but admitted she was aware of a sledgehammer incident because Dale told her about it. Dale, however denied any knowledge of a sledgehammer incident. In light of the evidence taken as a whole, the Arbitrator finds the testimony of Petitioner more persuasive and finds that Petitioner did sustain an accident which arose out of and in the course of his employment on January 17, 2017 and that proper notice was provided to respondent as required by the Act.

Having been told his claim would not be allowed, Petitioner continued to work his regular duties until he underwent surgery for unrelated bilateral carpal tunnel syndrome in March of 2017. Following his surgeries he returned to his regular duties for Respondent on April 26, 2017.

On May 1, 2017 Petitioner was assigned to place cylinder heads weighing approximately 150 pounds into a dumpster. Petitioner credibly testified that while shoving one of the heads off of a pallet into the dumpster he experienced an extreme exacerbation of his symptoms where after he reported the incident to Dale and was sent to Amber. Although Dale denies being told of an injury sustained on that day, Petitioner clearly spoke with Amber. He was given a paper with telephone numbers for the workers' compensation insurance carrier and Jason and also told to call Jason before he called the carrier. That same day Courtney Throne, Amber and Dale's sister sent a text message to her aunt, Petitioner's wife warning her that she needed to talk to Courtney's mother and Amber before Petitioner called Jason. Amber admitted completing a workers' compensation form, but no such document was placed into evidence. It is abundantly clear to this Arbitrator that Amber was aware that it was Petitioner's intent to make a claim for a work related injury.

In light of the evidence taken as a whole, the Arbitrator also finds that Petitioner sustained a second accident accident which arose out of and in the course of his employment on May 1, 2017 and that proper notice was provided to respondent as required by the Act.

As indicated above Petitioner candidly acknowledged he did not know that he had injured his neck. He thought the problem was with his arms. He further acknowledged that although he complained of his symptoms following the accidents, he never told Amber or Dale from the employer that he had a problem with his neck. Additionally, when Petitioner spoke with Amber May 1, 2017, he did not know he was having a problem with his neck, so he could not have told her about a neck problem. He indicated that he had no idea the problems he was experiencing were emanating from the neck until after the MRI of May 11, 2017.

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

The less than pristine histories contained in the medical records are not lost on the Arbitrator. However, in light of Petitioner's intellectual challenges and lack of sophistication in his oration, inconsistencies are understandable. Even during trial he described his symptoms in terms of his "whole body started tingling."

Dr. Purvines opined that Petitioner's described job activities from January 2017, striking pistons with a sledgehammer either caused or aggravated Petitioner's cervical condition. With regard to the accident of May 1, 2017 Dr. Purvines testified Petitioner probably already had a problem in his neck and his spinal cord was continuing to give him trouble and he felt the symptoms.

Dr. Robert Bernardi, although he agreed that Petitioner had disc herniations as described and surgically corrected by Dr. Purvines, did not believe Petitioner sustained any accidental injuries at work which caused the herniations. Specifically, Dr. Bernardi testified he was confident the disc herniations identified on the MRI study was not present in January 2017. He explained the disc herniation was huge, and there were signal changes on the MRI which suggested it was acute. Dr. Bernardi testified Petitioner made a remarkable recovery following the surgery performed by Dr. Purvines. He further testified that if Petitioner had severe cord compression for several months, he probably would not have done as well as he did in terms of his recovery. (

In general, the Arbitrator finds the testimony and opinions of Dr. Purvines more persuasive than those of Dr. Bernardi. While the Arbitrator disagrees with Dr. Bernardi's conclusion that Petitioner did not sustain injuries to his neck in work accidents of January 17, 2017 or May 1, 2017, does find Dr. Bernardi's opinion that the disc herniations revealed by the May 11, 2017 MRI were acute because there were signal changes on the MRI which suggested it was an acute injury Compelling.

Based upon the foregoing, and the record taken as a whole, the Arbitrator finds that Petitioner sustained injuries to his cervical spine as a result of the January 17, 2017 accident which were acutely aggravated and exacerbated by the accident of May 1, 2017, resulting in 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?

Issue (K): What temporary benefits are in dispute?

Respondent disputed its liability to pay medical and TTD benefits based upon the issues of accident, notice, and causation. Respondent does not dispute the reasonableness and necessity of the medical treatment provided, the cost of said treatment, or Petitioner's period of incapacity. Having found in favor of Petitioner on the issues of accident, notice, and causation, the Arbitrator finds Respondent is liable to pay medical expenses and TTD benefits.

Respondent shall pay reasonable and necessary medical services of $65,820.30, as set forth in Petitioner's exhibit 9, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall further pay Petitioner temporary total disability benefits of $360.00/week for 16 2/7 weeks, commencing 5/2/17 through 8/23/17, as provided in Section 8(b) of the Act.

These benefits will be awarded in 17 WC 20693 only.

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 neither party submitted an impairment rating. 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 Petitioner was engaged in heavy manual labor for Respondent tearing down and rebuilding locomotive engines. Following his cervical spine surgery he returned to work for a new employer filling vending machines. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 61 years old at the time of his injuries. Petitioner has diminished healing capacity and a low threshold for future injury as a result thereof. 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. As a result of his injuries Petitioner sustained disability to his cervical spine. According to Respondent's section 12 examiner the findings on Petitioner's May 11, 2017 MRI indicate acute injuries the cervical discs which ultimately required surgical intervention. Because the medical records and evidence taken as a whole corroborate the Petitioner's complaints of pain, weakness and loss of function, 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 10% loss of use of the person as a whole as a result of the January 17, 2017 accident and 15% loss of use of the person as a whole as a result on the May 1, 2017 accident, pursuant to §8(d)2 of the Act.

Issue (M) **Should penalties or fees be imposed upon Respondent?**

In light of the fact that Respondent had, at least, an arguable defense based upon the issues of accident, notice, and causation, Petitioner's claim for penalties is denied.

FINDINGS OF FACT

CONCLUSIONS

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROY MCGUIRE,

Petitioner,

vs.

20IWCC0152

NO: 17 WC 20719

MIDWEST POWER SOURCE, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, notice and nature and extent, and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of accident, but attaches the Decision of the Arbitrator for the Findings of Fact with the modifications noted below.

Petitioner testified that around January 17, 2017, he was using a sledgehammer to remove a piston and his "body from my neck down was tingling and wobbly." *T.64.* He testified that Zach Braundmeier was there when the incident happened, and Petitioner told him about the incident. *T.65-66.* Petitioner also testified:

Q: Did you tell anyone else about this incident?
A: I told Zach. Randy was standing over there next to him, and he said well, I think you need to tell Amber because Dale ain't going to do nothing. Just go straight to Amber. So that's what I did. *T.66.*

It is not clear from this testimony whether Petitioner was claiming that it was Zach or Randy who told him to tell Amber Braundmeier. But, later, Petitioner clarified that "the only one I told when it happened is Amber, Zach because he is the one that told me to go to Amber." *T.104.*

Petitioner testified that he talked to Amber that day or the next day and told her that he was "beating those packs out and I couldn't hold a sledgehammer anymore and my whole body from my neck down started tingling and wobbling, and I couldn't do it anymore. I need to see a doctor." *T.67.*

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Petitioner testified that he told Amber that his hands were hurting but Amber told him that Jason Tarasenko, Respondent's owner, would not allow him to see a doctor. Instead, Amber "came up with a plan" for Petitioner to save up his PTO (Personal Time Off) and short-term disability to have his carpal tunnel surgeries. *Id.*

Amber Braundmeier denied all of this. She testified that she does not remember talking to Petitioner in January 2017 about him hurting at work. *T.141.* It was in March when Petitioner came to her and asked her to start a short-term disability claim for carpal tunnel syndrome. *T.142, 150.* We note that Petitioner's bilateral carpal tunnel conditions are not part of Petitioner's claim before the Commission. *T.23.* Regarding whether Petitioner told anybody at Respondent about the sledgehammer incident, Amber testified:

Q: Did [Petitioner] ever tell you that he injured himself using a sledgehammer?
A: Not to me personally.
Q: Do you know if he told somebody else that?
A: Yes, it was brought up to, I think Dale and Randy on how it was, but I was never told. *T.155.*
...
Q: Now, and you said that ...[Petitioner] did tell Dale and Randy about a sledgehammer issue, correct?
A: That's, yes.
...
Q: So your testimony is [Petitioner] did tell Dale, the plant manager about a sledgehammer issue?
A: Yeah. *T.159.*

However, both Dale Lewis and Randy Throne disputed having any knowledge of a sledgehammer incident. Mr. Lewis testified that he knew nothing about a sledgehammer incident in January. *T.177.* He disagreed with Amber's testimony that Petitioner had told him about that incident. *T.178.* Mr. Lewis testified that during the first few months of 2017, Petitioner did not complain to him about any problems until May 1, 2017. *T.168.* Similarly, Mr. Throne testified that Petitioner told him in January 2017 that his hands were going numb but did not tell him that Petitioner had hurt himself using a sledgehammer. *T.183.* We find that Petitioner's complaints of hand numbness at that time would be consistent with his admittedly unrelated bilateral carpal tunnel syndrome.

We question when and how Amber became aware that Petitioner allegedly told Dale and Randy about the sledgehammer incident. Neither attorney asked detailed questions about this but, based on the above testimony, the Arbitrator wrote, "Amber denied knowledge of Petitioner reporting an injury to her, but admitted she was aware of a sledgehammer incident *because Dale told her about it.* Dale, however denied any knowledge of a sledgehammer incident." *Dec. at 9, emphasis added.* We find that this does not accurately reflect Amber's testimony. She did not say that Dale personally told her about the sledgehammer incident. Although she testified that Petitioner told Dale and Randy about the sledgehammer issue, she never testified how or when she came to know that.

We find Amber's testimony regarding what Dale and Randy knew about the alleged sledgehammer incident to be speculative. Furthermore, her testimony is inconsistent with Petitioner's own testimony about whom he told.

As discussed above, Petitioner testified that the only people he told about the sledgehammer incident were Zach and Amber. We find that Petitioner did not tell Dale or Randy about any

sledgehammer incident. We do, however, find Amber credible that neither Petitioner nor anybody else told her personally about any sledgehammer incident. The question remains whether Petitioner has proven that he told Zach about it and, if so, what significance that would have.

The first several paragraphs of the Arbitrator's Findings of Fact include statements without attributing the source of the testimony. Most of them are innocuous, agreed upon facts except for whether Zach Braundmeier was Petitioner's foreman. *Dec. at 3, ¶1.* The Arbitrator wrote, "the unrefuted testimony of Petitioner indicates he did tell his foreman, Zach about the incident." *Dec. at 6.* It is true that it is unrefuted that Petitioner told Zach since Zach did not testify and no longer works at Respondent. However, the claim that Zach had been Petitioner's foreman was refuted.

Petitioner testified that Zach "was supposed to be the foreman there at the time" of the accident. *T.65.* He testified that Zach was "my lead man." *T.116.* However, Randy Throne, a mechanic at Respondent, testified that Zach was not part of management. *T.194.* There does not appear to be any other testimony about whether Zach was a member of management and the Commission finds that Petitioner failed to prove that Amber's "husband Zach Braundmeier was Petitioner's foreman." *Dec. at 3.* However, this fact would primarily be relevant to the issue of notice, which we find is moot because Petitioner failed to prove the he sustained a compensable accident on January 17, 2017.

As an aside, we note that the only other testimony about an alleged sledgehammer incident in January is hearsay testimony from Petitioner's wife, Carla, which the Arbitrator properly did not rely upon in his decision.

Regardless of whether Petitioner may or may not have told Zach about the sledgehammer incident, the overriding fact is that none of the initial medical records mention such an event. Petitioner's first medical record is a January 27, 2017 visit with his primary-care-physician Dr. Jain, which states that Petitioner was there for immunizations. It was noted that Petitioner was negative for significant arthralgias, back pain, myalgias, paresthesias, and weakness. He had normal musculolskeletal strength and tone but he did have hypoesthesia in the bilateral median nerve distribution. Petitioner was diagnosed with bilateral carpal tunnel syndrome and referred to Dr. McKee.

Petitioner testified that he told Dr. Jain he had tingling from his neck down but that Dr. Jain didn't want to listen to what he had to say about the tingling in his neck, arms, and legs. *T.69, 103.* Petitioner also testified that he had a rubber band feeling around his abdomen during this time (*T.70*) but there are no medical records to support this. There is a physical therapy record from April 10, 2017, after his bilateral carpal tunnel surgeries, indicating a "rubberband" feeling around Petitioner's wrists, but nothing about his abdomen.

Petitioner testified that he also told Dr. McKee about all his symptoms. *Id.* However, Dr. McKee's February 10, 2017 record only mentions pain in both hands and numbness/tingling in the radial three digits, which had been going on for about six months.

On March 14, 2017, Petitioner underwent the bilateral carpal tunnel releases and a pre-operative physical indicated no positive exam findings except bilateral Tinel's and Phalen's signs. On that same date, Dr. McKee completed a short-term disability form indicating that Petitioner's disability was not due to an accident or Petitioner's employment and that Petitioner's symptoms first appeared in August 2016. These facts clearly do not support Petitioner's claim of a work accident with a sledgehammer in January 2017.

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Petitioner testified that after his carpal tunnel surgery while he was doing physical therapy, "I just sat around doing nothing, watched TV, bored." *T.72.* However, an April 17, 2017 physical therapy record indicates that he was "lifting and moving things in his garage all weekend but [continued] to have numbness and rubberband feeling in fingers with min pain." *Px4.* This medical record contradicts Petitioner's testimony about his physical abilities during that time.

Based on the above, Petitioner's claim that he had the "whole body" symptoms from January 17, 2017 onward is not persuasive. Petitioner worked full duty until his admittedly non-work-related carpal tunnel surgeries in March 2017. After his rehabilitation from those surgeries, he returned to work for Respondent at the end of April and worked three days "helping Randy build an engine." *T.73.* Although he claimed that his "body wasn't functioning right" during those three days (*T.74*), on cross-examination, Petitioner testified:

Q: And then when you started the day Monday, [5/1/17], do you remember what your symptoms were that day when you started the day?
A: On that Monday?
Q: Yeah.
A: I was relaxed and everything, and I don't know, I went to work and started – he told me to throw them heads in the dumpster and it all reoccurred again.

Amber testified that when Petitioner returned to work on April 26, 2017, after his carpal tunnel surgery, Petitioner clenched his fists, raised his hands and said, "I am a new man." *T.151, 157.* He then worked for three days with no problems. *Id.*

The Commission finds that Petitioner had a heavy-duty job, which did involve hitting metal pistons with a sledgehammer. However, Petitioner did not allege nor try this case as a repetitive trauma claim. Perhaps Petitioner did experience a "whole body" shock when he was using a sledgehammer in January 2017, but it seems that nothing would have come of that incident were it not for the events that took place on May 1, 2017. Petitioner did not seek any cervical treatment and did not incur any lost time from work due to any cervical issue until after May 1, 2017. It seems the only reason January 17, 2017 is a relevant date is because Petitioner told Dr. Purvines, on May 19, 2017, that this is when his problems began. However, as discussed above, this is not consistent with the medical evidence. Dr. Purvines opined that Petitioner's cervical herniation occurred on January 17, 2017, and that Petitioner's problems progressed since that time. However, Dr. Purvines was never told about any incident in early May 2017, which the records show is when Petitioner's symptoms severely worsened and which ultimately led to the recommendation for a cervical MRI and the referral to Dr. Purvines, a neurosurgeon.

The Commission finds the opinion of Respondent's Section 12 physician, Dr. Bernardi, to be more persuasive when he testified that the herniation on Petitioner's May 11, 2017 MRI is so "massive" and was causing such a "profound narrowing of his spinal canal," that it was the type of thing that did not evolve over weeks or months but, rather, hours or days. *Rx7 at 19.*

Based on all the above, we find that Petitioner failed to prove he sustained an accident on January 17, 2017. Although he may have experienced some temporary symptoms including a "shock" to his body on that date while using a sledgehammer, the evidence as a whole does not support a finding that there was any permanent change in Petitioner's physical condition or ongoing symptoms related to that event.

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We address Petitioner's May 1, 2017 accident separately in case number 17 WC 20693.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision filed November 14, 2018, is hereby reversed and all awards vacated.

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

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

DATED: MAR 4 - 2020

Maria E. Portela

Thomas J. Tyrrell

Kathryn A. Doerries

SE/
O: 1/7/20
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McGUIRE, ROY
Employee/Petitioner

Case# **17WC020719**

17WC020693

MIDWEST POWER SOURCE INC
Employer/Respondent

20IWCC0152

On 11/14/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2323 ROTH LAW OFFICES LLC
GEORGE ALBERS
2421 CORPORATE CENTRE DR #200
GRANITE CITY, IL 62040

0000 RUSIN & MACIOROWSKI LTD
R MARK COSIMINI
2506 GALEN DR SUITE 108
CHAMPAIGN, IL 61821

20IWCC0152

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

Roy McGuire
Employee/Petitioner

v.

Midwest Power source, Inc.
Employer/Respondent

Case # **17** WC **20719**

Consolidated cases: **17 WC 20693**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Springfield**, on **5/23/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of 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 _____

20IWCC0152

FINDINGS

On **1/17/17**, 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*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $**28,080.00**; the average weekly wage was $**540.00**.

On the date of accident, Petitioner was **61** years of age, ***married*** with **no** dependent children.

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

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

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

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

ORDER

Temporary Total Disability and Medical benefits are awarded in case number 17 WC 20693.

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 $**324.00**/week for a further period of **50** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **10% loss of use of the person as a whole**.

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

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

Michael K. Nowak, Arbitrator

10/11/18
Date

NOV 14 2018

ICArbDec p. 2

FINDINGS OF FACT

Petitioner was employed by Respondent Midwest Power Source, Inc. Prior to becoming Midwest, the company was known as Triple D Parts. That company was owned by Paula Lewis. Petitioner's wife, Carla, is the sister of Paula Lewis. Also employed by Triple D Parts were Paula's three children and the spouses of her two daughters. As of the dates in question in this case Paula's daughter, Amber Braundmeier was Respondent's office manager and her husband Zach Braundmeier was Petitioner's foreman. Also testifying, but no longer employed by Respondent was Paula's daughter Courtney Throne. Courtney's ex-husband Randy Throne was also employed by Respondent as a mechanic. Paula's son, Dale Lewis was Respondent's warehouse manager. Prior to the dates in question in this case Paula Lewis sold Triple D Parts to Jason who continued to operate the business as Midwest Power Source, Inc.

This case involves two claims which were consolidated for trial. The first involves an accident date of May 1, 2017, 17 WC 020693. The second involves an accident date of January 17, 2017, 17 WC 020719.

Petitioner has an eighth grade education which consisted of a special education curriculum. He cannot read or write very well. Since the eighth grade Petitioner has worked in various manual labor jobs. Petitioner testified his job duties for Respondent included tearing down and rebuilding locomotive engines, as well as cleaning parts.

One of Petitioner's job duties is to remove pistons from a cylinder-shaped liner which is also called a pack. Sometimes, the piston can simply be removed by hand, but sometimes, a sledgehammer is used to knock the piston loose.

Petitioner testified that on January 17, 2017, he was attempting to remove a piston from a pack. He indicated that generally the pack would be laid on its side on the floor and struck with the sledgehammer in what he described as a golf swing like motion. On that date, however he had been unable to move the piston with the pack lying horizontally so he had the pack standing up in a vertical position, and he used an overhead swing with a sledgehammer to strike the top of the piston. Petitioner indicated he immediately felt tingling in his neck all the way down to his toes.

Petitioner testified that Zach was in the vicinity when the incident occurred, and that Zach actually tried striking the piston a couple of times before discarding it. He further testified he told Zach about the symptoms he was feeling after striking the Piston while Zach was standing next to Randy. He then told Amber, the office manager, about the incident either January 17, 2017 or January 18, 2017. He further testified that Amber told him the owner of the company, Jason, would not allow it. Petitioner and his wife both credibly testified that he was the sole bread winner and that Mrs. McGuire suffers from a serious medical condition which requires them to maintain health insurance at their own expense. Consequently, Petitioner continued to work while suffering from symptoms. Although his speech is far from eloquent, the Arbitrator found the Petitioner's testimony, as well as that of his wife forthright and credible.

The first medical note admitted in evidence is dated January 27, 2017. Petitioner was evaluated by his primary care physician, Dr. Rajneesh Jain. (Px.1, Rx.1) Petitioner was noted to have diabetes and high cholesterol. The musculoskeletal exam was negative for significant arthralgias, back pain, and myalgias. The

neurological findings were negative for dizziness, headaches, paresthesias, and weakness. However, on exam, the neurologic testing revealed hypoesthesia in the bilateral median nerve distributions. Based upon the symptoms in the median nerve distributions, Dr. Jain diagnosed Petitioner with bilateral carpal tunnel syndrome. He referred Petitioner to a surgeon for the evaluation of the carpal tunnel syndrome. Dr. Jain's January 27, 2017 note does not make any mention of numbness from Petitioner's neck down to his toes and does not make any mention of Petitioner sustaining an injury at work.

On February 10, 2017, Petitioner was evaluated by Dr. Craig McKee who is a plastic surgeon. (Px.2, Rx.2) Dr. McKee diagnosed Petitioner with fairly severe bilateral carpal tunnel syndrome. He did not believe Petitioner was suffering from ulnar neuropathy. Petitioner indicated he had to acquire some sick time in order to be able to undergo surgery. Dr. McKee performed bilateral carpal tunnel releases March 14, 2017. (Px.2)

After a couple of follow-up visits, Dr. McKee evaluated Petitioner April 25, 2017. He noted Petitioner was complaining of tingling in all of his digits as well as complaining of stiffness in his hands. Petitioner was not experiencing any elbow pain, but Dr. McKee thought Petitioner may be suffering from cubital tunnel syndrome. Petitioner requested a full-duty release, and Dr. McKee granted the request discharging Petitioner from care without imposing any restrictions.

Petitioner was off work from March 14, 2017 through April 25, 2017, and he returned to work Wednesday, April 26, 2017. Petitioner's bilateral carpal tunnel syndrome is not part of this claim.

Petitioner testified that when he returned to work April 26, 2017, he was experiencing symptoms from his neck down.

Petitioner testified that on May 1, 2017, he used a forklift with a skid to move the heads/liners into a scrap bin. He testified he had to slide the heads off of a skid into a dumpster. Petitioner testified that while performing those job duties, he was hurting and was experiencing tingling in his neck down to his toes. He still felt like he had a rubber-band around his abdomen. He reported having a difficult time getting up from the ground and he was having problems with his whole body including his feet, neck, and arms.

Petitioner next sought medical treatment May 5, 2017. He was evaluated by Dr. Jain's nurse practitioner, Mara Knoche. (Px.1, Rx.3) Petitioner and his wife provided a history to Nurse Knoche of low back pain with numbness and tingling in his legs. Petitioner's primary discomfort was in the lower lumbar spine, and he indicated his symptoms radiated to the thighs. He described the symptoms as a constant pins and needles sensation. The note indicates this was an acute episode, but it also indicates the current episode of pain started five months earlier. Petitioner did not recall any precipitating event or injury. The note indicates it occurred at home. Aggravating factors contributing to the back pain were thought to possibly be job-related repetitive lifting with a back strain. On exam, hypoesthesia was noted in the bilateral L4 distribution. Petitioner was diagnosed with low back pain. X-rays taken of the low back revealed a mild anterolisthesis of L5 on S1 which was likely secondary to pars defects.

Petitioner returned to see Nurse Knoche May 9, 2017. Petitioner's symptoms were again most prominent in the lower lumbar spine, and they radiated to the thighs. The note indicates Petitioner reported the event which precipitated the pain was job-related repetitive lifting. Petitioner complained of neck pain which

was diffuse. He indicated the symptoms radiated to his arms and the symptoms consisted of a pins and needles sensation. Petitioner could not recall the time of initial onset. Nurse Knoche noted the symptoms were apparently ongoing, but they were not previously mentioned. On exam, positive neurological findings were identified including ataxia and weakness in both the arms and legs as well as numbness in the hand. Additionally, Petitioner was noted to be shuffling in a slowed and unsteady manner. Petitioner's reflexes were increased, and his speech pattern was thought to be pressured. Petitioner was referred to the St. John's Hospital emergency room.

The St. John's Hospital records were admitted in evidence as Petitioner's Exhibit 5 and Respondent's Exhibit 5. The chief complaint was listed as "stroke symptoms." The history indicates Petitioner had diffuse paresthesias and generalized malaise which started in January. Petitioner reported a sudden onset in January followed by constant symptoms since then. The symptoms included generalized weakness. On exam, Petitioner had a full range of motion with stability, muscle strength, and normal tone of his upper and lower extremities. A CT-scan of the head was performed, but it did not reveal any abnormalities.

On May 11, 2017, an MRI of the cervical spine was performed. It revealed severe cervical spondylosis with myelomalacia at C4-5 and C5-6.

Petitioner returned to see Dr. Jain May 12, 2017. Dr. Jain indicated Petitioner was sent to the emergency room for findings suspicious of cervical myelopathy with spastic quadriparesis, but Petitioner was evaluated for a stroke and was discharged. Dr. Jain referred Petitioner to Dr. Purvines for a consult.

The Arbitrator notes that the section 12 examination report of Dr. Bernardi references a May 17, 2017 workers' compensation form from Staunton Clinic, however the Arbitrator is not able to locate any such document in the record.

Petitioner saw Dr. Purvines May 19, 2017. (Px.7) The history indicates that about January 15, 2017, Petitioner had an incident at work while dismantling an engine. The history indicates Petitioner was hammering pistons out of an engine and had an abrupt onset of weakness and numbness in his extremities which persisted until the time of the visit with Dr. Purvines. Dr. Purvines noted a spastic gait and diffuse weakness in the upper extremities and the lower extremities. Dr. Purvines interpreted the MRI to show large central and right-sided herniated discs at C4-5 and C5-6 which were severely compressing the spinal cord. Dr. Purvines commented that the pathology likely occurred at the time of the work incident in January.

On June 1, 2017, Dr. Purvines performed surgery on Petitioner's neck. The procedures consisted of a discectomy, foraminotomy and fusion at the C4-5 and C5-6 levels.

Dr. Purvines post-operative note dated July 13, 2017 indicates Petitioner was doing quite well with substantially reduced or eliminated pain in his upper extremities and neck. On exam, Petitioner's strength and sensation in the bilateral upper extremities were thought to be normal, but Petitioner had decreased cervical range of motion. Dr. Purvines recommended a course of physical therapy to prepare Petitioner for his strenuous job. On August 23, 2017, Dr. Purvines allowed Petitioner to return to work in a full-duty capacity effective August 24, 2017.

Amber Braundmeier was called to testify. She denied speaking with Petitioner in January 2017 concerning any type of injury. She indicated that as the only person in the front office, all claims by injured workers go through her. The process is that a worker should report an injury to the supervisor, and then the supervisor will send the worker to Amber to complete the workers' compensation paperwork. The Arbitrator notes that the unrefuted testimony of Petitioner indicates he did tell his foreman, Zach about the incident.

Amber testified the first time she spoke with Petitioner about any type of physical complaint was on March 6, 2017 when Petitioner requested short-term disability forms for his unrelated carpal tunnel syndrome.

Dale Lewis also testified. He is the production supervisor for Respondent, and Amber's brother. He testified he had no knowledge of Petitioner injuring his neck in January 2017. He also testified he had no knowledge of Petitioner sustaining any type of injury as a result of using a sledgehammer. With respect to the job duties described by Petitioner, Mr. Lewis testified it would be improper for a worker to stand a liner on end so it was vertical and then strike the top of the liner with a sledgehammer. He explained that would not be useful in removing the piston, and it would render the liner useless.

Randy Throne also testified. He is a mechanic who performs many of the same job duties as Petitioner. He testified that they sometimes do stand the liners on end and strike them with a sledgehammer. Mr. Throne also testified he had no knowledge of Petitioner injuring his neck or any other body parts in January 2017.

Amber testified that when Petitioner returned to work April 26, 2017, he indicated he was a new man and gestured with his hands as though they were cured.

Randy testified Petitioner indicated he never felt better when he returned to work following the carpal tunnel surgeries. Randy also testified Petitioner performed his regular job duties from April 26, 2017 through April 28, 2017. Petitioner did not make any complaints of having any problems during that time period.

Randy testified that on May 1, 2017, he asked Petitioner to perform discard some cylinder heads. He indicated he did not see Petitioner after that time. Petitioner indicated that while pushing the heads off a pallet which was suspended by a fork lift into the dumpster he again experienced a jolt of pain like he had in January. He further indicated he walked over to Dale and Randy, told them about the incident and was referred to speak with Amber. Petitioner candidly admitted he did not tell them he had sustained a neck injury at that time because until the MRI was performed and he spoke with his doctor in mid May he had no idea the symptoms were coming from his neck.

Dale testified that on May 1, 2017, Petitioner came to him saying he could no longer perform his job duties. Dale immediately sent Petitioner to Amber to report his difficulties. Amber testified that when Petitioner came to her office May 1, 2017, he indicated that the workplace crippled him. She alleged Petitioner complained of problems with his leg and shoulder.

Amber allegedly documented the conversation between she and Petitioner. She testified she read the documentation to Petitioner which indicates Petitioner was not able to perform his job duties due to his leg and shoulder and not being able to hold on to anything. (Rx.6) She said Petitioner came in and told her he needed to file a workers' compensation claim. She also claimed she never spoke to Paula or Courtney on May 1, 2017.

Amber, Dale, and Randy each testified that Petitioner did not advise them of a new accident or new injury on May 1, 2017. The Arbitrator notes that there clearly was some communication regarding work related disability on that day. None of the witnesses indicated that they questioned Petitioner about his condition and its cause where after Petitioner denied a work accident.

Amber testified that she completed an accident report to be submitted to the workers' compensation insurance carrier, and she provided a copy to Petitioner. Petitioner denied ever receiving an accident report. Significantly, the Arbitrator notes no such report was offered into evidence. Further, Petitioner testified that Amber provided him a paper with telephone numbers for the workers' compensation carrier and Jason and told him to call Jason first.

The Arbitrator notes there were a number of inconsistencies in the testimony of Respondent's witnesses. By way of example, Amber testified that she was aware of an incident with a sledgehammer because Petitioner told dale and Randy about it, and presumably they told her. Dale, however denies knowing about a sledgehammer incident.

Courtney Throne was called by Petitioner as an adverse witness. Although at the time of Petitioner's injuries she no longer worked for Respondent, on May 1, 2017 she sent a text message to Mrs. McGuire warning that Petitioner was about to "fuck up" their lives and she should call mom (Paula Lewis) before Roy calls Jason. She vehemently denied speaking with anyone from Respondent on May 1, 2017 alleging instead that Petitioner was the one who told her he was claiming a work related accident. She had previously denied speaking with Petitioner since prior to his carpal tunnel surgeries in March of 2017. Ms. Throne was noted to be quite evasive in her answers and was simply not credible in her attempts to explain how she became aware of Petitioner's injury on May 1, 2017.

Petitioner testified that he first attempted to contact the workers' compensation insurance carrier, but got an answering machine so he then called Jason. Petitioner's wife testified that the call between Petitioner and Jason occurred at their home and she was listening to the conversation as the phone was set to speaker mode. Both agreed that Petitioner had told Jason of the accident which occurred on May 1, 2017. Petitioner was told Jason would not stand for him making a claim and that "I (Jason) gotta do what I gotta do, and you gotta do what you gotta do."

The Arbitrator notes that Jason was not called to testify.

At the request of Respondent, Petitioner was evaluated by Dr. Robert Bernardi on October 24, 2017. Both Dr. Purvines and Dr. Bernardi testified by way of evidence deposition.

Dr. Purvines testified by way of evidence deposition on September 12, 2017. (Px.10) Dr. Purvines first evaluated Petitioner May 19, 2017. Petitioner provided a history of hammering pistons out of an engine January 15, 2017 and having an abrupt onset of weakness and numbness in his extremities. (Px.10, pp.6-7) Petitioner also told Dr. Purvines that despite undergoing carpal tunnel surgery, he continued to have trouble with his arms and legs with difficulty walking and pain in his neck. Petitioner also told Dr. Purvines he was using a sledgehammer. (Px.10, p.7)

Dr. Purvines interpreted the MRI study from May 11, 2017 to show a large disc herniation at C4-5 which was severely compressing the spinal cord. He also identified a similar finding at C5-6 which was also severely compressing the spinal cord. (Px.10, p.10) Dr. Purvines rendered an opinion Petitioner's described job activities from January 2017 either caused or aggravated Petitioner's cervical condition. (Px.10, p.12)

Dr. Purvines performed surgery on Petitioner's neck consisting of a C4-5 and C5-6 anterior cervical discectomy and fusion. (Px.10, p.13)

Petitioner's attorney provided a history to Dr. Purvines of Petitioner moving heavy engine parts at about chest height and asked whether those job duties could cause or aggravate the cervical condition. Dr. Purvines testified Petitioner probably already had a problem in his neck and his spinal cord was continuing to give him trouble and he felt the symptoms. (Px.10, pp.14-16)

With respect to Petitioner's restrictions, Dr. Purvines acknowledged his work note dated August 23, 2017 indicating he allowed Petitioner to return to work in a full-duty capacity as of August 24, 2017. He further acknowledged that the full-duty release was rendered with the knowledge that Petitioner would be performing his regular job duties using a sledgehammer to pound on pistons. (Px.10, pp.42-43)

When asked about Petitioner's capabilities following the alleged incident from January 2017, Dr. Purvines testified Petitioner may not have been able to lift more than 5-10 pounds and may have had a difficult time lifting a bag of groceries. (Px.10, p.30)

Dr. Robert Bernardi testified on behalf of Respondent by way of evidence deposition on December 1, 2017. His testimony was based upon a section 12 examination he performed October 24, 2017. (Rx.7)

Following the October 24, 2017 IME, Dr. Bernardi prepared a 12-page report documenting a history provided by Petitioner, the medical records, diagnostic studies, Dr. Bernardi's exam of Petitioner, and Dr. Bernardi's opinions. The report was admitted in evidence at the time of Dr. Bernardi's deposition. (Rx.7, Dep. Ex.2)

Dr. Bernardi testified he was confident the disc herniation identified on the MRI study was not present in January 2017. He explained the disc herniation was huge, and there were signal changes on the MRI which suggested it was acute. He further opined that a disc herniation that large would cause rapidly evolving symptoms and not symptoms that would evolve over four or five months. (Rx.7, p.14)

Dr. Bernardi testified Petitioner made a remarkable recovery following the surgery performed by Dr. Purvines. He further testified that if Petitioner had severe cord compression for several months, he probably would not have done as well as he did in terms of his recovery. (Rx.7, p.16) Dr. Bernardi agreed with Dr. Purvines that Petitioner did not need any formal restrictions on his activities. (Rx.7, p.18)

Dr. Bernardi testified he could not conclude that Petitioner sustained an injury in mid-January 2017 involving his neck. He explained the disc herniation at C4-5 could not have been present for four months. He believed the disc herniation was present for a much shorter period of time. He further testified the spasticity with Petitioner's gait could not have gone unnoticed for several months without somebody picking up on it. (Rx.7, pp.22-23)

When asked about Dr. Purvines' opinion that Petitioner was suffering from pathology in January 2017, and the condition progressively got worse, Dr. Bernardi testified it was possible. However, he testified it was an unlikely scenario. He explained pressure on the spinal cord can cause hand symptoms. However, the symptoms would involve all of the fingers on both hands. It would not be dependent upon wrist posture or anything else, and it would not be intermittent. It would be constant. (Rx.7, pp.24-25)

Although he was of the opinion that the disc herniations revealed on the MRI study from May 11, 2017 were acute, Dr. Bernardi testified he could not conclude that Petitioner suffered from a work accident in May 2017. (Rx.7, pp.25-26)

At trial, Petitioner testified that following the surgery on his neck, the symptoms he had which included shaking, wobbliness, and everything including the rubber-band feeling around his abdomen went away. Petitioner testified his whole body was normal again. Petitioner also testified the only issues he still had as of the time of trial are with his little finger and ring finger. Petitioner believes it had something to do with his carpal tunnel. Petitioner did indicate that he could not move his head back too far. Petitioner testified his current job included filling vending machines and soda machines.

As indicated above Petitioner candidly acknowledged he did not know that he had injured his neck. He thought the problem was with his arms. He further acknowledged that although he complained of his symptoms following the accidents, he never told Amber or Dale from the employer that he had a problem with his neck. Additionally, when Petitioner spoke with Amber May 1, 2017, he did not know he was having a problem with his neck, so he could not have told her about a neck problem. He indicated that he had no idea the problems he was experiencing were emanating from the neck until after the MRI of May 11, 2017.

CONCLUSIONS

Although he was of the opinion that the disc herniations revealed on the MRI study from May 11, 2017 were acute, Dr. Bernardi testified he could not conclude that Petitioner suffered from a work accident in May 2017. He arrived at this conclusion based upon a number of factual determinations which are within the province of the Commission and with which the Arbitrator disagrees.

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

Issue (E): Was timely notice of the accident given to Respondent?

Petitioner credibly testified that on January 17, 2017 he sustained an injury while striking a piston with a sledgehammer. He further indicated that he told his foreman, Zach, that he had been injured and that Zach himself hit the piston a couple of times before throwing it into the trash. Petitioner was then directed to speak with Amber which he testified he did and was told that Jason would not allow a claim. Amber denied knowledge of Petitioner reporting an injury to her, but admitted she was aware of a sledgehammer incident because Dale told her about it. Dale, however denied any knowledge of a sledgehammer incident. In light of the evidence taken as a whole, the Arbitrator finds the testimony of Petitioner more persuasive and finds that Petitioner did sustain an accident which arose out of and in the course of his employment on January 17, 2017 and that proper notice was provided to respondent as required by the Act.

Having been told his claim would not be allowed, Petitioner continued to work his regular duties until he underwent surgery for unrelated bilateral carpal tunnel syndrome in March of 2017. Following his surgeries he returned to his regular duties for Respondent on April 26, 2017.

On May 1, 2017 Petitioner was assigned to place cylinder heads weighing approximately 150 pounds into a dumpster. Petitioner credibly testified that while shoving one of the heads off of a pallet into the dumpster he experienced an extreme exacerbation of his symptoms where after he reported the incident to Dale and was sent to Amber. Although Dale denies being told of an injury sustained on that day, Petitioner clearly spoke with Amber. He was given a paper with telephone numbers for the workers' compensation insurance carrier and Jason and also told to call Jason before he called the carrier. That same day Courtney Throne, Amber and Dale's sister sent a text message to her aunt, Petitioner's wife warning her that she needed to talk to Courtney's mother and Amber before Petitioner called Jason. Amber admitted completing a workers' compensation form, but no such document was placed into evidence. It is abundantly clear to this Arbitrator that Amber was aware that it was Petitioner's intent to make a claim for a work related injury.

In light of the evidence taken as a whole, the Arbitrator also finds that Petitioner sustained a second accident accident which arose out of and in the course of his employment on May 1, 2017 and that proper notice was provided to respondent as required by the Act.

As indicated above Petitioner candidly acknowledged he did not know that he had injured his neck. He thought the problem was with his arms. He further acknowledged that although he complained of his symptoms following the accidents, he never told Amber or Dale from the employer that he had a problem with his neck. Additionally, when Petitioner spoke with Amber May 1, 2017, he did not know he was having a problem with his neck, so he could not have told her about a neck problem. He indicated that he had no idea the problems he was experiencing were emanating from the neck until after the MRI of May 11, 2017.

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

The less than pristine histories contained in the medical records are not lost on the Arbitrator. However, in light of Petitioner's intellectual challenges and lack of sophistication in his oration, inconsistencies are understandable. Even during trial he described his symptoms in terms of his "whole body started tingling."

Dr. Purvines opined that Petitioner's described job activities from January 2017, striking pistons with a sledgehammer either caused or aggravated Petitioner's cervical condition. With regard to the accident of May 1, 2017 Dr. Purvines testified Petitioner probably already had a problem in his neck and his spinal cord was continuing to give him trouble and he felt the symptoms.

Dr. Robert Bernardi, although he agreed that Petitioner had disc herniations as described and surgically corrected by Dr. Purvines, did not believe Petitioner sustained any accidental injuries at work which caused the herniations. Specifically, Dr. Bernardi testified he was confident the disc herniations identified on the MRI study was not present in January 2017. He explained the disc herniation was huge, and there were signal changes on the MRI which suggested it was acute. Dr. Bernardi testified Petitioner made a remarkable recovery following the surgery performed by Dr. Purvines. He further testified that if Petitioner had severe cord compression for several months, he probably would not have done as well as he did in terms of his recovery. (

In general, the Arbitrator finds the testimony and opinions of Dr. Purvines more persuasive than those of Dr. Bernardi. While the Arbitrator disagrees with Dr. Bernardi's conclusion that Petitioner did not sustain injuries to his neck in work accidents of January 17, 2017 or May 1, 2017, does find Dr. Bernardi's opinion that the disc herniations revealed by the May 11, 2017 MRI were acute because there were signal changes on the MRI which suggested it was an acute injury Compelling.

Based upon the foregoing, and the record taken as a whole, the Arbitrator finds that Petitioner sustained injuries to his cervical spine as a result of the January 17, 2017 accident which were acutely aggravated and exacerbated by the accident of May 1, 2017, resulting in 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?

Issue (K): What temporary benefits are in dispute?

Respondent disputed its liability to pay medical and TTD benefits based upon the issues of accident, notice, and causation. Respondent does not dispute the reasonableness and necessity of the medical treatment provided, the cost of said treatment, or Petitioner's period of incapacity. Having found in favor of Petitioner on the issues of accident, notice, and causation, the Arbitrator finds Respondent is liable to pay medical expenses and TTD benefits.

Respondent shall pay reasonable and necessary medical services of $65,820.30, as set forth in Petitioner's exhibit 9, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall further pay Petitioner temporary total disability benefits of $360.00/week for 16 2/7 weeks, commencing 5/2/17 through 8/23/17, as provided in Section 8(b) of the Act.

These benefits will be awarded in 17 WC 20693 only.

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 neither party submitted an impairment rating. 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 Petitioner was engaged in heavy manual labor for Respondent tearing down and rebuilding locomotive engines. Following his cervical spine surgery he returned to work for a new employer filling vending machines. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 61 years old at the time of his injuries. Petitioner has diminished healing capacity and a low threshold for future injury as a result thereof. 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. As a result of his injuries Petitioner sustained disability to his cervical spine. According to Respondent's section 12 examiner the findings on Petitioner's May 11, 2017 MRI indicate acute injuries the cervical discs which ultimately required surgical intervention. Because the medical records and evidence taken as a whole corroborate the Petitioner's complaints of pain, weakness and loss of function, 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 10% loss of use of the person as a whole as a result of the January 17, 2017 accident and 15% loss of use of the person as a whole as a result on the May 1, 2017 accident, pursuant to §8(d)2 of the Act.

Issue (M) **Should penalties or fees be imposed upon Respondent?**

In light of the fact that Respondent had, at least, an arguable defense based upon the issues of accident, notice, and causation, Petitioner's claim for penalties is denied.

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

DONALD SCHROYER II,

Petitioner,

vs. NO: 17 WC 026949

STATE OF ILLINOIS,

Respondent.

20IWCC0153

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 temporary total disability, maintenance, vocational rehabilitation, and penalties and fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Com.*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

Temporary Total Disability

Entitlement to temporary total disability benefits is dependent on a claimant showing not only that he or she did not work but also that he or she was unable to work. *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 887, 559 N.E.2d 526, 531 (1990). A claimant is entitled to temporary total disability benefits until such time that claimant's condition has recovered to such a degree that the permanent nature of the injury is discernable. *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527, 542, 865 N.E.2d 342, 356 (2007). The dispositive question is whether the claimant's condition has stabilized, i.e. reached maximum medical improvement. *Interstate Scaffolding, Inc. v. Ill. Workers' Comp. Comm'n*, 236 Ill. 2d 132, 142, 923 N.E.2d 266, 271 (2010). Factors considered when determining whether a condition has stabilized include a release to return

to work, medical testimony and the extent of the injury. *Land & Lakes Co. v. Industrial Comm'n*, 359 Ill. App. 3d 582, 594, 834 N.E.2d 583 (2005).

Petitioner sustained an undisputed accident injury on July 17, 2017, when he struck his left shoulder and hip against electrical boxes after falling from a ladder. (T. pp. 16-17) He was treated in the Katherine Shaw Bethea Hospital emergency room that day for a closed traumatic dislocation of the AC joint, contusion of the chest, and contusion of the pelvis and was discharged that same day with work restrictions that prohibited him from using his left arm. (PX1) He presented to Physicians Immediate Care the same day he was discharged from Katherine Shaw Bethea Hospital, July 17, 2017, where he was prescribed the same work restriction as he had been given upon his discharge from Katherine Shaw Bethea Hospital. (T. p. 20) Respondent was unable to accommodate his restriction. (T. p. 20)

Petitioner transferred from Physicians Immediate Care to OrthoIllinois where he came under the care of Dr. Robin Borchardt on July 21, 2017. (PX3) Dr. Borchardt and his colleagues at OrthoIllinois, Dr. Scott Trenhaile and Certified Nurse Practitioner Michael Gilbertson, either continued the restriction that allowed Petitioner to use his right arm only or precluded him from working at all throughout Petitioner's treatment at OrthoIllinois. (PX3) Following a Functional Capacity Evaluation conducted by XRTS on June 14, 2018, that determined the weights Petitioner could safely handle with his left arm, Dr. Borchardt, on June 21, 2018, imposed permanent restrictions upon Petitioner's use of his left arm and discharged Petitioner from his care.

Petitioner being released from medical care on June 21, 2018, and not seeking further medical treatment after that date establishes June 21, 2018, as the date Petitioner's condition stabilized. Accordingly, the Commission modifies the Decision of the Arbitrator and declares Petitioner to have been temporarily totally disabled from July 18, 2017, through June 21, 2018.

Maintenance

Section 8(a) of the Act requires employers to pay for their employees' necessary physical, mental, and vocational rehabilitation, including the costs and expenses of maintenance. *Roper Contracting v. Industrial Comm'n*, 349 Ill. App. 3d 500, 505, 812 N.E.2d 65, 70, 285 Ill. Dec. 476 (2004); 820 ILCS 305/8(a) (2013). Maintenance is often a continuation of temporary total disability. *Connell v. Industrial Comm'n*, 170 Ill. App. 3d 49, 55, 523 N.E.2d 1265, 1269, (1988). Instances may arise when temporary total benefits cease but maintenance benefits for vocational rehabilitation continue. *Freeman United Coal Mining Co. v. Industrial Comm'n*, 318 Ill. App. 3d 170, 180, 741 N.E.2d 1144, 1152 (2000). Entitlement to rehabilitation is generally found when a worker experiences an injury that results in a reduction of earning power and the rehabilitation will improve the worker's earning capacity. *National Tea Co. v. Industrial Com.*, 97 Ill. 2d 424, 432, 454 N.E.2d 672, 676 (1983). A good faith effort must be made by a claimant seeking maintenance benefits. *Archer Daniel Midland Co. v. Industrial Comm'n*, 138 Ill. 2d 107, 115-16, 561 N.E.2d 623, 626 (1990).

Despite being allowed to return to work by Dr. Borchardt on June 21, 2018, Petitioner was unable to return to his normal and customary employment as a Stationary Engineer for Respondent given the residual effects of Petitioner's injury to his left arm and the permanent restrictions

imposed concerning the use of Petitioner's left arm. The parties recognized Petitioner's circumstances have resulted in him experiencing a reduction of earning power as contemplated in *National Tea Co.* and in need for rehabilitation to improve Petitioner's earning capacity.

Petitioner was contacted by a vocational rehabilitation specialist from Creative Case Management by telephone in September 2018, and they subsequently met over one-and-a-half hours to two hours at a local coffee house. (T. p. 40) The meeting ended with the vocational rehabilitation specialist stating that she would draft a résumé for him and would contact both his attorney and TriStar and then schedule another meeting with him for her to teach him how to apply for jobs and how to complete job applications. (T. p. 41) Petitioner testified he was not instructed by the vocational rehabilitation specialist to look for work. (T. p. 41) Petitioner provided the vocational rehabilitation specialist with his contact information but never heard from her. (T. p. 54)

Petitioner went without vocational rehabilitation from September 2018 through January 25, 2019. Between those dates, he switched attorneys, and, at the request of his new attorney, met with Kathleen Mueller, a vocational rehabilitation specialist from Independent Rehab Services, Inc., on January 25, 2019. (T. p. 43) She believed Petitioner had lost access to his "usual and customary line of work" and found him to be a candidate for vocational rehabilitation services. (PX6. p. 7) She and Petitioner met on February 27, 2019, March 6, 2019, and March 13, 2019. (PX11) She identified potential jobs for Petitioner and taught him how to search for jobs online, and he documented his job searches in a job search log that he gave to Ms. Mueller during their bimonthly meetings. (T. pp. 60, 45-46) Ms. Mueller testified to believing Petitioner possesses the desire to work and the skills to perform entry-level work given his physical limitations. (T. p. 73)

Petitioner made a good faith effort to participate in vocational rehabilitation with Creative Case Management and, then, with Independent Rehab Services. No evidence was offered to the contrary. The good faith participation with vocational rehabilitation along with his impairment of earning capacity due to his industrial accident entitle Petitioner to maintenance from the June 22, 2018, through the date of the arbitration hearing, April 17, 2019, and continued vocational rehabilitation.

Vocational Rehabilitation

The Commission modifies the **Findings** section of the Decision of the Arbitrator to add to the Arbitrator's findings, "The Arbitrator finds Petitioner is entitled to vocational rehabilitation as recommended by Kathleen Mueller."

The Commission modifies the **Order** section of the Decision of the Arbitrator to add, "Respondent shall provide and pay for the vocational rehabilitation as recommended by Kathleen Mueller."

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,250.10 per week for a period of 48-3/7 weeks, commencing July 18, 2017, through June 21, 2018, 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 maintenance benefits of $1,250.10 per week for 42-6/7 weeks, commencing June 22, 2018, through April 17, 2019, as provided for under §8(a) of the Act.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner $3,340.00 as provided for under §16 of the Act, $8,350.00 as provided for under §19(k) of the Act, and $2,730.00 as provided for under §19(l) of the Act.

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

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.

Pursuant to Section 19(f)(1) of the Act, this decision is not subject to judicial review. 820 ILCS 305/19(f)(1) (West 2013).

DATED: MAR 4 - 2020
KAD/mav
O: 01/07/20
42

Thomas J. Tyrrell

Maria E. Portela

DISSENT

I disagree with the award of penalties and attorney's fees under Sections 19(k) and 16, respectively.

The Arbitrator awarded $8,350.00 in penalties under Section 19(k) of the Act, penalties that represented 50% of the unpaid maintenance benefits after January 17, 2019, through the date of hearing, April 17, 2019. The Arbitrator also awarded attorney's fees, pursuant to Section 16, in the amount of $3,340.00, an amount representing 20% of the compensation owed to Petitioner as of the date of the arbitration hearing. Based on the evidence presented, the awarded penalties and attorney's fees under Sections 19(k) and 16 are not warranted.

Attorneys' Fees under Section 16

> 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 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 underpayment 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 insurance carrier. 820 ILCS 305/16 (2013).

Penalties under Section 19(k)

> 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) (2013).

In *Jacobo v. Ill. Workers' Comp. Comm'n*, the Court reviewed Illinois precedent for assessing penalties and attorneys' fees, finding penalties under Section 19(k) and attorneys' fees under Section 16 to be reserved for situations where the delay is premised on bad faith. The *Jacobo* Court explained:

> An award of penalties and attorney fees pursuant to Sections 19(k) and 16 are "intended to promote the prompt payment of compensation where due and to deter those occasional employers or insurance carriers who might withhold payment from other than legitimate motives." *McMahan v. Industrial Comm'n*, 289 Ill. App.

3d 1090, 1093, 683 N.E.2d 460, 463 (1997), *aff'd*, 183 Ill. 2d 499, 702 N.E.2d 545 (1998).

The standard for awarding penalties and attorney fees under Sections 19(k) and 16 of the Act is higher than the standard for awarding penalties under Section 19(*l*) because Sections 19(k) and 16 require more than an "unreasonable delay" in payment of an award. *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 514-15, 702 N.E.2d 545, 552 (1998). It is not enough for the claimant to show that the employer simply failed, neglected, or refused to make payment or unreasonably delayed payment without good and just cause. *McMahan*, 183 Ill. 2d at 515, 702 N.E.2d at 552. Instead, Section 19(k) penalties and Section 16 fees are "intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose." *McMahan*, 183 Ill. 2d at 515, 702 N.E.2d at 553. In addition, while Section 19(*l*) penalties are mandatory, the imposition of penalties and attorney fees under Sections 19(k) and Section 16 fees is discretionary. *Id.*

Jacobo v. Ill. Workers' Comp. Comm'n, 2011 IL App (3d) 100807WC, 959 N.E.2d 772, 777-778.

The imposition of penalties under Section 19(k) and attorney's fees under Section 16 requires a higher threshold be overcome than under Section 19(l). Whereas penalties under Section 19(l) are to be awarded whenever the employer or its carrier simply fails, neglects, or refuses to make payment or unreasonably delays payment without good and just cause, penalties under Section 19(k) and Section 16 require that not only is there a delay, but "the delay be deliberate or the result of bad faith or improper purpose. This apparent in the statute's use of the terms 'vexatious,' 'intentional' and 'merely frivolous.'" *Armour Swift-Eckrich v. Indus. Comm'n (Williams)*, 355 Ill. App. 3d 708, 712, 823 N.E.2d 1103, 1106 (2005).

The Arbitrator found Respondent's refusal to pay Petitioner weekly compensation benefits after January 17, 2019, to be unreasonable and vexatious. (AD, p. 9) This finding ignores the two checks Petitioner received from TriStar on April 2, 2019. (PX8) More significantly, the decision ignores the fact that Petitioner had not engaged in vocational rehabilitation for approximately four months and had not looked for work since being released to return to work on June 21, 2018. There is no evidence that the termination of Petitioner's benefits on January 17, 2019, was done deliberately, in bad faith or for an improper purpose and thus do not merit the imposition of penalties under Section 19(k) or the award of attorney's fees under Section 16. Therefore, I would reverse the decision awarding penalties under Section 19(k) and attorney's fees under Section 16.

Kathryn A. Doerries

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

SCHROVER II, DONALD
Employee/Petitioner

Case# **17WC026949**

STATE OF ILLINOIS
Employer/Respondent

20IWCC0153

On 6/10/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.25% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
1119 N CHURCH ST SUITE 407
ROCKFORD, IL 61101

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH BLEWITT
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

JUN 10 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

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
19(b)

Donald Schroyer II
Employee/Petitioner

v.

State of Illinois
Employer/Respondent

Case # **17** WC **26949**

Consolidated cases: _____

20IWCC0153

An *Application for Adjustment 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 **Kankakee, Illinois**, on **4/17/2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **7/17/2017**, Respondent ***was*** operating under and subject 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 $**97,508.84**; the average weekly wage was $**1,875.17**.

On the date of accident, Petitioner was **52** years of age, ***married*** with **1** dependent children.

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

Respondent shall be given a credit of $**61,605.00** for TTD, $**0.00** for TPD, $**38,492.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**97,419.00**.

Respondent is entitled to a credit for medical bills paid through its group medical plan under Section 8(j) of the Act. Respondent shall hold Petitioner safe and harmless from any and all claims that may be made against him.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $1,250.10/week for 78-2/7 weeks, commencing 7/18/17 through 1/16/19, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of $1,250.10/week for 13 weeks, commencing 1/17/19 through 4/17/19, as provided in Section 8(a) of the Act.

Respondent shall pay to Petitioner penalties of $3,340.00, as provided in Section 16 of the Act; $8,350.00, as provided in Section 19(k) of the Act; and $2,730.00, 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

6/4/19
Date

JUN 10 2019

Attachment to Arbitrator Decision
(17WC 26949)

FINDINGS OF FACT:

On July 17, 2017, Petitioner, Donald Schroyer, was employed as a Stationary Engineer for the State of Illinois at the Jack Mabley Development Center ("Respondent"). He had been employed by Respondent for approximately 26 years. This job required heavy labor including climbing on boilers, climbing ladders, fixing lights, ductwork, and attics. His main responsibility was to maintain the facility power plant and boilers. Prior to the Jack Mabley Development Center, Petitioner had worked as a Stationary Engineer for the Singer Zone Center mental health facility in Rockford.

Petitioner sustained an undisputed injury on July 17, 2017. On that date Petitioner had been called in to work at 3:00 a.m. to troubleshoot a problem with a boiler. He climbed up on top of the boiler and found an air leak. After repairing the leak, he descended down a ladder that was placed between the boiler and the air handler. While descending, the ladder slipped causing Petitioner to fall. According to Petitioner, as he fell, he struck his left shoulder and hip on electrical boxes. After falling he attempted to move his left shoulder and noticed that something was different as his collarbone was "sticking up."

Petitioner reported the incident to his supervisor, Kathy Rutherford. She told Petitioner to see the on-site nurse. The nurse examined Petitioner and recommended that he go to the emergency room. Petitioner testified that both the nurse and supervisor recommended that he go to the KSB Emergency Room in Dixon, Illinois.

At the emergency room Petitioner was examined by Dr. Ortman. X-rays were taken and a sling was applied. (PX 1) Petitioner was discharged with a diagnosis of closed traumatic dislocation acromioclavicular joint, contusion of chest and contusion of pelvis. He was referred to an orthopedic surgeon in Dixon as well as directed to go to Physicians Immediate Care in Dixon. (PX 1, p.28)

Petitioner presented to Physicians Immediate Care that same day and was seen by Dr. John Hopman. Petitioner was examined and additional x-rays were taken. The doctor diagnosed unspecified dislocation of the left acromioclavicular joint, and contusion of the lower back and pelvis. He limited Petitioner to right-handed work and referred Petitioner to an orthopedic surgeon for further evaluation. (PX 2, p. 14) Petitioner testified that Respondent was unable to accommodate the restriction.

Petitioner presented to OrthoIllinois where he was initially seen by Dr. Borchardt on July 21, 2017. Dr. Borchardt noted that x-rays taken did not show an acute fracture but demonstrated a third-degree shoulder separation. Dr. Borchardt assessed 1.) left shoulder pain; 2.) unspecified dislocation of the left acromioclavicular joint; 3.) contusion of the left shoulder; and 4.) contusion left front wall of thorax. The doctor continued Petitioner's restrictions and recommended an MRI of the shoulder. (PX 3, pp. 200-203, PX 5, p. 45)

Petitioner returned to Dr. Borchardt on August 3, 2017. The doctor noted Petitioner underwent the prescribed MRI on July 31, 2017. According to the doctor, the MRI suspected a tear of the superior and the posterior labrum with small associated paralabral cysts. There was advanced degenerative joint disease of the acomioclavicular joint with mild narrowing of the supraspinatus outlet. Also noted was tears of the coraclavicular ligaments and mild asymmetric atrophy of the teres minor muscle body. Dr. Borchardt referred Petitioner to Dr. Trenhaile, a shoulder specialist at Ortho Illinois. (PX 3, pp.197-198)
Petitioner saw Dr. Trenhaile on August 22, 2017. He interpreted the MRI to show an AC joint capsular rupture with slight offset superimposed on moderate to severe osteoarthropathy. Dr. Trenhaile assessed dislocation of the left acromioclavicular joint, 100%-200% displacement. The doctor prescribed a surgical procedure

consisting of left diagnostic and operative arthroscopy; distal clavical excision; joint debridement and AC joint reconstruction with hamstring allograft. (PX 3, pp. 192-195)

Petitioner underwent surgery on November 20, 2017. Dr. Trenhaile performed left shoulder arthroscopy, extensive debridement of the glenohumeral joint and subacromial space, open distal clavicle excision, and open hamstring autograft, coracoclavicular ligament and acromioclavicular ligament reconstruction. The postoperative diagnosis was left shoulder type 5 acromioclavicular separation. (PX 5, p. 154) Petitioner testified that the surgical delay was due to Tri-Star's, Respondent's third-party administrator, uncertainty as to whether Dr. Trenhaile's proposed surgery was the correct procedure.

Subsequent to the surgery, Petitioner received follow-up care from Dr. Trenhaile and his Physician Assistant Michael Gilbertson. Initially he had to wear a pillow sling. On December 28, 2017 Mr. Gilbertson prescribed physical therapy and recommended Petitioner continue to wear the pillow sling while out in public. (PX 3, pp. 177-178) Physical therapy was initiated on January 5, 2018. The sessions continued through April 2018. (PX 3)

On February 22, 2018, Mr. Gilbertson noted that Petitioner was progressing well. He recommended Petitioner follow-up with Dr. Borchardt for optimization of therapy and possible transition to full duty work. At that time, Mr. Gilbertson released Petitioner to work with a five-pound lifting restriction. (PX 3, pp.111-112) Petitioner testified that Respondent did not accommodate the restriction. He continued to receive temporary total disability benefits every two weeks.

Petitioner saw Dr. Borchardt on May 9, 2018. The doctor recommended that Petitioner transition into work hardening therapy. (PX3, pp. 27-28) Petitioner testified that Tri-Star would not approve a work conditioning program.

On May 23, 2018, Dr. Borchardt stated that Petitioner would benefit from a work conditioning program, but noted that it had not been approved. Therefore, the doctor recommended a functional capacity evaluation. (PX 3, pp. 13-14)

On May 29, 2018 Petitioner received a letter from the State Employee Retirement System (SERS). The letter indicated that Petitioner had been approved for occupational disability benefits. These benefits were paid in addition to his temporary total disability payments. The letter indicated that he would receive an occupational disability benefit for the period from July 21, 2017 through April 30, 2018, less any payments received from workers compensation for the same period. The letter further provided that he would receive monthly disability benefits thereafter. (PX 10)

Petitioner underwent a valid functional capacity evaluation on June 14, 2018 at Ortho Illinois. According to the report authored by physical therapist Rachel Viel, "[Petitioner] is able to safely perform "occasional" lifting between 17.54 and 65 pounds depending on the lift. [Petitioner] is able to safely perform "frequent" lifting between 15 and 25 pounds depending on the lift. Please refer to section 8 of this report for specific material handling capacities." The evaluator provided that "[g]iven the high degree of cooperation during this test, there is no reason to believe the client would abuse the discretionary authority to self-monitor and self-regulate the following accommodations: Overhead use of the upper extremities, particularly during weight bearing work. Break workloads down into manageable increments." Ms. Viel further provided that "[i]n order to improve the clients tolerance to work above the shoulder level, essential to his occupation, he would benefit from a work conditioning program. Informal reassessment at least bi-weekly. Discharge if there are compliance issues, if the client reaches a functional plateau or is able to return to full duty..." (PX 4)

Petitioner returned to Dr. Borchardt on June 21, 2018. Dr. Borchardt reiterated his opinion that Petitioner would have benefited from work conditioning. He noted however, that same was not authorized and as such, Petitioner

should be placed on permanent restrictions. At that time, Dr. Borchardt released Petitioner from his care. (PX 3, pp. 8-9) Dr. Borchardt completed a "Report of Work Status and Restrictions" form. The doctor provided that Petitioner could return to work on June 21, 2018 with the following restrictions: "Lowest height lift – bilateral lift from 10 inches to waist: 50 pounds; Heaviest lift – bilateral lift from 20 inches to waist: 60 pounds; Floor lift: 40 pounds; waist level lift: 50 pounds; weight carry: 50 pounds; Shoulder level lift: 30 pounds; Overhead lift: 15 pounds; Push: 45 pounds; Pull: 35 pounds." (PX 4, p.11)

Petitioner testified that he presented the restriction form to his employer. He was not offered any type of work. Petitioner testified to a letter he received from his employer indicating that he had two options at that point in time. The letter dated July 3, 2018 states, "This office is in receipt of your CMS-95 Physician's Statement, dated June 27, 2018. The physicians statement indicates that you are permanently and totally disabled for employment from your occupation. Personnel Rule 303.145 of the Illinois Administrative Code requires 'an employee's disability leave shall terminate when an employee is no longer temporarily disabled when he/she is found to permanently disabled and unable to perform a substantial portion of his/her regularly assigned duties…Your options are as follows: 1.) Resign. Resignation will not effect any disability payments you are currently receiving. 2.) Retire, if you are eligible." (PX 9) Petitioner testified that since he was not old enough to receive a retirement benefit, he chose to resign.

Petitioner testified that in August 2018, he received a letter from Respondent indicating they were sending him to Dr. Shane Nho of Midwest orthopedics at Rush for a Section 12 examination. Petitioner stated that he received the notice of the examination along with a travel check approximately a week after the scheduled appointment (Dr. Nho's records indicate that the exam was scheduled for July 24, 2018). (PX5, p. 10) Petitioner provided that he called Tri-Star to inform them of this. The exam was then re-scheduled for August 28, 2018.

Pursuant to Respondent's request, Petitioner underwent the Section 12 examination with Dr. Nho on August 28, 2018. The doctor noted that Petitioner was still complaining of pain in the superior aspect of the left shoulder. An examination revealed limitation in range of motion and x-rays obtained showed a coracoid fracture and mild shoulder osteoarthritis. Dr. Nho opined that Petitioner had left shoulder pain after AC joint reconstruction either post-surgical pain or secondary to a coracoid fracture. The doctor felt that a causal relationship existed between Petitioner's condition of ill-being and the work injury. Dr. Nho felt the coracoid fracture might be contributing to Petitioner's shoulder pain, weakness and dysfunction. The doctor recommended consideration for coracoid fixation or non-surgical treatment. Lastly, Dr. Nho indicated that Petitioner's MMI status depended on whether Petitioner elected to undergo surgical correction of the coracoid fracture. (PX 5, pp. 21-22)

Petitioner testified that in September 2018, he met with a vocational counselor from Creative Case Management. The meeting took place at a Starbucks in Rockford. According to Petitioner, when the interview concluded, the vocational counselor indicated she would fill out paperwork and contact his attorney and Tri-Star. She indicated that she would get back to him in order to work on completing a resume and how to apply for jobs. Petitioner testified that she did not tell him to look for work.

In January 2019 the payments from Tri-Star stopped. He indicated that he was paid through the 16th or the 17th of January. Since that date he has only received two checks, each for one day of compensation.

Petitioner testified that on January 25, 2019, he met with Ms. Kathy Mueller of Independent Rehab Services. Petitioner provided that Ms. Mueller indicated that she would work with him to complete a resume and also instruct him on how to apply for jobs. Petitioner testified that approximately a week later he began working with Ms. Mueller in an attempt to find new employment. These activities included preparing a resume, learning how to make online applications, and how to complete job search forms. Petitioner stated that he met Ms. Mueller approximately every two weeks. In between visits he would apply for 15 to 20 jobs every week. He testified that he had obtained three interviews for positions such as a construction helper, a parts runner and at a

Menard's store. The day before the arbitration hearing Petitioner had an interview for a position as a car porter with an automobile dealership.

Petitioner testified that he continues to have difficulty with his left shoulder. He wakes up in middle of the night with shoulder pain if he sleeps on the left side. He no longer plays catch with his daughter. The shoulder strap of his driver side seat belt rubs against his shoulder irritating it and causes pain. On occasion he takes Aleve to reduce pain. He does not take prescription medication.

Ms. Kathy Mueller of Independent Rehab Services testified on behalf of Petitioner in this matter. Ms. Mueller indicated that she has a Masters degree in rehabilitation counseling and that she is a certified rehabilitation counselor. She is also a licensed clinical professional counselor and a certified ergonomic assessment specialist. She has been performing work as a rehabilitation counselor for approximately 10 years. 80% of her work involves assisting workers injured on the job. She also testified that she had worked for the State of Illinois as a vocational counselor on approximately five occasions.

Ms. Mueller described the events of the initial vocational assessment of Petitioner. She obtained information regarding his medical condition, his educational background and prior work history. After the interview she conducted a transferable skills analysis based upon the information obtained from Petitioner. She noted that Petitioner had "very basic computer skills" and that as part of the vocational process they would work on computer skills training. She noted that in regard to transferable skills, Petitioner had worked as a stationary engineer for 27 years. She indicated that a job performed more than 20 years ago would not lead to current transferable skills. She also noted that Petitioner had some experience with automobiles, but no formal training. She did feel that Petitioner was a candidate for vocational services that included looking for new employment. She prepared three different resumes in order to take advantage of different versions of Internet job application software. They also worked on interview skills since Petitioner had not looked for work in 27 years. She also showed him how to complete job search sheets. Ms. Mueller confirmed that Petitioner had been instructed to look for 15 to 20 jobs a week. She also stated that she believed Petitioner was in compliance with all of their expectations.

Ms. Mueller testified that she was familiar with Tri-Star's case manager. She testified that she had communicated with the case manager via email. She had no response from Tri-Star. In addition, she has submitted bills for vocational services to Tri-Star that remain unpaid. When asked if she had received any emails or letters or anything from Tri-Star, Ms. Mueller said she had not. When asked if she provided Tri-Star with documentation of services rendered, Ms. Mueller stated that she had sent the initial report, her progress report, the rehabilitation plan, and invoices. She stated that to the best of her knowledge she had sent most of the job logs to Tri-Star. When asked if anyone from Tri-Star had specifically requested the job logs from her, Ms. Mueller stated that they had not. Finally, when asked if Petitioner was employable Ms. Mueller stated:

> "Well, I believe he's employable. He has certainly the motivation to work, the desire, and he's been fully cooperative. He's got skills that probably would lend to more entry-level work given his physical limitations. So I believe he can work."

On cross-examination, Ms. Mueller was asked if 24 jobs was an accurate total of the number of jobs Petitioner had applied for. Ms. Mueller indicated that she did not think so. She was then asked if she had contacted any employers on the job logs to see if Petitioner had actually applied. Ms. Mueller indicated that she had assisted with certain applications and therefore knew that he had applied. She also indicated that contacting an employer during the middle of the application process could draw a "red flag" to an application. She did indicate that if Petitioner was ruled out as a candidate after an application and interview she might call the employer to see how the interview went in order to determine what efforts could be improved.

With respect to Issue (L): WHAT TEMPORARY BENEFITS/MAINTENANCE ARE IN DISPUTE, the Arbitrator finds the following:

Petitioner filed a Request for Hearing pursuant to Section 19(b) of the Act. The completed Request for Hearing Form contains a claim by Petitioner for temporary total disability benefits from the day after the accident (July 18, 2017) through the date of hearing (April 17, 2019). In response, Respondent claims liability for TTD through June 21, 2018. Neither party listed a period of maintenance benefits, although Respondent claimed a credit for $38,429 in maintenance payments. Respondent also claims credit of $61,605 for TTD.

It appears Respondent's position is that Petitioner it is not entitled to any compensation after June 21, 2018, the date of Petitioner's last visit with Dr. Borchardt at Ortho Illinois. The Arbitrator finds that Respondent's position is not supported by the totality of the evidence. The documentary evidence shows that Petitioner received a restriction form from Ortho Illinois that he immediately provided his employer. This fact is shown by Ortho Illinois records which reveal that the employer called Ortho Illinois on June 25, 2018 and June 27, 2018 asking for additional information regarding the work restriction slip. (PX 3, pp. 6-7) Petitioner testified that his employer would not take him back to work and did not offer any alternate employment. In fact, he was given only two choices, either to retire or resign. Petitioner testified that since he was not eligible for retirement, he proceeded with resignation. Just prior to being presented with the options of retiring or resigning, Petitioner received a letter indicating that he had been approved for occupational disability through the State Employee Retirement System (SERS). That letter indicated he would continue to receive occupational disability benefits which were reduced by the payment of Workers' Compensation. There is nothing in that letter, or any other correspondence, indicating he must look for work to maintain benefits. Petitioner testified he was never given any instruction by Respondent to make a job search. In fact, he testified that he was under the impression that he was prohibited from working while receiving workers' compensation benefits.

Petitioner also testified that he was not instructed to look for work by the vocational counselor at Creative Case Management, Respondents vocational provider. The first person to instruct Petitioner to engage in a job search was Kathy Mueller of Independent Rehab Services, Petitioner's choice of vocational provider.

Commission Rule 9110.10 provides that a vocational assessment be performed by employer's rehabilitation counselor when it is clear that the employee will not be able to resume his or her employment which they were engaged in at the time of the injury. It is clear that such a report should have been prepared at the end of June 2018. While there is reference to an assessment being prepared by Creative Case Management no report from the assessment was offered at trial. Therefore, the Arbitrator is unable to determine whether Respondent was compliant with Commission rules and whether or not the assessment was reasonable and comprehensive.

In contrast, Petitioner presented a written assessment as required by Rule 9110.10 and made his vocational counselor available the time of hearing. The Arbitrator finds Ms. Mueller to be credible and her plan to be reasonable. The Arbitrator also notes that Ms. Mueller found Petitioner to be cooperative and motivated to return to work. Ms. Mueller testified that Petitioner had met her expectations during the eight weeks that she had worked with him. Respondent did not offer any evidence that contradicted her testimony.

In the case of Interstate Scaffolding, the Supreme Court stated that when the claimant seeks TTD benefits, the "dispositive inquiry is whether the claimant's condition has stabilized." Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Comm'n, 236 Ill.2d 132 (2010), that is, whether the claimant has reached maximum medical improvement (MMI). In this case, Petitioner's treating physician, Dr. Borchardt, on three separate occasions (May 9, 2018, May 23, 2018 and June 21, 2018) recommended Petitioner transition into work hardening therapy. On each occasion, the doctor noted that Tri-Star would not approve a work conditioning program. As a result of the denial, the doctor recommended a functional capacity evaluation. Petitioner ultimately underwent a valid FCE. By June 21, 2018, Dr. Borchardt reiterated his opinion that Petitioner would

have benefited from work conditioning. He noted however, that same was not authorized and as such, Petitioner should be placed on permanent restrictions and released Petitioner from his care. It is clear from the records submitted that if not but for Respondent's denial of the prescribed work hardening, Dr. Borchardt would not have hastened the completion of treatment. As noted above, the doctor stated, "I have discussed with him that he would have benefited from further work conditioning, but further work conditioning was not approved by his work comp insurance." The Arbitrator notes the need for work conditioning was also confirmed by Ms. Viel, the therapist who performed the FCE, who felt Petitioner would benefit from a work conditioning program. Based on these statements it is clear that Petitioner's condition had not reached the point of MMI on June 21, 2018. He would have received additional medical treatment had Tri-Star authorized further care.

In addition, Respondent's own Section 12 evaluation indicates that Petitioner's condition had not reached MMI. Petitioner was seen by Dr. Shane Nho of Midwest Orthopedics at Rush on August 28, 2018 at the request of Tri-Star. The question of whether Petitioner had reached MMI was posed to Dr. Nho in Tri-Star's letter dated July 6, 2018. Respondent did not offer Dr. Nho's records at arbitration. Petitioner offered the records of Dr. Nho as Petitioner's Exhibit 5. Dr. Nho specifically answered "No" in response to the MMI question. He also stated that Mr. Schroyer's prognosis was "guarded" and that he was limited to "no work involving the left shoulder." (PX 5)

Respondent offered no vocational evidence at the arbitration hearing. Nor did they provide any evidence of compliance with Commission Rule 9110.10. The only vocational evidence offered was the testimony of Ms. Mueller and her February 12, 2019 report. (PX6) In the report, Ms. Mueller states that Petitioner has lost his ability to work as a Stationary Engineer. She also indicates that he would need computer training and on-the-job training for most of the positions she felt he was capable of obtaining. (PX 6) In order to determine that a claimant has reached MMI it must be shown that the claimant's condition has stabilized to the extent that they were able to reenter the workforce. Kelley v. Carlinville Rehabilitation, 19 IWCC 0047 (2019). A claimant's restrictions can severely hinder employability. The Arbitrator finds that the combination of claimant's age, limited work experience, work restrictions, and need for vocational training and assistance precluded Petitioner from re-entering the workforce. Therefore, he was not at MMI until he began working with Ms. Mueller. The Arbitrator awards TTD from July 18, 2017 through January 16, 2019. The Arbitrator awards maintenance beginning on January 17, 2019, the date of Ms. Mueller's initial evaluation, through the date of hearing.

With respect to Issue (O); IS VOCATIONAL REHABILITATION NECESSARY, the Arbitrator finds the following:

The Arbitrator finds that Petitioner is entitled to vocational rehabilitation as recommended by Ms. Mueller, a certified vocational rehabilitation counselor. The evidence shows that Petitioner is physically unable to return to his previous occupation as a Stationary Engineer. Ms. Mueller noted that Petitioner was very motivated to participate in rehabilitation and return to work. The Arbitrator notes that Respondent has not provided any vocational rehabilitation assessment. Therefore, the Arbitrator adopts the opinions of Ms. Mueller including the need for computer skills training as well as job seeking and job placement assistance. Respondent is ordered to pay for the services of Ms. Mueller to pursue the services she has outlined in her report. Respondent is directed to continue payment of maintenance benefits from the date of hearing and to continue during Petitioner's participation in vocational rehabilitation.

With respect to Issue (M) SHOULD PENALTIES OR FEES BE IMPOSED UPON RESPONDENT, the Arbitrator finds the following:

On March 1, 2019, Petitioner filed a Petition for Penalties under Sections 19(k), 19(l), and Attorney's Fees under Section 16 of the Workers' Compensation Act. No response was filed by Respondent.

Section 19(l) of the Act provides:

"In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under section 8(a) or section 8(a) have been so withheld or refused, not to exceed $10,000."

A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay. 820 ILCS/305/19(l).

Section 19(l) penalties are in the nature of a late fee and the imposition of such penalties "is mandatory when an employer or insurance carrier is late in making a payment but cannot provide adequate justification for its delay." McMahan v. Industrial Commission 183 Ill.2d 499, 515 (1998).

Section 19(k) requires claimant to meet a higher standard than 19(l) 19(k) provides, in pertinent part, "in case where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation, then the Commission may award compensation additional to that otherwise payable under the Act to 50% of the amount payable at the time such award." 820 ILCS 305/19(k).

Petitioner testified that he was paid weekly compensation benefits through January 16, 2019. He also described the timeliness of those payments as follows:

> "I have never received a check in a reasonable time either. I don't know if that's irrelevant, but they just never came – – the only ones that ever came in a weekly time was the last two I got for one day each. The rest of them are – – if I get paid, it's supposed to be paid on the fifth it might come on the 20th. It might come on the 21st. Like, the last two Christmases we had, we had no checks. They were supposed to have been sent on the 21st they don't come until January sometime there is no rhyme or reason when the checks come. I don't understand that."

Inasmuch as more than 14 days has passed since his last compensation payment, there is a rebuttable presumption of unreasonable delay. In addition, Petitioner established a pattern of late payments when benefits were being paid. Respondent presented no evidence to justify nonpayment of benefits. Attorney's fees and penalties are appropriate in this case because there was no legitimate dispute. Although the Request for Hearing Form indicates Respondent disputed disability after June 21, 2018, no evidence was presented to justify that dispute. Petitioner presented his restrictions to his employer in a timely basis. He was told that there was no work available for him within the restrictions. Shortly thereafter he was mailed a letter that told him his only options were to retire or resign from his employment with the State of Illinois. None of the correspondence received from the State of Illinois indicated that he was required to look for work. Petitioner testified that when he met with Respondent's vocational consultant; he was not directed look for work. This testimony was unrebutted and no report from the vocational consultant was offered by Respondent.

Vocational consultant Mueller testified that Petitioner has been fully cooperative with her efforts. She further testified that she had emailed her reports and job-search logs to Tri-Star's adjuster. She indicated that she has had no response from Tri-Star. In addition, she has received no payment for the services she has rendered.

The Arbitrator finds Respondent's conduct in refusing to pay weekly compensation since January 17, 2019 was unreasonable and vexatious. In addition, Respondent has engaged in repeated dilatory behavior such as delaying surgery for three months, refusing to authorize work conditioning and repeated late payment of TTD benefits. Based on the above, the Arbitrator finds Petitioner is entitled to Section 19(l) penalties in the amount of $2,730.00 (91 days at $30.00 per day from January 17, 2019 through April 17, 2019 – the date of hearing).

Further pursuant to 19(k) the Arbitrator awards $8,350.00, which is equal to 50% of the unreasonably delayed maintenance benefits. Finally, the Arbitrator awards attorney's fees of $3,340.00 – 20% of the unpaid compensation due and owing as of the date of hearing.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard Woolard,

Petitioner,

vs. NO: 15 WC 20308

The American Coal Co.,

20IWCC0154

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 exposure, accident, causation and nature and extent, reverses the Decision of the Arbitrator and denies Petitioner's claim for compensation, for the reasons stated below.

Findings of Fact

Petitioner testified that he graduated high school and has worked in the coal mines for "[t]hirty-seven [years] total, counting surface at the prep plant." (T.9). He noted that he worked underground from approximately 1976 to 1998 at Sahara Coal Company and "[f]rom '89 till '98, I worked underground at Kerr-McGee, and they called it American Coal later. They sold it to American Coal." (T.9-10). He agreed that while working in the coal mines he was regularly exposed to welding and cutting fumes as well as rock and coal dust. (T.10). He agreed that he last worked at American Coal on 11/6/14[1] in their Galatia mine, and that he was 60 years old at that time. (T.10-11). He indicated that he was "... a dozer operator on the long coal stacker feeding the plant so they could process the coal." (T.11). He agreed that he was exposed to and did breathe coal dust on that date, and that he stopped working then when he "hit a big wind row rut, you can call it, and injured my back." (T.11). He agreed that he has not worked anywhere

[1] The Arbitrator incorrectly found the date of accident/last exposure to be 11/6/16. (Arb.Dec.[Form], p.2).

since and that he is currently on Social Security Disability for his back and because of a blood clotting issue. (T.11-12).

Petitioner agreed that he graduated from Eldorado High School in 1972, that from approximately 1972 to 1974 he did some carpentry work for his father; from 1974 to 1976 he worked at Scott Ladd picking groceries and operating a fork truck; in 1976 he went to work in the coal mines for Sahara Coal and he worked there until 1988; and from January 1989 through November 2014 he worked for Kerr-McGee, which became American Coal. (T.12-13). He agreed that while working in the coal mine his job classification was of a utility worker where he "[b]uilt air stoppings for ventilation, carried oil and roof bolts and material to the roof bolter." (T.13-14). He agreed that this was underground, and that he did this for about three years. (T.14). He agreed he worked as a roof bolter for four to five years and that this involved putting bolts in the roof of the mine. (T.14). He indicated that they were drilling through "[m]ainly rock", and that as a result he was exposed to a lot of rock dust when he was actually drilling. (T.14). He agreed that he was a continuous miner operator, actually mining coal, for three to four years. (T.14-15). He also worked on a bull gang for a year and a half, which involved "[a] little bit of whatever they need, shoveling on the belt or going on belt moves or even going in a unit when somebody is off, like on a ram car that hauls coal." (T.15).

In addition, Petitioner noted that he worked in a classification called "out-by", which is "... kind of like bull gang. Well, at Kerr-McGee you might be a supply man and drive a diesel powered Getman and haul supply into the units." (T.15-16). He agreed that "out-by" means you're not actually working at the face of the coal "... unless you get sent in to a unit." (T.16). He agreed that he was classified as "in-by", noting that "... when you're running, like a ram car or shuttle car we had at Sahara, you load the coal from the miner buggies, we called them buggies back then, and you drove to the feeder, and it went out on the belt lines." (T.16). He agreed (by nodding his head) that he was on belt maintenance where "[w]e had to extend the belts on the units when they – they would get so many cross cuts from the feeder, you would have to move the feeder out of the way and extend the belt line... Put in the rollers and pull the belt on." (T.16-17). He agreed that this was a pretty physical job. (T.17). He also agreed that he was a mine examiner for around three years, which included a lot of walking, and that he worked in the prep plant at Kerr-McGee. (T.17-18). He noted that the latter involved "[j]ust shoveling where it needed to be, and a lot of times you done [sic] a lot of washing with a fire hose." (T.18). He believed that the prep plant was 34 feet or three stories and that "[t]hey had an elevator for a while, but it kept breaking down so they just gave it up." (T.18). He noted that he also ran a haul truck hauling the refuge or "gob", and that his final classification was as a dozer operator. (T.18-19).

Petitioner agreed that most if not all of his jobs in the coal mines required heavy manual labor, noting that "... even like the haul trucks and stuff, you had to lift 5-gallon buckets of oil and antifreeze and climb the steps on the haul trucks." (T.19). He noted that the haul truck had tires that were over eight feet tall. (T.19).

Petitioner indicated that he currently has breathing problems that he first started noticing "[p]robably ten years ago", or approximately 2008. (T.19-20). When asked what he would be doing when he noticed this shortness of breath, he stated "[j]ust when I would try to walk or

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putting oil and antifreeze up on -- after climbing the steps with them and climbing the steps in the plant." (T.19-20). He agreed that the jugs or buckets of oil and antifreeze were 5-gallon buckets weighing about 40 to 50 pounds each. (T.20). He testified that "[y]ou got to hold onto the ladder with one hand and throw it up with the other when you get up to the top." (T.20).

Petitioner indicated that even though his last job involved running a dozer with a cab "... you still get dust in there... [I]t just come like through the doors, I would say, and it had a filter behind your seat that was supposed to filter it out, but half the time they was clogged up. And if the air conditioner wasn't working on it, you would have to run with the doors open, and you really got it then." (T.21). He noted that the air conditioner was not working "[q]uite a bit" and that "[a] lot of times there wouldn't even be nobody there to fix it, and you didn't have another dozer to switch out, you know, so you would have to run it or shut the place down." (T.21-22). He indicated that at the end of his shift "... if you had them doors open, your face would be black" and your clothes would be dirty. (T.22). He agreed that he worked an 8-hour shift "... unless they needed you to stay over if somebody didn't show up on the shift that follows." (T.22). He also agreed that with the schedule they had he would work seven days on and one day off, then seven days on and two days off and finally seven days on and three days off until it would start over again. (T.23). He stated that "... you would switch shifts every seven days, midnights, seconds and day shift." (T.23).

Petitioner testified that currently he would be able to walk at a normal pace for half a block before he would become short of breath. (T.23). He also noted that he gets out of breath just climbing about four or five steps. (T.23). In addition, since noticing breathing problems about ten years ago, he noted that his breathing is getting worse. (T.23-24). However, he indicated that he is not taking any breathing medication at this time. (T.24). He stated that his breathing problems affect his activities of daily living, noting that "... we got a pool out by the side of our house. It's an above ground pool, and I can go out there and swim around in it a little bit and then walk back in the house, and I'm so short of breath, it's just – I never thought it would be that way." (T.24). He noted that he used to hunt rabbit and deer but he can no longer do it "... because of my back and because of my shortness of breath." (T.25). He also indicated that he can't mow his yard anymore and that he has to have his son-in-law do it. (T.25). He stated that he does not do any type of physical labor around the house such as maintenance or anything like that, and that he is unable to get his mail. (T.25). He noted "[s]he [presumably his wife] gets it on her way home from work because it's about 100 yards to my mailbox." (T.25). He indicated if he could walk 100 yards to get his mail "I would have to sit down when I got there." (T.26).

Petitioner stated that he does not go shopping with his wife anymore, noting that "I can't stand to walk. Like maybe I could go in a small little store just, you know, for a little bit or something. But a far as Wal-Mart or anything like that, there's no way... [b]ecause of my back and my lungs." (T.26). He indicated that while working in the mines he would have to stop and take breaks because of his breathing problems, specifically when "... climbing those steps in the plant, and like sometimes we'd change roller and screens and stuff on the floors of the plant, and I would get out of breath." (T.26-27).

Petitioner noted that his treating physican is Dr. Kimball Ewell. (T.27). He indicated that

he has never gone to Dr. Ewell for his breathing problems, noting that "I never figured it would do any good." (T.27). He stated that Dr. James Alexander is the company doctor, and that he never visited Dr. Alexander for primary care visits or anything. (T.27-28). He agreed that he never had a desk job where he would just sit down or do anything other than manual labor. (T.28). He claims he is not able to use a computer or type. (T.28). He also maintains that he does not smoke and has never smoked. (T.28). He agreed that he has back problems as well as high blood pressure, for which he takes medication. (T.28-29). In addition, he agreed that he had a blood clot in his leg because of a genetic problem called Factor V Gene Leiden. (T.29).

Petitioner agreed it was fair to say that he completed his job in the coal mines every day but that towards the end he was having more difficulty than when he began. (T.29). When asked how he would get to the dozer he operated, Petitioner stated "I drove my own personal truck out to the dozer parking where we switched shifts, you know, because it was about 200 yards to the dozer parking from the plant, and I would park my truck there because I couldn't walk out there." (T.29-30). When asked if other workers would do the same thing, he noted that "[s]ometimes some of the contractors would park beside me there, you know, and be doing dozer work and stuff on the refuge piles." (T.30).

When asked if he would be physically able to do his last job in the mine today, Petitioner responded: "[n]o way." (T.30).

On cross examination, Petitioner indicated his last job at the mine was as a dozer operator and that he did this for around three years. (T.31). He stated that he started receiving Social Security Disability "[p]robably three years ago, approximately" and that he had been approved for same "[p]robably a year" after his last day worked. (T.31).

Petitioner agreed he was laid off the following April [2015] after he had his dozer accident and injured his back. (T.32). He agreed it was a general layoff at the time, noting that "[t]hey laid off four or five there at the plant... But I wasn't returning, anyway." (T.32).

Petitioner agreed that over the years he worked at the mine they did NIOSH chest x-ray screening for black lung. (T.33). However, he did not think they did a breathing test because of his blood pressure, but he was not sure about that. (T.33-34). He indicated he could not remember if they wrote to him after his chest x-ray to tell him what it revealed. (T.34). He stated he was diagnosed with the blood clot after he had shoulder surgery. (T.34). However, he could not remember the year that occurred, but noted it was before he left work for good. (T.34). He stated that he now takes Coumadin every day and that he has been told he will have to take that for the rest of his life. (T.35).

Petitioner testified that he currently spends his day watching television. (T.37). When asked if he has any hobbies, he noted "[n]ot that I can do anymore... I can't even stand up for too long because of my back." (T.37). He indicated that he does not travel at all because "... traveling in a vehicle hurts my back, you know." (T.37). He agreed that he has to change positions often, noting that "[l]ike when we got out of the car just driving from my house to here, it's slow going for a few steps." (T.38). He estimated that the drive is about 30 something miles and that it took probably 40 minutes. (T.38). When asked to describe the property he lives on, he

noted that he has five acres that's mainly grass, which his son-in-law cuts for him, and that the driveway goes down a hill. (T.38-39). When asked if he does anything outside at all anymore, Petitioner replied: "[n]ot much, if anything." (T.39).

Medical Records

An AP view chest x-rays interpreted by radiologist Dr. Hisham Youssef on 11/18/06 noted that it was a "negative study." (RX5). It was also noted that "[t]he lungs are clear. Heart size and pulmonary vessels are normal. No pleural fluid. No pneumothorax." (RX5).

In an Eldorado Primary Care office note dated 7/16/13 it was noted that the patient presented for a recheck of hypertension and that "[s]ymptoms include headache, while ***symptoms do not include dizziness or shortness of breath***." (Emphasis added) (RX6). Examination of the chest and lungs revealed "... on auscultation, normal breath sounds, no adventitious sounds and normal vocal resonance." (RX6).

PA view chest x-rays interpreted by radiologist Dr. Hisham Youssef on 10/11/13 noted 1) no active disease, 2) prior rotator cuff repair, right shoulder, and 3) ILO form completed. (RX4).

In a report dated 5/20/15, board certified radiologist and NIOSH certified B-reader Dr. Henry K. Smith noted that "[t]here is interstitial fibrosis of classification p/p, all zones involved, of a profusion 1/1. There are no chest wall plaques, calcifications, thickenings or large opacities. Heart size is normal. There is minimal thoracic atherosclerosis. Mild degenerative changes are seen in the bony structures of the lower thoracic spine." (PX2). The impression was "[s]imple coal-worker's pneumoconiosis with small opacities, primary p, secondary s, all zones involved bilaterally, of a profusion 1/1." (PX2).

In a report dated 9/22/15, Dr. Suhail Istanbouly noted an assessment of coal workers' pneumoconiosis "... based on this patient's occupational history, chest x-ray, symptoms, and pulmonary function test findings. Coal-worker's pneumoconiosis is a significant contributor to this patient's respiratory symptoms (chronic cough, sputum production, and exertional dyspnea). It is advisable from medical standpoint for this patient not to go back to work in the coal mines and to avoid any further coal dust inhalation." (PX1 [Istanbouly Dep.] Ex.2; RX5).

In a Prudential Group Disability Insurance "Capacity Questionnaire" completed by family practice physician Dr. Kimball Ewell on 2/4/16 it was noted that Petitioner was not capable of full or part-time work and the estimate for when he would be capable of full-time return to work was stated to be "never." (RX7). It also noted that the patient did not have the work capacity to stand and walk or sit for up to 8 hours continuously. (RX7).

In a report dated 3/26/16, Dr. Cristopher Meyer found that "[t]he lungs are well expanded without small round, smaller irregular or large opacities. There is atherosclerotic calcification in the thoracic aorta. The cardiac silhouette is not enlarged. The bones and soft tissues are unremarkable." (RX1 [Meyer Dep.] Ex.B). Dr. Meyer's impression was "[n]o radiographic findings of coal workers' pneumoconiosis." (Dep.Ex.B). At the bottom of this report, Dr. Meyer noted that "[s]ubsequent to completing the above dictation and the ILO B-reading form, I have

reviewed a narrative summary and B-reading form provided by Henry K. Smith D.O. in reference to this examination. I disagree with his reported findings of primary opacities of size "p" with profusion of 1/1. The lungs are clear; image noise may simulate small opacities but the same pattern is also seen throughout the soft tissues. This is a normal examination with no findings of coal workers' pneumoconiosis." (Dep.Ex.B).

A spirometry study performed on 6/9/16 was interpreted as normal without improvement post-bronchodilator and with normal diffusion capacity. (RX3).

In a report dated 11/23/16, Dr. James Castle noted that he "... reviewed a chest x-ray on CD-ROM dated 5/20/15 from Ferrell Hospital. It is my opinion that there were no parenchymal abnormalities consistent with pneumoconiosis. This film was essentially normal except for obesity." (RX2 [Castle]Dep.] Ex.C). In addition, Dr. Castle indicated "[i]t is my opinion with a reasonable degree of medical certainty based upon a thorough review of all the data including the medical histories, physical examinations, radiographic evaluations, physiologic testing, and other data that Mr. Richard Woolard does not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to coal mine dust. Mr. Woolard certainly worked in or around the underground mining industry for a sufficient enough time to have possibly developed coal workers' pneumoconiosis if he were a susceptible host." (Id.). However, Dr. Castle stated that "Mr. Woolard did not demonstrate any consistent physical findings indicating the presence of an interstitial pulmonary process. He did not have the consistent finding of rales, crackles, or crepitations. His pulmonary examination was essentially normal on virtually all occasions." (Id.). He also noted that "[t]he majority of radiographic reports indicated that there were no findings of coal workers' pneumoconiosis or a coal mine dust induced lung disease. On most occasions it was felt that the chest x-ray was entirely normal." (Id.). In addition, Dr. Castle stated that pulmonary function studies were essentially normal. (Id.). As a result, Dr. Castle opined that "... Mr. Woolard does not have any evidence of respiratory impairment from any cause including coal workers' pneumoconiosis and coal mine dust exposure." (Id.).

In an Eldorado Primary Care office note dated 7/18/17 it was recorded that Petitioner presented with complaints of rib pain of sudden onset five days prior along with "... associated shortness of breath, while there has been no associated cough..." (RX7). Examination of the chest and lungs revealed "... on auscultation, normal breath sounds, no adventitious sounds and normal vocal resonance." (RX7).

PA and lateral chest x-rays performed on 7/18/17 and interpreted by Dr. Hisham T. Youssef noted "no active disease or significant interval change from 10/11/2013." (RX7). The findings were as follows: "[l]ungs are clear of active infiltrate. No pleural fluid or pneumothorax. Heart size and pulmonary vessels are normal. Mild to moderate thoracic spondylosis. Prior right rotator cuff repair again noted with visualized orthopedic hardware in place and intact." (RX7).

A CT scan of the chest performed on 7/21/17 and interpreted by Dr. Hisham T. Youssef noted "[l]ungs are clear of active infiltrate. Mild bilateral dependent atelectasis. No pleural fluid, pneumothorax or focal lung mass. Mediastinum and hila negative for lymphadenopathy or

mass. Small benign calcified mediastinal and hilar lymph nodes secondary to old healed granulomatous disease. The thoracic aorta is normal in position and negative for aneurysm or dissection…" (RX7). The impression was 1) no active cardiopulmonary disease, and 2) benign to moderate changes as described. (RX7).

Testimony of Dr. Suhail Istanbouly (7/5/17)

Dr. Istanbouly testified that he is a member of the American College for Chest Physicians and that roughly speaking about 30 percent of his practice deals with the care and treatment of coal miners. (PX1, pp.5,16). He noted that he also performs black lung examinations for the U.S. Department of Labor and that he is currently the director of the pulmonary department at Herrin Hospital, a position he has held since 2005. (PX1, p.5). In addition, he is the director of the intensive care unit at Carbondale Memorial and past director of intensive care at Herrin Hospital. (PX1, pp.5-6). The Commission also notes that Dr. Istanbouly's CV indicates he is board certified in internal, pulmonary and critical care medicine. (PX1 [Istanbouly Dep.] Ex.1].

Dr. Istanbouly agreed that at the request of Petitioner's attorney he examined Mr. Woolard on 9/22/15 for evaluation for possible coal workers' pneumoconiosis. (PX1, p.6). He recorded a history of working as a coal miner for 38 years, 22 underground and 16 on the surface. (PX1, p.7). He noted a last month of employment of November 2014 and the fact that Petitioner never smoked. (PX1, p.7). He indicated Mr. Woolard had multiple chronic respiratory symptoms, including chronic daily cough with mild sputum production in addition to exertional dyspnea. (PX1, p.7). He also noted that "[t]he PFT did reveal mild obstructive defect. The x-ray did reveal mild interstitial fibrosis consistent with coal workers' pneumoconiosis." (PX1, p.8).

Dr. Istanbouly testified that a person can have a positive chest x-ray for coal workers' pneumoconiosis and be asymptomatic, especially if it is early stage, but that "[g]enerally speaking, we are talking about chronic lung disease. So chronic respiratory symptoms include chronic cough, sputum production, shortness of breath on exertion, wheezing, recurrent respiratory infections. That kind of complaint." (PX1, p.8). He also noted that a person can have coal workers' pneumoconiosis and not know they have it. (PX1, p.8).

Dr. Istanbouly indicated that his physical examination of the chest was normal. (PX1, p.9). However, he agreed that a person does not have to have an abnormality on physical exam of the chest in order to have coal workers' pneumoconiosis, noting that "[i]f it is early stage, it's not unusual." (PX1, p.9). Dr. Istanbouly agreed that the pulmonary function test showed a mild obstruction. (PX1, p.9). When asked the cause, he testified that "[t]he only risk factor he had is long-term coal dust exposure, so that was in my opinion the culprit for the abnormality on his PFT." (PX1, p.9). He also noted that it was possible for someone with simple coal workers' pneumoconiosis to have normal PFTs. (PX1, p.10). When asked if that means their lungs haven't been damaged, Dr. Istanbouly noted that it was more accurate to say that "… the damage is still in the early stage." (PX1, p.10). He also noted that it was possible that a person could have focal impairment of the lungs yet still have overall normal or global function. (PX1, p.10). Likewise, he stated that it was possible that a person can have shortness of breath but have normal pulmonary function. (PX1, p.10).

Dr. Istanbouly indicated he personally reviewed and interpreted the chest x-rays performed at Farrell Hospital on 5/20/15. (PX1, p.11). He agreed he customarily reviews and interprets chest x-rays in the care and treatment of his own patients, and that he "... rel[ies] on both my opinion and the B reader opinion. And I have to admit, very rarely I disagree but it has happened before that I disagreed with the B reader, but the vast majority of the cases really I don't disagree." (PX1, p.11). He noted that the x-rays in this case were of diagnostic quality and that "[i]t did reveal mild interstitial changes. Now I don't do profusion but per the B reader the profusion was 1/1 primary P, secondary S, all zones involved bilaterally." (PX1, p.12). He testified that you do not need to be a B reader to diagnose somebody with coal workers' pneumoconiosis, and that in his practice in Southern Illinois he regularly diagnoses coal miners with same. (PX1, p.12). He noted that he does not always have a B reading when he diagnoses one of his patients with coal workers' pneumoconiosis. (PX1, p.12). He indicated that in those situations he relies upon his own training and expertise "[p]lus other x-rays. Like a lot of my patients I do review their chest x-rays and chest CT scans, and it does show interstitial changes or micro nodularity but these studies have never been read by a B reader. But for me, I don't wait for a B reader to tell me that the abnormality on these x-rays is related to black lung." (PX1, p.12).

Dr. Istanbouly testified that he diagnosed Petitioner with coal workers' pneumoconiosis and that the cause was "[l]ong-term coal dust inhalation." (PX1, p.13). He noted that in general PFT findings are not necessary to diagnose CWP, but that it was relevant in this case "[b]ecause [Petitioner] never smoked before. He denies being diagnosed with asthma during childhood or early adulthood. The only risk factor found in his history is long-term coal dust exposure." (PX1, p.13). He indicated that not every coal miner who is exposed to coal dust gets coal workers' pneumoconiosis. (PX1, p.14). He agreed that CWP can cause scarring and a form of emphysema to occur, and that the scar tissue is sometimes referred to as fibrosis, which is permanent. (PX1, p.14). He noted that the scarring and fibrosis of CWP cannot carry on the function of normal, healthy lung tissue, and that by definition if you have CWP you have an impairment of lung function, at least at the site of the scar or fibrosis. (PX1, p.14). He indicated that CWP is related to coal dust inhalation, and that "[t]here are other forms of pneumoconiosis which is not related to coal dust, like silicosis or asbestosis." (PX1, p.15).

Dr. Istanbouly testified that there is no cure for coal workers' pneumoconiosis and that it is a chronic disease that can sometimes be slowly progressive, but that is not the rule. (PX1, p.15). He noted that Petitioner "... does have [a] certain degree of impairment" and that the cause of this impairment was "[l]ong-term coal dust exposure." (PX1, p.15).

Dr. Istanbouly indicated that "[d]efinitely in this patient with the abnormality on the x-ray and the PFT, in addition to his chronic symptoms, it is advisable for him from a medical standpoint not to go back to work in the coal mines to prevent the progression of his lung disease." (PX1, p.16). He indicated that additional exposure to coal dust could cause the damage to keep getting worse. (PX1, p.16). He also stated that "[t]here is no safe level" of dust exposure for someone with coal workers' pneumoconiosis. (PX1, p.16). He noted that "[m]edically speaking, I wouldn't recommend this patient to go back to work in the coal mine." (PX1, p.17). He agreed that having coal workers' pneumoconiosis makes an individual more susceptible to respiratory infections and pneumonias. (PX1, p.17). When asked whether it was his

recommendation that Petitioner have no further exposure to coal dust, Dr. Istanbouly replied: "[d]efinitely." (PX1, p.17).

Dr. Istanbouly indicated that based upon his findings and within a reasonable degree of medical certainty, he believed that Petitioner has damage to his lungs as a result of occupational exposure to coal dust. (PX1, pp.16-17).

On cross examination, Dr. Istanbouly agreed that he saw Petitioner just one time and that the purpose of his visit was for an evaluation relative to his State black lung claim. (PX1, p.18). He also agreed that on average he performs five to seven examinations a month at the request of attorneys, and that they are always at the request of claimant attorneys. (PX1, p.18).

Dr. Istanbouly agreed Petitioner advised him that he had no past medical diagnosis of respiratory disease, and that he related that he had a runny nose and cough in the morning with the only other trigger for that cough identified as brisk walking. (PX1, p.18). He conceded that dyspnea on exertion is associated with conditions other than respiratory disease, and that deconditioning is associated with dyspnea on exertion. (PX1, pp.18-19). He also acknowledged Petitioner told him that his physical capacity was limited "[d]ue to lower back pain and arthritis." (PX1, p.19). He indicated Petitioner was 5' 9-1/2" tall and weighed 279 pounds, which worked out to a BMI over 40, which was obese. (PX1, p.19). He noted that Petitioner did not relate taking any breathing medication either in the past or at the time of his examination. (PX1, p.19).

When asked if he reviewed any medical records, Dr. Istanbouly responded "[o]nly what he provided me verbally." (PX1, pp.19-20). He agreed that Petitioner did not tell him that he left the mines because of a respiratory disease or symptoms. (PX1, p.20). However, he noted that Petitioner "... does have these respiratory symptoms which is part of the complaint. So he did not leave because of them but he did have a problem in the last year of employment." (PX1, p.20). When asked what difficulties Petitioner had in his job, Dr. Istanbouly stated: "[h]e didn't complain directly about his job but he did have respiratory symptoms related to the nature of his job... [T]he cause of the problem to start with is environmental exposure." (PX1, p.20).

Dr. Istanbouly agreed that GERD is associated with cough and that Petitioner was taking Paroxetine, an antidepressant. (PX1, p.21). He also agreed that Lisinopril is an ace inhibitor and that one of the side effects is a cough. (PX1, p.20). Likewise, he agreed that Petitioner was taking Xarelto for DVT. (PX1, p.21).

Dr. Istanbouly agreed that the diagnosis of chronic bronchitis that he made was based upon what Petitioner told him "[i]n addition to the abnormality on the PFT." (PX1, p.21). He once again noted that he interpreted the PFT as revealing mild obstructive defect. (PX1, p.21). He indicated that he considered the American Thoracic Society (ATS) to be an authority on interpretative strategies for pulmonary function testing. (PX1, pp.21-22). He noted that the basis for his opinion that Petitioner has an obstruction is "[t]he ratio of FEV1 to FVC", or a reduced FEV1/FVC ratio. (PX1, p.22). He noted that "[i]t is age related now with the most up-to-date guidelines [per the ATS], and 68 for his age is still considered low." (PX1, p.22). He did concede, however that the ATS specifically states in their interpretive strategy that the FEV1/FVC ratio should not be used to determine the severity of obstruction, noting that "I

diagnosed obstructive defect based on the ratio. I decided it is mild based on the value of FEV1 and FVC. So the intensity, no, I didn't use it to assess the intensity of the defect." (PX1, p.22). He indicated that he found it to be mild based on a "[n]ormal FEV1 and FVC with reduced FEV1 slash FVC." (PX1, p.23). He agreed that the ATS states that you look to the FEV1/FVC ratio to determine whether an obstruction is present and that you look to the FEV1 percent to determine severity, not the ratio. (PX1, p.23). He likewise agreed that Petitioner's FEV1 percent was 107 percent, which was absolutely normal, noting ".... That's why it is mild. That's why I called it mild because it is normal but the ratio is abnormal." (PX1, p.23). He indicated that less than 80 percent is considered abnormal. (PX1, p.23).

When asked whether he knows the lower limit of normal for Petitioner's FEV1/FVC ratio, Dr. Istanbouly responded: "[l]et me tell you something. The way I calculate it quickly in my mind, if you are 70 years old, the low normal is 67 percent. If you are 50 years old, the low normal is 70 percent. So 61, I know 68 is low." (PX1, p.24). He noted that the ATS is his authority for this. (PX1, p.24). He agreed that in this case both Petitioner's forced vital capacity and his FEV1 exceeded 100 percent of predicted, and that physical examination of this gentleman's chest revealed no sign of disease. (PX1, pp.24-25). He likewise agreed that he is neither an A nor a B reader. (PX1, p.25). When asked whether it was correct that he cannot say whether the film is a 1/0 profusion or 0/1 profusion, Dr. Istanbouly responded: "[n]o. All what I can tell [is] whether it's mild, moderate or severe. But numerical system, no, I don't do that." (PX1, p.25).

Dr. Istanbouly noted that the chest x-ray dated 5/20/15 "... was good quality because it was digital copy." (PX1, p.25). When asked whether all digital films are of good quality, he replied: "[g]enerally speaking, yes." (PX1, p.25). Finally, he agreed that the Department of Labor requires B readings for their films. (PX1, p.25).

Testimony of Dr. Cristopher Meyer (10/7/16)

Board-certified radiologist and certified B-reader (through 12/31/18) Dr. Meyer testified that he is currently Vice Chair of Finance and Business Development and professor of diagnostic radiology at University of Wisconsin Hospital and Clinics in Madison, Wisconsin. (RX1, pp. 4,15). He noted that he spends 50 percent of his time in clinical radiology, reading chest x-rays and CT scans two to three days a week and 20 percent in academic time, or one day a week researching and writing, along with one day of administrative time. (RX1, p.16). He indicated that his average week involves reading somewhere between 200 and 250 chest x-rays and 20 to 40 chest CT scans. (RX1, p.16).

Dr. Meyer testified that he had reviewed the PA chest radiograph taken of Petitioner on 5/20/15. (RX1, p.41). He noted that the diagnostic quality of these films was Quality 3 due to image noise and mottle. (RX1, p.41). He noted that this "... gives the film a grainy look that mimics 'p' type opacities. The distinction, however, is made by the fact that that grainy appearance occurs not only over the lung parenchyma but actually over the entire chest and outside the patient in the surrounding air and in the patient's soft tissues." (RX1, pp.41-42). He agreed that this mottle would then affect all lung zones. (RX1, p.42).

Dr. Meyer testified that his interpretation of the film revealed that "[t]he lungs were clear without small rounded, small irregular or large opacities. There was some atherosclerotic calcification in the thoracic aorta. My impression was no radiographic findings of coal workers' pneumoconiosis." (RX1, p.42).

On cross exam, Dr. Meyer stated he does roughly 30 to 40 B-readings a week. (RX1, p.43). He agreed a B-reader is preferred to just a radiologist who is not a B-reader with respect to reading a chest x-ray for the presence or absence of an occupational disease. (RX1, p.43).

When asked whether CWP causes scarring, Dr. Meyer testified that "[i]n the general term coal workers' pneumoconiosis can result in some lung fibrosis, most commonly in the upper zones." (RX1, p.44). He indicated that he is not saying that CWP does not happen or begin in the lower lobes, noting that "... when it is extensive [it] can extend down to the bases. The typical description of coal workers' pneumoconiosis is that it begins in the upper zones, most commonly in the apical and posterior segment of the right upper lobe greater than the left upper lobe, and does not begin generally as a basilar process." (RX1, p.44). When asked if it can, Dr. Meyer stated: "[i]n the pattern of distribution of coal and small nodules, I have to say I've not seen that described in the literature." (RX1, pp.44-45).

Dr. Meyer agreed that there is no treatment for coal workers' pneumoconiosis. (RX1, p.45). However, he declined to weigh in on whether a person can have CWP by x-ray and still have a normal physical exam, noting that he's a radiologist and that that would be outside his area of expertise. (RX1, p.45). He noted that such a question would be better answered by a pulmonary medicine physician. (RX1, p.45). When asked the same question as to a person having CWP by x-ray and normal pulmonary function studies, Dr. Meyer noted that "I do know that mild simple coal workers' pneumoconiosis is generally asymptomatic." (RX1, p.45).

When asked if he was saying there were no abnormalities on those films, and not just none related to CWP, Dr. Meyer responded: "[i]f these films were to come through on a regular clinical workday, it would be read as no acute cardiopulmonary disease. There would be no additional findings." (RX1, pp.45-46). He agreed, however, that a negative film for CWP does not necessarily rule out the disease. (RX1, p.47). He also agreed that on autopsy or biopsy, many coal miners that had negative chest x-rays for CWP actually had it pathologically. (RX1, p.47).

Dr. Meyer admitted that he did not actually pass the B-reading test the first time he took it while he was in the military many years prior to taking it at the end of 1998 and when he started B-reading in January of 1999. (RX1, p.47). He agreed that he testified on direct that CWP normally starts in the upper lung zones. (RX1, pp.49-50). When asked if he knew of any recent studies that disagreed with that, Dr. Meyer noted that there was a study "... recently published by Laney and Petsonk that did look at distribution of small pneumoconiotic opacities. There were significant problems with that study, however." (RX1, p.50). He indicated that some of the problems with the study was that "... it had no pathologic proof, and they had no CT correlation. They also only had smoking data available for 10 percent of their patient population, and they looked at the lung distribution when it was the most severe." (RX1, p.50). Dr. Meyer stated that he did not dispute the fact that "... when coal workers' pneumoconiosis becomes more severe, it's diffuse and involves all lung zones. The real question has to do with when coal

workers' pneumoconiosis starts as an early disease, and that's actually been supported by extensive pathologic literature looking at particle distribution based on lymphatic clearance of particles." (RX1, p.50). He also pointed out that "[t]hey took the reports; they didn't actually go back and look at the examinations themselves." (RX1, p.51).

Dr. Meyer agreed he did not find anything related to coal workers' pneumoconiosis on the x-rays, noting that "I didn't find any nodules, no small opacities, no large." (RX1, p.52). Therefore, he agreed it was a zero over zero (0/0), not a zero over one (0/1). (RX1, p.52). Dr. Meyer noted that this is one of the toughest distinctions for a radiologist to make. (RX1, p.52). He also agreed with the statement found in the Laney Petsonk study to the effect that individual coal macules are generally too small to be appreciated on chest x-ray, noting that "[m]ost of the nodules that we see on chest x-rays are actually what are known as summation shadows, which means that multiple coal macules superimposed on one another form a shadow that's big enough for us to see." (RX1, p.53). Thus, he agreed Petitioner could have still CWP on a pathological level even though he read this chest x-ray as negative. (RX1, p.53).

Dr. Meyer disagreed with the study's statement to the effect that "[o]verall, the findings demonstrate that small opacities on chest x-rays of coal miners are not predominantly in upper lung zones and suggest that the distribution of small radiographic opacities among coal miners is more diverse than suggested in some textbooks and expert opinions." (RX1, p.54). He noted that "... it depends on the extent of disease. I believe that in early coal workers' pneumoconiosis, the small opacities are upper-zone predominant and that as the disease becomes more extensive, or more diffuse, then all six zones can be involved." (RX1, p.54). He indicated that his point was that "... this study really wasn't designed to describe early coal workers' pneumoconiosis changes." (RX1, p.55).

Dr. Meyer agreed that it was fair to say that similar experts with similar credential may disagree on the reading of chest films, especially in the Category 1 stage. (RX1, p.58). He also agreed that when he spoke of mottle, it refers to the whole film and not just the lung zones. (RX1, p.58). He noted that the distinction is made by looking in the soft tissues and that "[o]ftentimes, [in] the lateral chest wall or axilla you will see the same pattern of sort of a grainy appearance to the examination." (RX1, p.59).

On re-direct examination, Dr. Meyer stated that "[s]imple pneumoconiosis typically won't progress once exposure ceases." (RX1, p.59). He noted that Petitioner did not have either progressive massive fibrosis or cor pulmonale, and that there was no evidence of bulla or hyperinflation on the films. (RX1, p.59). Dr. Meyer testified that "... certainly we know that coal workers' pneumoconiosis is typically an upper-zone predominantly nodular disease", and he concurred with articles by Cohen and Velho in 2002 and Remy-Jardin a few years ago that expressed similar findings. (RX1, p.64). He indicated that he did not pass the B-reader exam the first time because he did not fully understand the difficulty and the preparation work that should have been done ahead of time. (RX1, p.60).

Testimony of Dr. James Castle (8/2/17)

Dr. Castle testified he is board certified in internal medicine with a subspecialty of

pulmonary disease. (RX2, p.4). He noted he quit seeing patients in the hospital in about 2003 or so, and quit seeing patients in the office altogether about the first of January of 2007 when he decided to semi-retire. (RX2, p.12). He indicated that he is now working part time performing medicolegal exams and record reviews. (RX2, p.12). Dr. Castle stated that he became a B-reader in 1985 and that his current certification is good through 6/30/17. (RX2, pp.13-14).

Dr. Castle agreed that at the request of defense counsel he reviewed the medical records of Petitioner. (RX2, p.21).

Dr. Castle testified that based on his review of the medical record he did not believe Petitioner suffers from chronic bronchitis, noting that that diagnosis did not appear anywhere in the medical he reviewed. (RX2, p.34). He noted that to determine whether an obstruction is present "[y]ou look for the ratio of the FEV1 to FVC, also known as the FEV1 percent." (RX2, p.34). He indicated that if the FEV1/FVC ratio is above the lower limit of normal an obstruction is not present, and that Petitioner's FEV1/FVC in the testing done by Dr. Istanbouly (68) was above the lower limit of normal (65.79). (RX2, p.35). Thus, he noted that "[t]here was absolutely no obstruction based on ATS [American Thoracic Society] and ERS [European Respiratory Society] criteria." (RX2, p.36). He also indicated that with an FEV1 percent predicted of 107 there was no impairment present should an obstruction have been shown. (RX2, p.36).

Dr. Castle testified that he reviewed the chest x-ray dated 5/20/15 and opined that "... there were no parenchymal abnormalities consistent with pneumoconiosis. This film was essentially normal except for obesity." (RX2, p.36).

Dr. Castle indicated it was very unlikely for simple pneumoconiosis to progress once the exposure ceases. (RX2, p.40). He noted he subscribes to the position of the ATS that an older worker with a mild pneumoconiosis may be at low risk for working in currently permissible exposure levels until they reach retirement age. (RX2, p.40). He also stated the Mine Safety Health Administration doesn't require a worker diagnosed with CWP to cease all exposure to coal dust, "... but they are to be offered a position with lower dust exposure." (RX2, pp.40-41).

When asked his final conclusions regarding Petitioner, Dr. Castle testified that "[i]t is my opinion with a reasonable degree of medical certainty based upon a thorough review of all the data including the medical histories, physical examinations, radiographic evaluations, physiologic testing, and other data, that Mr. Richard Woolard does not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to coal mine dust." (RX2, p.41). Dr. Castle went on to state that "Mr. Woolard did not demonstrate any consistent physical findings indicating the presence of an interstitial pulmonary process. He did not have the consistent findings of rales, crackles or crepitations. His pulmonary examination was essentially normal on virtually all occasions. The majority of radiographic reports indicated that there were no findings of coal workers' pneumoconiosis or a coal mine-induced lung disease. On most occasions it was felt that the chest X-ray was entirely normal. That was my personal opinion as well as that of Dr. Cristopher Meyer, radiologist and B reader. Only Dr. Henry Smith felt that the chest X-ray did show findings consistent with minimal coal workers' pneumoconiosis. Therefore, it is my opinion that Mr. Richard Woolard does not have

radiographic findings indicating the presence of coal workers' pneumoconiosis." (RX2, p.43).

Dr. Castle testified that when he applied the AMA Guides to the Evaluation of Permanent Impairment, 6th Edition, to the results of Petitioner's objective testing "[h]e would be in class zero." (RX2, p.45). He also opined that from a ventilatory standpoint Petitioner was capable of heavy manual labor. (RX2, p.45).

On cross examination, Dr. Castle testified that coal workers' pneumoconiosis is "... a chronic dust disease brought about by the inhalation of coal mine dust over a period of working in or around the coal mines. It's manifested by the presence of an abnormal chest X-ray with small, round regular-type opacities primarily in the upper lung zones but depending upon the severity may involve the middle and occasionally the lower lung zones. The disease may or may not be symptomatic. An individual can have the abnormal chest X-ray with no symptoms whatsoever and no findings other than the abnormal chest X-ray. They can be symptomatic and they may have disability or impairment, I should say, and/or disability related to that process. In the more severe stages of the disease it is known as complicated pneumoconiosis or progressive massive fibrosis, although the lower stages of that process are generally not disabling or may not be disabling. Certainly the higher stages typically would be disabling." (RX2, pp.48-49).

Dr. Castle indicated that CWP is a type of interstitial lung disease and that scarring and fibrosis can occur as part of the disease process. (RX2, p.49). However, he noted that scar tissue does not participate in gas exchange or in physiologic function. (RX2, p.49). He stated that to his knowledge there is no cure for coal workers' pneumoconiosis, and that the scarring and fibrosis is permanent and irreversible. (RX2, p.50). He also agreed that the scarring and fibrosis represents an alteration in the function of the involved lung tissue. (RX2, pp.50-51).

When asked whether CWP can progress in the absence of further dust exposure, Dr. Castle responded: "[i]t can. It's very unusual and it would again depend upon the extent of the disease process... [but] it would be extraordinarily unlikely for somebody with no or minimal disease to progress to any great idea [sic] after cessation of exposure." (RX2, p.51). He indicated that removing someone from the dust exposure "... might be a further preventative for somebody that doesn't have [CWP] but, you know, I think it is important to recognize that people ... even with minimal degrees of abnormality, as has been noted by the American Thoracic Society in today standards, could continue to work without any significant risk of further significant progression." (RX2, p.52). He agreed, however, that that doesn't mean they are not at risk of progression or that people are not still getting CWP even at so-called "safe" levels of dust exposure. (RX2, pp.52-53). Dr. Castle noted that "... most people that work in the mines do not get coal workers' pneumoconiosis." (RX2, p.54). He agreed that you have to be a susceptible host to get the disease and certain people are more susceptible than others, and that we just don't know who those people are. (RX2, p.54). He also agreed that a person can have CWP and not know they have it, noting that "... most people that have it are asymptomatic." (RX2, pp.54-55).

Dr. Castle agreed that it was fair to say a spirometry test will tell you the type of abnormality and its severity but will not tell you the etiology. (RX2, p.55). He likewise agreed that you can have shortness of breath despite having normal PFTs. (RX2, p.55). He also agreed that it is not unusual for a person to have normal PFTs and still have CWP. (RX2, p.55). He

even agreed that it was possible for a person to have a portion or a lobe of their lung removed and still have PFTs that are within the range of normal, although he noted that it wasn't very common and that it would depend on the underlying disease process and how much of the lung was removed. (RX2, p.57). He stated that spirometry is "... a total reflection of the ability or function of the entire pulmonary system." (RX2, p.57).

Dr. Castle acknowledged that he did not take a history from or speak to Petitioner in any way. (RX2, p.58). He also agreed that he did not speak to his examining or treating physicians and did not perform a physical examination. (RX2, p.58). However, he did not feel that not doing his own testing or personally examining Petitioner placed him at a distinct disadvantage provided he has an adequate enough data base which contains objective and historical information. (RX2, pp.58-59). He indicated that reading chest X-rays "... is a subjective means of making an objective evaluation" and that "[t]here is a possibility of both intraobserver and interobserver variation." (RX2, p.60).

Dr. Castle noted he is no longer a B-reader given his certification expired 6/30/17 and he chose not to recertify. (RX2, p.63). He stated he has "... been a B reader consecutively for 32 years, never failed an examination, and I frankly am not doing that many B read[ings], and some of the equipment that's required now to do that is expensive. And since it just wasn't going to be cost effective for me to continue to maintain that so I elected not to do it." (RX2, p.63).

Dr. Castle agreed that the ATS statement doesn't say that older workers nearing retirement are not at any risk of developing the disease or the disease worsening, only that they may be at low risk. (RX2, pp.66-67). He likewise agreed that it's fair to say the ATS states there is no safe level of dust exposure. (RX2, p.67).

Dr. Castle agreed that he rated the 5/20/15 chest x-ray as a quality two film, while Dr. Meyer categorized it as quality three, which he noted "... simply indicates there's something present so that it's not a perfect film but that neither of them would be sufficient to render the film uninterpretable for pneumoconiosis." (RX2, p.67). He indicated that a better quality film would not necessarily change his answer "... because the fact that a film is not quality one doesn't make it uninterpretable, and you take that into consideration as part of the interpretation... [A]nd if it is something that renders the film not interpretable, you mark it as unreadable and explain that." (RX2, pp.67-68).

When asked whether Petitioner's shortness of breath could be attributable to CWP, Dr. Castle replied: "[i]f he had it, I guess it possibly could, although I will tell you that it's a distinct minority of individuals who have the disease have any impairment related to it." (RX2, p.72). He noted that "... the vast majority of people that have it don't have any symptoms at all. But if they did have symptoms, then shortness of breath would be the most common." (RX2, p.73). He also agreed that in most CWP cases physical findings indicating the presence of an interstitial pulmonary process -- such as rales, crackles or crepitations -- are not there. (RX2, p.73). However, he agreed that not having those findings, in and of themselves, does not mean he does not have the disease. (RX2, p.73).

On re-direct examination, Dr. Castle agreed that treatment records are "always

important" in assessing whether someone has an occupational disease, and that an individual's complaints, physical findings, review of systems and testing like chest x-rays over time would be reflected in those records. (RX2, pp.74-75). He noted that based on the spirometry performed at Methodist Hospital, and using Knudson predicteds and NHANES 111 for a 61 year old individual, 69 inches in height, the forced vital capacity and FEV1 would be 131 percent predicted. (RX2, p.76). He also confirmed that whatever the predicteds, the ratio for that testing, which in this case was 75 percent, will not change, and that it is that ratio that we look at to determine whether it's above or below the lower limit of normal and thus whether an obstruction is present. (RX2, pp.76-77). He noted that in this case Petitioner "... had a normal ratio and therefore he had no obstruction." (RX2, p.77). He agreed that even if there was an obstruction, he has no impairment because of the FEV1 percent. (RX2, p.77).

When asked about the grading of film quality, Dr. Castle noted that "[t]here will always be minor differences between interpreters" but that he and Dr. Meyer both found deficiencies in the 5/20/15 x-ray. (RX2, p.78). He agreed that it's very important that an interpreter recognizes a problem with film quality in his or her interpretation and that if someone reads a film as quality one and it's not, and doesn't recognize it as such, then that can lead to a misinterpretation. (RX2, pp.78-79).

On re-cross examination, Dr. Castle noted that he disagreed with the premise that if someone characterizes the film as quality three then they are more likely to under-read the film compared to if it was a quality one film. (RX2, pp.79-80).

Conclusions of Law

The claimant in an occupational disease case has the burden of proving both that he suffers from an occupational disease and that a causal connection exists between the disease and his employment. *Freeman United Coal Mining Co. v. Ill. Workers' Comp. Comm'n*, 999 N.E.2d 382, 389, 376 Ill. Dec. 499, 506 (5th Dist. 2013); citing *Anderson v. Industrial Comm'n*, 321 Ill. App. 3d 463, 467, 748 N.E.2d 339, 254 Ill. Dec. 893 (2001). Whether an employee suffers from an occupational disease and whether there is a causal connection between the disease and the employment are questions of fact. *Bernardoni v. Industrial Comm'n*, 362 Ill. App. 3d 582, 597, 840 N.E.2d 300, 298 Ill. Dec. 530 (2005); *Anderson*, 321 Ill. App. 3d at 467. Where conflicting medical testimony is presented, it is for the Commission to determine which testimony is to be accepted. *Martin v. Industrial Comm'n*, 91 Ill. 2d 288, 294, 437 N.E.2d 650, 63 Ill. Dec. 1 (1982).

§1(d) of the Occupational Diseases Act ("ODA") states, in pertinent part:

> A disease shall be deemed to arise out of the employment if there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is performed and the occupational disease. The disease needs not to have been foreseen or expected but after its contraction it must appear to have had its origin or aggravation in a risk connected with the employment and to have flowed from that source as a rational consequence.

> An employee shall be conclusively deemed to have been exposed to the hazards of an occupational disease when, for any length of time however short, he or she is employed in an occupation or process in which the hazard of the disease exists... If a miner who is suffering or suffered from pneumoconiosis was employed for 10 years or more in one or more coal mines there shall, effective July 1, 1973 be a rebuttable presumption that his or her pneumoconiosis arose out of such employment.

§1(e) of the ODA states, in pertinent part:

> "Disablement" means an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body.

§ 1(f) of the ODA states, in pertinent part:

> No compensation shall be payable for or on account of any occupational disease unless disablement, as herein defined, occurs within two years after the last day of the last exposure to the hazards of the disease.

In the present case, the experts differed as to whether chest x-rays performed on 5/20/15 proved the presence of coal worker's pneumoconiosis ("CWP"). While it is true that Dr. Meyer agreed that a negative x-ray does not necessarily rule out CWP, that is not the same as saying that Petitioner in fact suffers from the disease. Instead, Petitioner bears the burden of proving by a preponderance of the credible evidence all the elements of his claim, including the threshold consideration of whether he even has an occupational disease, including CWP.

Furthermore, while it is true that Petitioner worked as a coal miner for 37 years, the provisions set forth in Section 1(d) of the Occupational Diseases Act – wherein a rebuttable presumption exists that a coal miner's pneumoconiosis arose out of such employment if he or she was employed for 10 years or more in one or more coal mines -- does not apply, by a plain reading of the statute, unless and until it is shown that the claimant has CWP.

The evidence shows Petitioner last worked in the mine on 11/6/14. He claims that he is a non-smoker and that he started noticing breathing problems "[p]robably ten years ago", or in approximately 2008. However, a review of the record of primary care physician Dr. Ewell during the period leading up to Petitioner's last day of work in the mines (11/6/14) reveals no references to any breathing complaints along these lines, other than to several episodes of sinusitis commonly associated with a cold or flu. The record also shows that Petitioner actually stopped working for Respondent following a back injury, not for any breathing-related issues, only to be laid off and never to return to work again, for Respondent or any other employer. Petitioner also claims that his breathing has gotten worse since he left Respondent's employ and that it affects his daily activities. However, once again, a review of the medical record fails to reflect any ongoing complaints relative to a diagnosis of CWP or any other chronic respiratory ailments during this period, and in fact much of his current complaints voiced at arbitration could just as easily be explained by the limitations placed upon him by his back injury as well as his obesity. In addition, Petitioner is not taking any breathing medication at this time, nor has he ever been prescribed breathing medication at any point.

Furthermore, two prior chest x-rays, taken in 2006 and 2013, were interpreted as negative for CWP, and chest x-rays performed on 7/18/17 were interpreted by the same radiologist who reviewed both the 11/18/06 and 10/11/13 studies, Dr. Youssef, as revealing "no active disease or significant interval change from the 10/11/2013." (RX7).

As to the radiological study at the heart of the current dispute, performed on 5/20/15, Drs. Istanbouly and Smith believe it shows simple CWP, although the former is not a B-reader. In contrast, Drs. Meyer and Castle, both of whom were B-readers at the time of their review of the study, believe that it does not evidence signs of CWP. The doctors also differ as to their interpretation regarding the quality of the films, and the criteria one utilizes in order to evaluate those films. However, the Commission notes that the quality of the film in question would appear to be critical in accurately interpreting same, and the simple fact that no concerns were voiced by any physician as to the quality of the x-rays taken before and after the 5/20/15 study, which were found to be negative, lends credence to the opinion of Dr. Castle that the failure to adequately take into consideration deficiencies in quality can lead to misinterpretation. Thus, the diagnosis of simple CWP by Drs. Istanbouly and Smith is called into question by the dubious diagnostic quality of the film, especially given that every physical examination of Petitioner's chest by every physician to date has been normal.

Furthermore, there is no reason to believe that Petitioner suffers from an obstructive respiratory disease, despite Dr. Istanbouly's claim of "mild obstructive defect", given the results of the pulmonary function testing which Dr. Castle found to be above the lower limit of normal.

Therefore, upon a thorough review of the evidence, including the deposition testimony of the various physicians, the Commission finds the opinions of Respondent's §12 physicians, Drs. Meyer and Castle, to be more persuasive and worthy of greater weight than those offered by Petitioner's §12 physicians, Drs. Istanbouly and Smith.

Based on the above, and the record taken as a whole, particularly the opinions of Drs. Meyer and Castle, the Commission reverses the decision of the Arbitrator and finds that Petitioner failed to prove by a preponderance of the credible evidence that he suffers from an occupational disease that arose out of and in the course of his employment on or about 11/6/14, and failed to prove that said condition was causally related to his employment.

The Commission further notes that even if Petitioner had proven the presence of an occupational disease, he failed to prove disablement within two years of the date of last exposure, as required by the Act. More to the point, while Dr. Istanbouly agreed that patients with CWP should avoid the coal mining environment, there is no evidence that any physician has specifically restricted Petitioner from returning to work due to an occupational disease. Indeed, Dr. Castle opined that from a ventilatory standpoint, Petitioner was capable of heavy manual labor. Thus, disablement has not been shown to have occurred within two years of the date of last exposure, and as a result Petitioner's claim would likewise be denied.

Accordingly, Petitioner's claim for compensation is denied.

20IWCC0154

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's award dated 10/1/18 is vacated and Petitioner's claim for compensation is hereby denied.

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

DATED:
o: 1/7/20 MAR 5 - 2020
TJT/pmo
51

Maria E. Portela

Kathryn A. Doerries

DISSENT

I dissent. I believe that the evidence supports the Arbitrator's finding that Petitioner suffers from simple coal worker's pneumoconiosis, per the opinions of Drs. Istanbouly and Smith, whose estimable credentials and practical experience, in my opinion, more than make up for the fact that the former is not a B-reader. More importantly, the record clearly shows that Petitioner worked in the coal mining industry for 37 years, 22 of which were spent underground in a coal mine. By his own account, he was regularly exposed to welding and other fumes as well as rock and coal dust. He also testified without refutation that his breathing problems began about ten years earlier, or around 2008, and that he currently has difficulty performing everyday activities because of this. Furthermore, Petitioner is not and has never been a smoker.

As a result, and in light of Dr. Istanbouly's persuasive opinion, as well as that of Dr. Smith, I believe Petitioner proved by a preponderance of the credible evidence that a) he suffers from simple CWP, b) he is disabled and unable to return to his usual and customary employment due to his respiratory condition, c) that this disablement occurred within two years of the last date of exposure pursuant to §1(f) of the ODA, d) his occupational disease arose out of and in the course of his employment with a last date of exposure of 11/6/14, and e) his current condition of ill-being relative to his diagnosis of CWP is causally related to his employment.

Thus, I would affirm the Arbitrator's well-reasoned and thorough decision in its entirety, and award benefits accordingly.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WOOLARD, RICHARD
Employee/Petitioner

Case# **15WC020308**

THE AMERICAN COAL COMPANY
Employer/Respondent

20IWCC0154

On 10/1/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.32% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 & JORDAN
ROMAN P KUPPART
3 S MAIN ST SUITE 2
HARRISBURG, IL 62946

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

20IWCC0154

☐ Injured 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

RICHARD WOOLARD
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

Case # **15** WC **020308**

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 **Herrin**, on **August 9, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of 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 **Disease, and Sections 1(d)-(f) of the Occupational Diseases Act**

20IWCC0154

FINDINGS

On **November 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 $**47,867.56**; the average weekly wage was $**920.53**.

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

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

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

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

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

ORDER

PETITIONER HAS PROVEN THAT HE HAS COAL WORKERS' PNEUMOCONIOSIS AND IS DISABLED BECAUSE OF HIS OCCUPATIONALLY INDUCED LUNG DISEASE, WHICH WAS CAUSED BY HIS OCCUPATIONAL EXPOSURE WITH RESPONDENT.

PETITIONER HAS PROVEN THAT HIS COAL WORKERS' PNEUMOCONIOSIS WAS PRESENT AND HE WAS DISABLED BY THE DISEASE WITHIN TWO YEARS OF HIS LAST EXPOSURE AS REQUIRED BY SECTION 1(F).

RESPONDENT SHALL PAY THE PETITIONER THE SUM OF $ 552.32/WEEK FOR A PERIOD OF 30 WEEKS, AS PROVIDED IN SECTION 8(D)(2) OF THE ACT, BECAUSE THE INJURIES SUSTAINED CAUSED A PERMANENT AND PARTIAL DISABLEMENT TO THE EXTENT OF 6% MAW.

RESPONDENT SHALL FURTHER PAY FOR NECESSARY FUTURE MEDICAL SERVICES, AS PROVIDED IN SECTION 8(A) 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.

Edul Lee
Signature of Arbitrator

9/28/18
Date

OCT 1 - 2018

FINDINGS OF FACT

On October 31, 1996, Petitioner underwent an x-ray of the chest. (RX5) This impression was of a negative study.

On November 19, 2006, Petitioner underwent an x-ray of the chest. (RX5) The impression was of a negative study.

On October 11, 2013, Petitioner underwent an x-ray of the chest. (PX4) The impression was of; no active disease, and prior rotator cuff repair, right shoulder.

On November 11, 2014, Petitioner presented to Dr. Clayton Ford with a complaint of back pain. (RX4) Dr. Ford noted that Petitioner was being seen for a work comp injury to his lower back. It was noted that Petitioner worked at American Coal. Petitioner reported that he was going down a hill on his ride when he was jarred in his seat. Petitioner advised that he could barely stand after the injury. Petitioner was assessed with a lumbar strain, and Petitioner advised that he had an appointment with his primary care doctor, Dr. Ewell, that day at 4 pm.

On May 30, 2015, Dr. Henry K. Smith reviewed a chest x-ray taken on May 20, 2015. (PX2) Dr. Smith is board certified in radiology and is a NIOSH certified B-Reader. (PX3) Dr. Smith passed his initial B-Reader examination in 1987, and maintained his certification status continuously over 23 years. (PX3) Dr. Smith found that the chest film was a quality 1 film. Dr. Smith's impression was of simple coal workers' pneumoconiosis with small opacities, primary p, secondary s, all zones involved bilaterally, of a profusion 1/1.

Petitioner filed an Application for Adjustment of Claim with the Illinois Worker's Compensation Commission on June 15, 2015. Petitioner listed his date of accident as November 6, 2014, and listed that the accident occurred from inhalation of coal mine dust, including but not limited to, coal dust, rock dust, fumes and vapors for a period in excess of 34 years.

On September 22, 2015, Dr. Suhail Istanbouly examined Petitioner and authored a report outlining the test results, diagnosis, and his opinions at the request of Petitioner's counsel. (PX1, Exhibit 2).

Dr. Istanbouly reported that Petitioner was a 61 years old male who has been coughing on a daily basis for a year. The cough is mild to moderate in intensity and occurs mostly in the morning. The cough also gets triggered by brisk walking. It was noted that Petitioner gets exertional dyspnea. The cough is productive of mild white-yellowish sputum, a few teaspoons full in size per day. Dr. Istanbouly noted that Petitioner gets short of breath walking one block or less. Petitioner reported no history of asthma in the past. Petitioner is a non-smoker. (PX1, Exhibit 2).

Dr. Istanbouly obtained Petitioner's occupational history. (PX1, Exhibit 2). He noted that Petitioner did work as a coal miner for a total of 38 years, 22 years as an underground coal miner

and 16 years as a surface coal miner, with his last month of coal mining career being in November, 2014.

Dr. Istanbouly reported that Petitioner's spirometry testing revealed a mild obstructive defect. Dr. Istanbouly personally reviewed the chest x-ray from Ferrell Hospital which was obtained on May 20, 2015. He also reviewed a B-reading of that same film. Dr. Istanbouly ultimately assessed Petitioner with coal workers' pneumoconiosis. He advised Petitioner to avoid further coal dust inhalation and to avoid going back into the mines to avoid any further lung damage. (PX1, Exhibit 2).

On June 9, 2016, Petitioner underwent a pulmonary function test at the request of Dr. Jeff Selby. (RX3) The interpretation was of normal spirometry without improvement post-brochodilator, and of normal diffusion capacity.

On October 7, 2016, Dr. Christopher A. Meyer testified via evidence deposition at Respondent's request. (RX1) Dr. Meyer testified that he is a board certified radiologist who has a B-Reading certificate. Dr. Meyer testified that he currently works as the Vice Chair of Finance and Business Development and professor of diagnostic radiology at the University of Wisconsin Hospital and Clinics in Madison, Wisconsin.

Dr. Meyer testified that he reviewed a PA and lateral chest x-ray of Petitioner dated May 20, 2015. (RX1) Dr. Meyer testified that the film was a quality 3 film, but was of diagnostic quality. Dr. Meyer testified that it was his impression that there were no radiographic findings of coal workers' pneumoconiosis on that film. However, Dr. Meyer agreed that it was fair to say that experts with similar credentials may disagree on the reading of chest films, especially those in Category 1 of pneumoconiosis.

On cross-examination, Dr. Meyer agreed that a negative chest x-ray for coal workers' pneumoconiosis does not necessarily rule out the disease. (RX1) Dr. Meyer further agreed that many coal miners have had negative chest x-rays for coal workers' pneumoconiosis, but on biopsy or autopsy it is shown that they actually had the condition pathologically. Dr. Meyers agreed with the Laney and Petsonk study which stated, "[i]ndividual coal macules are generally too small to be appreciated on chest x-rays". Dr. Meyers explained that "[m]ost of the nodules that we see on chest x-rays are actually what are known as summation shadows, which means that multiple coal macules superimposed on one another form a shadow that's big enough for us to see." (RX1)

On July 5, 2017, Dr. Istanbouly testified via evidence deposition at Petitioner's request. (PX1). Dr. Istanbouly testified that he is board certified in critical care medicine and pulmonary medicine. Dr. Istanbouly testified that he does black lung examinations for the U.S. Department of Labor. He has been the medical director of the pulmonary department at Herrin Hospital since 2005. He is also the director of the Intensive Care Unit at Carbondale Memorial Hospital and that he has been the director of the Intensive Care Unit at Herrin Hospital.

Dr. Istanbouly testified that he evaluated Petitioner on September 22, 2015. (PX1) Dr. Istanbouly testified that he took a detailed history from Petitioner, performed a physical examination and reviewed the pulmonary function testing and the chest x-ray.

Dr. Istanbouly testified that the pertinent aspects of Petitioner's history were that Petitioner had worked as a coal miner for 38 years, 22 of them underground and 16 years on the surface. That his last month of employment was November 2014. That Petitioner never smoked. That Petitioner had multiple chronic respiratory symptoms, including chronic daily cough with mild sputum production in addition to exertional dyspnea.

Dr. Istanbouly testified that it is not unusual for miners with simple coal worker's pneumoconiosis to be asymptomatic. He testified that if the miner was symptomatic they could have chronic cough, sputum production, shortness of breath on exertion, wheezing, and recurrent respiratory infections. Dr. Istanbouly testified that Petitioner's physical examination of his chest was normal. Dr. Istanbouly testified that it is not unusual for someone with early stages of coal workers' pneumoconiosis to have a normal physical examination of the chest. Dr. Istanbouly testified the pulmonary function studies Petitioner performed revealed a mild obstructive defect. Dr. Istanbouly's opinion was that Petitioner's mild obstructive defect was caused by his long term coal dust exposure, as that was his only risk factor.

Dr. Istanbouly testified that a person with coal workers' pneumoconiosis could have pulmonary function testing that is completely normal, which is not unusual in the early stages of the disease. Dr. Istanbouly testified that spirometry is a measure of the global impairment of both lungs rather than a focal impairment of a portion of the lungs. Dr. Istanbouly testified that a person could even have shortness of breath but have a normal pulmonary function test.

Dr. Istanbouly testified that he personally reviewed Petitioner's chest x-ray which was taken on May 20, 2015. (PX1). Dr. Istanbouly testified that he personally reviewed and interpreted Petitioner's chest film, as he normally does in the care and treatment of his patients. Dr. Istanbouly testified that the chest x-ray was of diagnostic quality, and that it revealed mild interstitial changes. Dr. Istanbouly testified that the B-reader read the film and found that the profusion was 1/1 primary P, secondary S, all zones involved bilaterally. Dr. Istanbouly testified that you do not have to be a B-reader in order to diagnose someone with coal workers' pneumoconiosis. He went on to testify that there are no B-readers at any of the hospitals that he's affiliated with. Dr. Istanbouly testified that the closest B-reader was approximately 80 miles away. (PX1).

Dr. Istanbouly testified that coal workers' pneumoconiosis is caused by the inhalation of coal dust that causes irritation and inflammation that will ultimately end up forming tiny scars. Dr. Istanbouly testified that the scarring is sometimes referred to as fibrosis, and that the scarring and fibrosis permanent. Dr. Istanbouly further testified that the scarring and fibrosis cannot carry on the function of normal health lung tissue. Dr. Istanbouly testified that, by definition, if you have coal workers' pneumoconiosis that you have an impairment of the function of the lungs, at least at the site of the scar or fibrosis. Dr. Istanbouly testified that only exposure to coal dust can cause coal workers' pneumoconiosis. Dr. Istanbouly testified that there is no cure for coal workers' pneumoconiosis. (PX1).

Dr. Istanbouly testified that, based upon on a reasonable degree of medical certainty, Petitioner's coal workers' pneumoconiosis was caused by his long term coal dust inhalation. Dr. Istanbouly testified that, while abnormal pulmonary function test findings are not necessary to diagnose someone with coal workers' pneumoconiosis, Petitioner's findings of a mild obstructive defect were particularly relevant to his diagnosis because he had no other risk factors that could have caused the condition other than long term coal dust exposure.

Dr. Istanbouly testified that based on Petitioner's x-ray and pulmonary function test abnormalities, in addition to his chronic symptoms, it is not advisable for Petitioner to ever return to work in the coal mines. Dr. Istanbouly testified that any additional exposure to coal dust could cause the damage to his lungs to worsen.

On August 2, 2017, Dr. James R. Castle testified via evidence deposition on behalf of the Respondent. (RX2) Dr. Castle testified that he is a pulmonologist who is board certified in internal medicine with a subspecialty in pulmonology. Dr. Castle testified that he had a practice in Roanoke, VA for thirty years, beginning in 1977. Dr. Castle testified that in the course of his practice he saw patients with all different types of chest disease. Dr. Castle testified that he semi-retired in 2007, and does not see patients any more, but he continues to do medicolegal types of exams and records reviews. Dr. Castle was paid $3,700.00 to perform a B-Reading and an independent medical review. (PX4) Dr. Castle testified that he performs 5 – 6 reviews like this per month, and approximately 15 per year at the request of Respondent's counsel, Mr. Werts.

Dr. Castle testified that he was a B reader, but that his certification expired on June 30, 2017. (RX2) Dr. Castle explained that some of the equipment that's now required to do B-Readings is expensive and it's not cost effective for him to continue to maintain his certification. Dr. Castle testified that he categorized the May 20, 2015, chest x-ray as a quality 2 film, and that Dr. Meyer categorized it as a quality 3 film.

Dr. Castle testified that had reviewed medical records and films regarding Petitioner. (RX2) Dr. Castle testified that it was his opinion, within a reasonable degree of medical certainty, that Petitioner does not have any pulmonary disease or impairment as a result of his occupational exposure.

Dr. Castle testified that he does not know if the chest x-rays dated, January 3, 1989, October 31, 1996, or October 11, 2013, were read by B-Readers. Dr. Castle testified that he is only certain that they are board certified radiologists because it's a requirement of the hospital's accreditation.

Dr. Castle testified that the American Thoracic Society recommended NHANES III prediction equation when doing pulmonary function studies. (RX2) Dr. Castle agreed that if Dr. Selby was not using the NHANES III prediction equation, then he was not following the recommendations of the American Thoracic Society.

On cross-examination Dr. Castle conceded that he had never met, spoken to, taken a history from, or physically examined the Petitioner. (RX2) Dr. Castle also agreed that he did not have the charts or notes from any of the physicians that personally evaluated the Petitioner, so he does not know what questions were posed to Petitioner or what answers were obtained.

Dr. Castle testified that it would be fair to say that similarly qualified physicians can, and do, disagree as to the findings on chest x-rays. (RX2) Dr. Castle testified that the only possible cause of pneumoconiosis is exposure to coal dust, and that there is no cure for that condition. Dr. Castle testified that he scarring and fibrosis that occurs in the lungs from pneumoconiosis is irreversible and permanent. Dr. Castle agreed that the scarring and fibrosis is an alteration of the lung tissue, and is also an alteration of the function of the involved lung tissue. Dr. Castle further agreed that the condition of pneumoconiosis can progress absent further coal dust exposure. Dr. Castle acknowledged that there are contradictory opinions as to whether or not there is a "safe" level of coal dust exposure, but even exposure to the alleged "safe" levels of coal dust are still causing some worker's to develop pneumoconiosis.

On cross-examination, Dr. Castle testified that an individual could have coal workers' pneumoconiosis and not know it because most people that have it are asymptomatic. (RX2) In fact, Dr. Castle testified that the vast majority of people who have coal workers' pneumoconiosis don't have any symptoms at all. On cross-examination, Dr. Castle agreed that a patient can still have shortness of breath despite having normal PFTs. Dr. Castle further stated that having a normal PFT does not mean that the lungs are undamaged, it simply means that lung function is normal. Dr. Castle testified that it was even possible to have a normal PFT after a portion, or a lobe, of a patient's lung has been removed. Dr. Castle testified that spirometry is a measure of the function of the entire pulmonary system rather than a measure of focal areas or impairments of the lung. Dr. Castle also agreed that it was possible for a patient to have coal workers' pneumoconiosis without any abnormalities on physical examination of the chest.

On July 18, 2017, Petitioner underwent an x-ray of the chest. (RX7) The impression was of no active disease or significant interval change from October 11, 2014.

Testimony

On August 9, 2018, Petitioner testified at arbitration. The issues in disputes were accident, causation, and Sections 1(d) and 1(f) of the Occupational Disease Act.

Petitioner testified that he is 64 years old, and has been married to Barbara Woolard for thirty-eight years. Petitioner testified that he graduated from high school, which was the furthest he went with his education.

Petitioner testified that he had thirty-seven years of coal mining employment. Petitioner testified that he graduated from Eldorado High School in 1972, and from 1972 – 1974 he did some carpentry work with his father. Petitioner testified that from 1974 – 1976 he worked at Scott Ladd picking groceries and operating a fork truck. Petitioner testified that in 1976 he went to work in the coal mines at Sahara Coal, where he worked until 1988. In January 1989 – November 2014 he worked at Kerr-McGee, which became American Coal.

Petitioner testified that while working in the coal mines he was regularly exposed to coal dust and rock dust. Petitioner testified that he was also around welding fumes and cutting fumes.

Petitioner testified that while working in the coal mines he held the job classification of a utility worker, which was underground, for about three years. As a utility worker Petitioner built air stoppings for ventilation, and carried oil, roof bolts, and material to the roof bolter. Petitioner testified that he also worked as a roof bolter for four to five years, which drilling through coal and rock. Petitioner testified that he was exposed to a lot of rock dust when he was actually drilling. Petitioner testified that he was a continuous miner operator for three to four years, which was at the face of the coal and actually mining the coal. Petitioner testified that he was on a bull gang for a year and a half, which is basically filling in wherever is needed. For example, shoveling on the belt, or going on belt moves, or going to work in a unit when someone is off work.

Petitioner testified that he also worked in the job classification of out-by, which is similar to the position of bull gang, but you aren't actually working at the face of the coal unless you're sent in to a unit. Petitioner testified that he also worked the job classification of in-by, which is in the unit running a ram car or shuttle car, or loading coal from the miner buggies and driving them to the feeder. Petitioner testified that he also worked on belt maintenance, which would require him to move the feeder out of the way and extend the belt line. He would put in the rollers and pull the belt line on. Petitioner testified that it was a pretty physical job. Petitioner testified that he also worked as a mine examiner for about three years. Petitioner testified that it required a lot of walking. Petitioner testified that he worked in the prep plant at Kerr-McGee, which required a lot of shoveling and washing with a fire hose. Petitioner testified that the prep plant was three stories tall which required him to go up and down a bunch of stairs. Petitioner testified that he also ran a haul truck, which required him to haul the refuge, gob. Petitioner testified that as the dozer operator he worked on the long coal stacker feeding the plant so they could process coal for approximately three years.

Petitioner testified that most, if not all, of his jobs in the coal mines required heavy manual labor. Petitioner testified that even when working on the haul trucks he would have to lift five gallon buckets of oil and antifreeze and climb steps in to the haul trucks. Petitioner testified that the tires on the haul trucks were over eight feet tall.

Petitioner testified that he last worked at American Coal, at the Galatia Mine, on November 6, 2014. Petitioner testified that he was 60 years old at that time. Petitioner testified that his job classification on that date was as the dozer operator. Petitioner testified that on that day he was exposed to, and did breathe, coal dust. Petitioner testified that on that date he injured his back and hasn't worked anywhere since then. Petitioner testified that he is currently on Social Security Disability. Petitioner testified that he received disability benefits because of his back and because of a blood clotting issue that he has. Petitioner testified that he believes he was approved for disability about a year after he stopped working.

Petitioner testified that he has breathing problems to this day. Petitioner testified that he first started noticing a change in his breathing ten years ago. Petitioner testified that he would notice

that he would get short of breath while trying to walk or putting oil or antifreeze up, or after climbing the steps with them and climbing the steps of the plant. Petitioner testified that the buckets of oil and antifreeze were approximately 40-50 pounds each.

Petitioner testified that even though there was a cab on the dozer, dust would still get inside while running the machine. Petitioner testified that the dust would come in through the doors, and while there was a filter behind the seat that was supposed to filter out the dust, most of the time it was clogged up. Petitioner also testified that if the air conditioner wasn't working you had to run the dozer with the doors open, "...and you really got it then." Petitioner said the air conditioner didn't work quite a bit, because no one would be there to fix it. Petitioner testified that if you had to leave the doors open your face would be black by the end of the day and your clothes would be dirty.

Petitioner testified that he worked eight hour shifts, unless he was needed to stay over because someone called in. Petitioner testified that he worked seven days on with one day off, then he would work seven days on with two days off, and then he would work seven days on with three days off. Then the cycle would start over. Petitioner testified that he would switch shifts every seven days from midnights, to seconds, and then day shift.

Petitioner testified that as of today, he could walk at a normal pace for about half of a block before he would become short of breath. Petitioner testified that he gets out of breath after climbing four or five steps. Petitioner testified that since his breathing problems began ten years ago they have gotten worse. Petitioner testified that he's not currently taking any breathing medication.

Petitioner testified that his breathing problems affect his daily life. Petitioner testified that he used to rabbit and deer hunt, but he can't do so anymore because of his back and shortness of breath. Petitioner testified that he can't mow his own lawn anymore, that his son-in-law does it for him. Petitioner testified that he can't do any physical labor or maintenance around his home. Petitioner testified that he can't walk to get his mail at the mailbox because it's 100 yards from the house, and he'd have to sit down once he got there. Petitioner testified that he also can't go shopping with his wife anymore because he can't stand to walk due to his back and lungs.

Petitioner testified that while working in the mines he would have to stop and take breaks because of his breathing problems, specifically when climbing steps in the plant, when they'd change rollers and screens on the floors of the plant. Petitioner testified that he would actually drive his personal truck to the dozer parking because it was 200 yards from the plant to the dozer parking, and he couldn't walk out there. Petitioner testified that, as of today, there was no way he could physically do the job that he last performed in the coal mines.

Petitioner testified that his family doctor is Dr. Ewell. Petitioner testified that he did not go to Dr. Ewell for his breathing problems because, "I never figured it would do any good." Petitioner testified that Dr. James Alexander was the company doctor, meaning that it was the local doctor the company would have him go to if he was injured or had a problem. Petitioner testified that he didn't regularly see Dr. Alexander for primary care visits or anything else.

Petitioner testified that he has never had a desk job, or any type of job besides manual labor. Petitioner testified that he can't use a computer or type at all.

Petitioner testified that he has never smoked. Petitioner testified that he has high blood pressure, which he treats with medication. Petitioner testified that he has a blood clot in his leg due to a genetic condition that causes blood clotting issues. Petitioner testified that he takes Coumadin for that condition.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, and WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner has sustained an injury that arose out of an in the course of his employment. Section 1(d) of the Illinois Workers' Compensation Diseases Act states, in pertinent part:

> A disease shall be deemed to arise out of the employment if there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is performed and the occupational disease. The disease needs not to have been foreseen or expected but after its contraction it must appear to have had its origin or aggravation in a risk connected with the employment and to have flowed from that source as a rational consequence. An employee shall be conclusively deemed to have been exposed to the hazards of an occupational disease when, for any length of time however short, he or she is employed in an occupation or process in which the hazard of the disease exists...If a miner who is suffering or suffered from pneumoconiosis was employed for 10 years or more in one or more coal mines there shall, effective July 1, 1973 be a rebuttable presumption that his or her pneumoconiosis arose out of such employment. 820 ILCS 310/1(d)

On May 20, 2015, Petitioner underwent an x-ray with PA & Lateral views of the chest for pneumoconiosis at Ferrell Hospital. On May 30, 2015, Dr. Henry Smith, a board certified B-Reader for over 23 years, performed a chest film interpretation and B-Reading. Dr. Smith's impression was of simple coal workers' pneumoconiosis with small opacities, primary p, secondary s, all zones involved bilaterally, of a profusion 1/1. Dr. Istanbouly testified that he physically examined Petitioner, and took a detailed medical and occupational history. Dr. Istanbouly also testified that he read Petitioner's chest x-ray films dated May 20, 2015, and that it was his opinion within a reasonable degree of medical certainty that Petitioner had coal workers' pneumoconiosis. Dr. Istanbouly testified that the cause of Petitioner's diagnosis was exposure to coal mine dust.

Dr. Istanbouly's testimony reveals his significant experience and credentials in the field of pulmonary studies. Dr. Istanbouly testified that he is board certified in critical care medicine and pulmonary medicine. Dr. Istanbouly testified that he does black lung examinations for the U.S. Department of Labor. He has been the medical director of the pulmonary department at Herrin Hospital since 2005. He is also the director of the Intensive Care Unit at Carbondale Memorial Hospital and that he has been the director of the Intensive Care Unit at Herrin Hospital. Drs. Istanbouly and Smith's extensive experience, leads the Arbitrator to find that Petitioner has met his burden of proof in establishing that he has simple coal workers' pneumoconiosis.

Although Respondent's experts, Dr. Meyer and Dr. Castle, disagree with the findings and diagnosis of Drs. Smith and Istanbouly, their opinons are found to be less credible by way of their own testimony. On cross-examination, Dr. Meyer agreed that a negative chest x-ray for coal workers' pneumoconiosis does not necessarily rule out the disease. Dr. Meyer further agreed that many coal miners have had negative chest x-rays for coal workers' pneumoconiosis, but on biopsy or autopsy it is shown that they actually had the condition pathologically. Dr. Meyers agreed with the Laney and Petsonk study which stated, "[i]ndividual coal macules are generally too small to be appreciated on chest x-rays".

Dr. Castle conceded that he had never met, spoken to, or physically examined the Petitioner. Dr. Castle also testified that he no longer does examinations for black lung, and has not done so since 2014. Dr. Castle is retired from his active medical practice Dr. Castle testified that it would be fair to say that similarly qualified physicians can, and do, disagree as to the findings on chest x-rays. Dr. Castle testified that the only possible cause of pneumoconiosis is exposure to coal dust, and that there is no cure for that condition.

Given the totality of the evidence, the Arbitrator finds Drs. Smith and Istanbouly to be more credible than Drs. Meyer and Castle. Therefore, the Arbitrator finds that Petitioner has satisfied the requirements of Section (d) of the Act. It is apparent that Petitioner's coal workers' pneumoconiosis arose out of his employment as a coal miner, and that there is a causal connection between the conditions under which Petitioner worked and coal workers' pneumoconiosis. Petitioner worked as a coal miner for 37 years, which is well over the statutorily required 10 years, and he was diagnosed with coal workers' pneumoconiosis. According to Section (d), there is a rebuttable presumption that his coal workers' pneumoconiosis arose out of his employment in the coal mines. The Respondent has not credibly rebutted that presumption.

Therefore, Petitioner proved by a preponderance of the evidence that he was afflicted with coal workers' pneumoconiosis and that it arose out of his employment.

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

The Arbitrator finds Petitioner has sustained a permanent partial disability of 15% of the person as a whole. This value is supported by the Commission's recent decision in *Robinson* where that Petitioner had the same diagnosis, similar complaints, but a lower category x-ray reading of 1/0

or 0/1. *Hugh James Robinson v. The American Coal Company*, 17 I.W.C.C. 0045, 09 W.C. 45865.

WITH RESPECT TO ISSUE (O), THE APPLICABILITY OF SECTIONS 1(e) and 1(f) OF THE OCCUPATIONAL DISEASES ACT, THE ARBITRATOR FINDS AS FOLLOWS:

Section 1(e) of the Occupational Diseases Act states, in pertinent part, "{d}isablement" means an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body." 820 ILCS 310/1(e) The Arbitrator finds that Petitioner has satisfied the requirements of Section (e) of the Act. The Petitioner testified to increased respiratory difficulty with his activities of daily living, like walking or climbing stairs. Dr. Istanbouly also testified that the inhalation of coal dust that causes irritation and inflammation that will ultimately end up forming tiny scars. Dr. Istanbouly testified that there is no cure for coal workers' pneumoconiosis, and that it is a chronic condition. Dr. Castle agreed that the scarring and fibrosis that occurs in the lungs from pneumoconiosis is irreversible and permanent. Dr. Castle testified that the scarring and fibrosis is an alteration of the lung tissue, and is also an alteration of the function of the involved lung tissue.

Section 1(f) of the Occupational Diseases Act states, in pertinent part, "[n]o compensation shall be payable for or on account of any occupational disease unless disablement, as herein defined, occurs within two years after the last day of the last exposure to the hazards of the disease." 820 ILCS 310/1(f) Petitioner last worked a day of coal mine employment on November 6, 2014. Petitioner has not worked in the coal mines and has not had any other exposure to coal mine dust since that date. On May 20, 2015, Petitioner underwent an x-ray with PA & Lateral views of the chest for pneumoconiosis at Ferrell Hospital. Dr. Smith's impression was of simple pneumoconiosis, category p/p, 1/1. Since the Petitioner obtained the coal workers' pneumoconiosis diagnosis within two years of leaving Respondent's employment, he meets the requirement under Section 1(f) of the Act.

Based on the totality of the evidence, and the factual findings above, the Arbitrator finds that the Petitioner is entitled to occupational disease benefits to the extent of 6% MAW.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Samuel Settle,

Petitioner,

vs. NO: 17 WC 11313

Continental Tire,

Respondent.

20IWCC0155

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 total disability ("TTD"), and nature and extent, and being advised of the facts and law, partially modifies the Section 8.1b analysis in the Decision of the Arbitrator. The Commission otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator placed "weight" on the second factor regarding Petitioner's occupation. The Arbitrator correctly assessed that Petitioner's regular occupation involved heavy duty factory work. Petitioner's position also required him to stand his entire shift. The Commission assigns **some weight** to this factor.

The Arbitrator also placed "weight" on the third factor regarding Petitioner's age at the time of the work accident. The Arbitrator correctly assessed that Petitioner was 57 years old on the date of accident and was neither particularly young nor old. The Commission assigns **minimal weight** to this factor.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 19, 2018, is modified as stated herein.

20IWCC0155

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 $30,000.00. 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 5 - 2020

o: 1/7/20
TJT/jds
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SETTLE, SAMUEL
Employee/Petitioner

Case# **17WC011313**

CONTINENTAL TIRE
Employer/Respondent

20IWCC0155

On 9/19/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.29% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
ROBERT C NELSON
420 N HIGH ST PO BOX Y
BELLEVILLE, IL 62222

0299 KEEFE & DePAULI PC
JAMES K KEEFE JR
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

20IWCC0155

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

SAMUEL SETTLE
Employee/Petitioner

v.

CONTINENTAL TIRE
Employer/Respondent

Case # **17** WC **011313**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Mt. Vernon, IL**, on **July 11, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0155

FINDINGS

On **09/23/2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$50,739.00**; the average weekly wage was **$975.75**.

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

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

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

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

Respondent is entitled to a credit of **$2,234.16** under Section 8(j) of the Act.

ORDER

Respondent is to pay the medical bills identified in Petitioner's Exhibit #6, as provided in Sections 8(a) and 8.2 of the Act subject to the medical fee schedule; $3,155.00 to Dr. Ben Houle; $1,155.00 to Anesthesia Associates of Southern IL Surgery Center; $9,515.44 to Physicians Surgery Center at Good Samaritan; and $150.00 to Crossroads Rural Health Wayne City. Furthermore, the Petitioner shall be reimbursed $2,755.29 for medical bills paid by Petitioner.

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 $585.45/week for 25.8 weeks, because the injuries sustained caused the 12% loss of the right leg, as provided in Section 8(e) of the Act.

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

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

Edward Lee

Signature of Arbitrator

9/13/18

Date

SEP 19 2018

FINDINGS OF FACT

20IWCC0155

MEMORANDUM FOR THE DECISION OF ARBITRATOR

This claim involves an injury to Petitioner's right leg. The parties agree that the issues are causation, TTD in light of causation being in dispute and the responsibility and liability to pay medical charges as causation is in dispute. The parties agree that accident, notice, earnings, period of TTD and Respondent's claim of credit for non-occupational indemnity is not in dispute. The sole issue in dispute, then, is causation.

The Petitioner had no symptoms in the right knee before the accident.

On September 23, 2016 the Petitioner was 57 years old, married with no dependent children. He had worked for the Respondent for 39 years. During the days weeks and months before September 23, 2016 he did not experience any knee pain or restrictions. He had not missed any work in his tenure with the Respondent for difficulties with his knee. He had not seen a doctor for his knee nor had he had x-rays before September 23, 2016.

The Petitioner had symptoms immediately after the accident.

On September 23, 2016 the Petitioner twisted his right knee while preparing to remove rubber jammed up under a conveyor belt. As he moved his weight back onto his right knee he heard a loud pop and felt immediate numbness in his leg. He promptly reported the injury to the Respondent. The Respondent's accident report, marked as Petitioner's Exhibit #1, notes a consistent history. The report documents an assessment of the Petitioner and notes that he is limping. His right knee was swollen so that his pant leg was cut up to the knee area to obtain access to the knee. The EMT, Robin Lenard, noted that "when flexing of the knee for any deformities the employee comes out of chair". The EMT applied ice to the knee and provided Ibuprofen 800 mg. The Petitioner was sent to Convenient Care and placed on sedentary duty.

The post-accident therapy records note objective and subjective symptoms

Petitioner introduced into evidence Work Fit Physical Therapy records from 09/26/16 to 11/07/16. The visits are described as follows: On 09/26/16 the Petitioner was using a cane. His range of motion was reduced, flexion being only 2 out of 5. He was assessed with right knee strain/ possible meniscus tear/ or ligament tear and given a knee brace. Therapy continued for approximately one month for the same assessed right knee strain/ possible meniscus tear/ or ligament tear. On September 30th he was still using a cane swelling persisted and he remained on sedentary duty. On 10/07/16, swelling persisted. On 10/11/16 (the sixth visit) swelling was decreased and he was feeling better but remained on sedentary duty. He was told to ice his knee 2-3 times a day for 15-20 minutes. On the seventh visit, 10/12/16, Petitioner still used a cane complaining of problems walking on uneven ground but reported that he was feeling better, a 2 out of 10 pain. Petitioner returned for his eighth visit on 10/13/16 still on sedentary duty. He had no cane but did have a new knee sleeve. Swelling was decreased. He was instructed to ice his leg 2-3 times a day for 15-20 minutes. Petitioner returned for his ninth visit on 10/17/16. He remained on light duty, his knee continued to improve and, he was ordered to continue to ice it 2-3 times a day for 15-20 minutes. On 10/19/16 the tenth physical therapy visit the Petitioner remained on light duty. He reported that he was feeling better and continued to use a knee sleeve and he was ordered to continue icing the knee. At the eleventh assessment on 10/21/16 Petitioner complained of only a little discomfort. He was still on light duty and was still ordered to ice the knee. He continued to use his knee sleeve. Throughout the each of 11 visits through 10/21/16 the reported assessment

remained the same: "right knee strain/ possible meniscus tear/ or ligament tear". On 11/07/16 the paperwork notes that the knee was better and charted minimal if any discomfort.

The Section 12 examiner offered a causal opinion

The Respondent offered as its Exhibit 1 the deposition of its Section 12 examiner and board-certified orthopedic surgeon, Dr. George Paletta, who had conducted an examination on 02/01/17. Dr. Paletta found some swelling, flexion reduced by 15%, joint line tenderness medially and positive rotatory sign (pg.12). He reviewed the 12/27/16 MRI of the right leg discussing early degenerative joint disease as well as a complex tear in the medial meniscus (pg. 7). Dr. Paletta reached two diagnoses: patellofemoral pain with arthritis and medial meniscus tear (pg.13).

When asked whether the work accident described by the Petitioner caused a menial meniscus tear, he said "*it is my opinion that it either caused or aggravated that tear, yes, sir*" (pg.15; lines 12 & 13). He noted that the Petitioner had a mechanism of injury which was a twisting injury with his body weight loaded on it, a common cause of a meniscus tear.

The surgeon's opinion that the accident caused the meniscus tear was based on the Petitioner's reported history. The Petitioner described persistent difficulty that did not fully resolve leading to Dr. Paletta's opinion that the need for arthroscopy was related to the injury (Rx1 pg. 16). Even if the symptoms temporarily abated but returned when he became more active again, he still may have had a torn meniscus. (Rx1 pg.24; line 15). The doctor further explained that while meniscus tears can wax and wane getting better or worse the change may be activity related (Rx1 pg. 22).

On the other hand, if the Petitioner had no symptoms for approximately one month (between November 7, 2016 and December 8, 2016), then the injury would have caused only a temporary aggravation and the need for arthroscopy would not be related to the injury (Rx1 pg. 17). The nature of the tear indicates that it was a long-standing meniscus tear (Rx1 pg. 25). Petitioner did have a degenerative condition in his knee but in the medial area, it was mild. Dr. Paletta explained that such a tear can become symptomatic and then, even without surgery, asymptomatic. In other words, the symptoms can wax and wane (Rx1 pg. 8).

Arbitration Testimony

The Petitioner was the only witness to testify at arbitration. He worked for the Respondent for 41 years; for the first 39 years leading to the accident he had no knee complaints, limitations or treatment. His job was very physical and involved standing most of the time. He also served on the fire department in Wayne City, IL and fought fires. He had had no knee problems with any activities.

After the incident the Petitioner had immediate swelling and severe pain in his knee causing him to report the injury immediately. Since the injury and until the time of his surgery his knee never felt right. He took Ibuprofen consistently after the accident (T.15). He had not taken it before(T.15). After the injury he began wearing a knee brace and wore it continuously until the time of surgery (T.16). He bought 3 or 4 braces so that he would always have a clean one. He was to return to regular duty on October 23rd, 2016 but did not do his regular work because his co-workers would not allow him to; they would push him out of the way if he tried to do something too strenuous (T.17). He distinguished discomfort, when his knee doesn't feel right, from pain, when it hurts (T.40). The Petitioner testified that he told the therapist in November 2016 he had discomfort (T.40). The discomfort never stopped from the time of the accident until the time of surgery. Until November 7, 2016 he had persistent problems in the injured right knee with activity. When going down stairs, his knee would grind. He had trouble lifting. He learned to drive with only his left foot because he had pain in the right knee when holding down the accelerator and braking (T.18, 19). He was driving with

his left foot when he saw the therapist on November 7, 2016 and continued to until after surgery. Up to November 7, 2016 his condition waxed and waned depending on how long he was on his leg (T.19 but never returned to baseline. Following November 7, 2016, he was off until December 5th, 2016. In that interim he had symptoms. On November 18th, 19th and 20th (deer hunting season) he tried to hunt but it was too painful to climb a ladder stand or walk hills. He stayed home with his knee iced or hunted out of a ground blind. When he returned to work on December 5th attempting to do his regular duties really aggravated his knee (T.23). Petitioner had surgery on May 10th, 2017 (T. 24). Until then, his condition stayed the same (T. 25).

Following surgery and at the present time the Petitioner testified to pain especially with carrying something heavy, descending stairs, or standing two to three hours (T. 25). He gets a sharp pain if the leg twists. He does not quickly pivot well. He cannot do deep squats. He has not had a new twisting injury (T.37).

CONCLUSION OF LAW

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

The Arbitrator concludes Petitioner's current condition of ill-being is causally related to the 09/23/2016 date of injury. In support of this conclusion the Arbitrator notes the following: Dr. Paletta stated that *"it is my opinion that it (the accident) either caused or aggravated that tear, yes, sir"* (Pg. 15,12 &13). The mechanism of injury was consistent with the nature of the tear. He agreed, though, that if in fact the symptoms did resolve as of November 2016 and the Petitioner had no symptoms for approximately one month until December 2016 the accident would have only temporarily aggravated the pre-existing condition (Rx.16 & 17). On the other hand, if Petitioner's symptoms never fully went away the doctor opined that the need for arthroscopy would be related to the injury he described (Rx.16,4-7).

The Arbitrator considers the Petitioner's demeanor and finds his testimony credible. The Petitioner testified believably in a straight forward manner that he had never had difficulties before the incident and had persistent difficulties thereafter. He remained symptomatic from the date of the accident through the date of surgery. The only inference of abatement was a single hand-written entry on November 7th, 2016. Dr. Paletta explained that the condition may wax and wane with changes in activity level. The Petitioner testifies to persistent problems with specific activities. It is clear his symptoms did not abate for a period as long as a month. The Arbitrator balances the Petitioner's creditable testimony against the handwritten paper noting he was "a lot better" on 11/07/16. Petitioner testified that at that time he was not yet active and, when he attempted to become active his knee was painful. He explained that between November 7, 2016 and December 5, 2016 he could not continue to hunt without bad pain although wearing knee brace and taking Ibuprofen. Until the surgery he drove with his left knee to avoid aggravating the right. The Arbitrator finds the Petitioner's condition never returned to baseline.

The following case law establishes that the absence of symptoms prior to an event and the persistent presence after creates a chain of events sufficient to determine the event caused the symptoms and the need to treat them.

In Steak N Shake v. IWCC, 2016 IL App (3d) 150500WC, the Appellate Court considered the case of a restaurant manager who was injured by simply wiping down tables on a busy day. She had pre-existing arthritis of her thumb. The sole doctor's opinion claimed that the activity

caused *"manifestation of symptoms"* but that her current symptoms were not related to her movement. Despite Dr. Wysocki's ultimate opinion regarding causation the Arbitrator, Commission, Circuit and Appellate Court all found for the Petitioner based on the sequence of events theory. The Commission noted she was asymptomatic before the event but had extensive symptoms and treatment thereafter. That sequence was sufficient to support a finding of causation. Her medical evidence showed an ongoing condition that began the day of the incident and therefore was inconsistent with Dr. Wysocki's opinion that the incident was not a causative of claimant's condition. Since she was asymptomatic before, had immediate onset of symptoms after. The history was sufficient to establish a causal relationship. The Court noted it as well settled that the Commission can infer causation from a sequence of lack of symptoms prior to an industrial accident with symptom manifestation immediately following. It cited Freeman United Coal Min. Co. v. Industrial Comm'n, 318 Ill. App.3d 170, 175, 251 Ill. Dec. 966. The employer pointed out that Dr. Wysocki's opinion was the only medical opinion about causation but, the court disagreed with his conclusion since Wysocki admitted that she was pain free before the incident and wiping tables caused *"symptom manifestation"*.

In Corn Belt Energy Corp v. IWCC, 56 N.E.3d 1101, 404 Ill.Dec. 688 (2016) an employee twisted his back while exiting a truck. He denied experiencing any similar problems in the week before the injury but had seen his chiropractor eight times in the year of the injury, the last being approximately one month prior. The Commission found the back condition compensable.

In Jeffery Howard III v. St. Clair County Highway Department (16 IWCC 0187) the Commission considered whether a claimant's need for new knee was compensable. The Petitioner had had an extensive pre-existing arthritic condition. Petitioner stepped in a hole twisted and fell injuring his knee. Thereafter he sought treatment. The medical testimony concluded that the Petitioner had additional pain that accelerated the need for surgery. The Section 12 examiner agreed the accident caused pain resulting in the Petitioner seeking medical treatment. The Petitioner had six prior orthoscopic surgeries but the last was 28 years before the accident. Despite the arthritic condition and treatment, he was able to perform his relatively heavy labor job before the accident. The Commission felt that the work accident accelerated the need for surgery and found it compensable.

In Taylor v. Alpha (16 IWCC 0170) The Petitioner was in good health relative to her knee for more than three years before the accident. After the accident the knee problems were consistent ongoing and undebated. Again, the Commission referred to a *"chain of events analysis"* pointing to the causal connection. It affirmed the decision of the Arbitrator who decided that *"To say that Petitioner may have sustained a knee strain as a result of the work accident which should have resolved three to four weeks after the accident and that Petitioner's present condition of ill-being is due solely to a pre-existing condition disregards the 'chain of events' analysis"*.

In Navistar, Inc. v. IWCC, 22 ILWCLB 117, Ill.App.2d (2014) the Commission found a causal relationship between the Petitioner's knee injury and his work accident. The Respondent claimed that the Petitioner had serious arthritis before the injury but, he had had no symptoms. After twisting his knee, however, the Petitioner had a medial meniscus tear and underwent total knee arthroscopy. The Commission found the claimant credible in stating that he had no symptoms prior to the work accident, worked full duty and never received treatment for his knee prior. Further he had immediate and consistent knee pain thereafter. The Petitioner's doctor said the injury was the straw that broke the camel's back causing the underlying arthritic conditions to be symptomatic.

See also Peabody Coal v. Industrial Comm'n, 571 N.E.2d 1182, 213 Ill.App.3d 64 (Ill. App. 5 dist. 1991) wherein the Court noted that *"casual connection between work duties and condition of ill-being maybe established by chain of events including workers' compensation claimant's ability to perform job duties before date of accident and inability to perform said duties following that day"*.

Issue L: Nature and extent of Petitioner's injury.

The Arbitrator determines the permanent partial disability based on 820 ILCS 305/8.1b.

1. There was no impairment rating as discussed in subsection (a). The Arbitrator then considers the remaining four factors in subsection (b).

2. The Petitioner's occupation leading up to the Arbitration has been in heavy factory work. He stands all day. The Arbitrator places weight on this factor.

3. Petitioner was 57 years of age at the time of the incident and was neither a younger nor older person. The Arbitrator places weight on this factor.

4. The Petitioner's future earning capacity would not be affected because he has continued to work through difficulties particularly with standing. While Petitioner has changed jobs, he does not make a claim for loss of earnings. The Arbitrator places no weight on this factor.

5. The records of the treating surgeon, Dr. Ben Houle, discuss the diagnosis, treatment, and release to regular work. The treatment record does not confirm nor question the Petitioner's complaints. The Arbitrator places little weight on this factor.

The Respondent shall pay Petitioner permanent partial disability benefits of $585.45 per week for 25.8 weeks because the injury sustained caused 12% loss of use of the right leg as provided in Section 8(e)(12) of the Act.

Issue K: What temporary benefits are in dispute (TTD)?

The Arbitrator concludes that Respondent owes Petitioner TTD benefits from 05/04/2017 to 06/18/2017 (6 4/7 weeks). Respondent disputed causation but not the period of TTD. The Arbitrator finds that the period is consistent with the Petitioner's treating doctor's reports marked as (Px.2).

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

The Arbitrator concludes that all the medical treatment provided to the Petitioner was reasonable and necessary and Respondent is responsible for the medical bills incurred as a result thereof. Respondent is to pay the medical bills identified in Petitioner's Exhibit #6 as provided in 8(a) and 8.2 of the Act subject to the fee schedule: Dr. Ben Houle, $3,155.00; Anesthesia Associates of Southern IL Surgery Center, $1,155.00; Physicians Surgery Center at Good Samaritan, $9,515.44;

and Crossroads Rural Health Wayne City, $150.00; and, furthermore, Petitioner should be reimbursed directly in the amount of $2,755.29 for medical bills paid by Petitioner.

Respondent shall be given a credit for all amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of services for which Respondent is receiving a credit, as provided in Section 8(j) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Thomas Flisk,

Petitioner,

vs.

NO: 18 WC 8435

20IWCC0156

City of Chicago,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission corrects the decision of the Arbitrator at page 2 of the Form decision under "Findings" to show that the date of accident was 7/3/17 (not 7/6/17).

The Commission also corrects the decision of the Arbitrator at page 2 of the Form decision under "Order" to show that Petitioner was entitled to TTD from 7/7/17 (not 7/17/17) through 4/13/18 and from 6/6/18 through 6/21/18, for a period of 42-3/7 (not 42-1/7) weeks.

Finally, the Commission strikes language at page 2 of the Form decision under "Order" wherein the Arbitrator found that TTD "... shall continue weekly until Petitioner's work status changes or until the Respondent has a valid reason under [t]he Act to terminate benefits in the

future" since this essentially amounts to an award of prospective temporary total disability, which is premature and not provided for under the Act.

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 8/21/18 is affirmed and adopted with changes as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,072.00 per week for a period of 42-3/7 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 reasonable and necessary medical expenses to Illinois Bone and Joint in the amount of $230.00, pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the treatment prescribed by Dr. Theodore Fisher, including surgery, pursuant to §8(a) and §8.2 of the Act.

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

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

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

The party commencing 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 - 2020
o:1/21/20
MP/pmo
68

Marc Parker

Maria E. Portela

Kathryn A. Doerries

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

FLISK, THOMAS
Employee/Petitioner

Case# **18WC008435**

CITY OF CHICAGO
Employer/Respondent

20IWCC0156

On 8/21/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% 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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AL KORITSARIS
180 N LASALLE ST SUITE 1925
CHICAGO, IL 60601

0010 CITY OF CHICAGO CORP COUNSEL
D TAYLOR CHITTICK
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CHICAGO, IL 60602

20IWCC0156

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)

Thomas Flisk
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **18** WC **8435**

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, Illinois**, on **June 21, 2018 & July 16, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20 IWCC0156

FINDINGS

On the date of accident, **7/6/17**, 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*** 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 $**83,616.00**; the average weekly wage was $**1,608.00**.

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

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

Respondent shall be given a credit of $**56,640.38** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

ORDER

Temporary Total Disability
Respondent shall pay Petitioner & his Attorney of Record the temporary total disability benefits of $1072.00/week for 42 1/7 weeks, commencing July 17, 2017 through April 13, 2018 and June 6, 2018 through June 21, 2018, as provided in Section 8(b) of the Act and shall continue weekly until Petitioner's work status changes or until the Respondent has a valid reason under The Act to terminate benefits in the future.

Medical benefits
Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $230.00 to Illinois Bone and Joint, as provided in Sections 8(a) and 8.2 of the Act.

The Arbitrator hereby ORDERS prospective medical treatment prescribed by Dr. Theodore Fisher. This Order includes all the pre surgical testing and medical treatment. This Order includes all the reasonable and necessary post surgical treatment under section 8. shall be the responsibility of the Respondent. Said authorization shall be in writing to the providers per their own requirements. Respondent shall pay for all medical services associated with said treatment pursuant to the medical fee schedule as provided in Sections 8 of the Act.

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

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

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

#001Arb. George Andros

Signature of Arbitrator

Aug 21, 2018

Date

AUG 21 2018

18 WC 8435 FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator makes the following Findings of Facts:

It is undisputed that on July 3, 2017, Petitioner Thomas Flisk suffered a neck injury that arose out of and in the course of his employment with the City of Chicago. Petitioner testified that on July 3, 2017, he was injured while manually positioning heavy material on his forklift. Petitioner testified that he works as a laborer for the City of Chicago. Petitioner described his typical work day which primarily included operating a forklift, carrying material, unloading material and transporting material. He testified that the job is labor intensive and that he is required to perform lifting to accomplish his tasks. Petitioner testified that he worked in that position for over twenty years.

Mr. Flisk testified regarding the mechanism of injury when he stated that he felt a sharp pain in and pop in his neck while attempting position heavy material on his forklift. He testified that he felt a pain in his neck during the maneuver. He testified that the pain worsened significantly over the next few days at which time he notified his employer of the event. Mr. Flisk testified that he sought treatment at Mercy Works the City clinic for his injuries. Mr. Flisk testified he was working full duty with no difficulty at the time of the incident.

The Petitioner testified that prior to the date of injury he was working full duty with no difficulty. The Petitioner testified that he had prior injuries to his neck. He testified that he initially injured his neck in 2001 in a work-related incident, that required surgical intervention. He testified that he was able to return to work full duty once he recovered. He testified that he worked full duty with no issues until January 5, 2015, when he sustained another injury to his neck, while working for the City of Chicago.

He testified that he underwent an additional surgery to his neck following that incident. Mr. Flisk testified that he returned to work full duty after being cleared by his medical doctor after that surgery. Mr. Flisk testified that he continued to work full duty from November of 2016 to July 3, 2017 with no neck issues until he sustained an acute injury on that date.

On July 6, 2017, Mr. Flisk went to MercyWorks complaining of neck pain at a 8-10 level on a pain scale. (Pet. Ex. 1, p. 2). The record notes that he was driving a forklift, unloading material when he injured his neck. *Id.* On physical examination, it is noted that he had reduced range of motion with flexion and extension. *Id.* X-rays were performed at the clinic that day and he was prescribed medication in the form of Hydrocodone. *Id.* Mr. Flisk was taken off work by the medical staff that day and was instructed to follow-up in ten (10) days. *Id.* On July 13, 2018, Mr. Flisk returned to MercyWorks complaining of the same neck pain with no improvement of his symptoms. (Pet. Ex. 1, p. 3). An additional medication was prescribed in the form of Flexeril and he was given a script for physical therapy. *Id.* Mr. Flisk was kept off work at this time. He testified that he began receiving disability benefits from the City of Chicago. *Id.*

Mr. Flisk testified that he began therapy at MercyWorks and the records indicate that he underwent seven (7) sessions over the next two (2) weeks. *Id.* On August 3, 2018, he followed-up with MercyWorks and denied any improvement in his symptoms following the physical therapy regimen. (Pet. Ex. 1, p. 4). At this time, an MRI of the lower back was ordered by the staff and he was instructed to follow-up after the MRI. *Id.* Mr. Flisk was kept off work by Dr. Anderson at this time. *Id.* Mr. Flisk testified that he continued to get disability benefits at this time. Mr. Flisk testified that he had the MRI of his cervical spine.

On August 17, 2017, Mr. Flisk underwent an MRI of the cervical spine performed at Mercy Hospital. (Pet. Ex. 2, p. 25-27 of 52). The MRI findings showed a prominent left central disc protrusion at C7-T1 focally effacing the anterior thecal sac as well as left foraminal stenosis. (Pet. Ex. 2, p. 27 of 52). Further, the MRI showed post-surgical changes of the cervical spine including posterior fusion spanning the C3 and C7 levels and discectomy spanning the C5 and C6 levels. *Id.*

On August 18, 2017, he returned to MercyWorks for a follow-up appointment. *Id.* He complained of neck pain with numbness down his left arm. *Id.* He was kept off work by Dr. Anderson and his medication prescription for Norco was refilled. *Id.* Further, Dr. Anderson referred him to spine specialist Theodore Fisher, M.D. at this time. *Id.* Petitioner testified that he went to go see Dr. Fisher as recommended by MercyWorks.

On September 6, 2017, Mr. Flisk presented to Dr. Fisher of the Illinois Bone and Joint Institute complaining of neck pain. (Pet. Ex. 2, p. 45 of 52). Dr. Fisher reviewed the MRI film and noted a herniated disc at C7-T1 and stenosis at C6-7. (Pet. Ex. 2, p. 46 of 52). Dr. Fisher ordered a CT scan of the cervical spine to evaluate the fusion focusing at C6-7. *Id.* He was kept off work at this time and was prescribed at Medrol Dosepak. *Id.* On October 3, 2017, he underwent the CT of his cervical spine at Bright Light Radiology. (Pet. Ex. 2, p. 6, 7 of 52).

On October 4, 2017, Mr. Flisk returned to see Dr. Fisher complaining of neck pain with numbness down the left arm. (Pet. Ex. 2, p. 43 of 52). Dr. Fisher recommended that Mr. Flisk continue with physical therapy at this time. (Pet. Ex. 2, p. 44). Further, he recommended a cervical epidural injection. *Id.* Dr. Fisher also noted that if Mr. Flisk does not improve with therapy and injection that he would move forward with posterior surgery in the form of hardware removal of his C3 through C7 hardware and extending the fusion to the C7-T1 level. *Id.*

On November 15, 2017, he followed up with Dr. Fisher and the record notes that he had not had the epidural steroid injection that was recommended. (Pet. Ex. 2, p. 41 of 52.). The Petitioner testified that it took a long time for the City of Chicago to approve the injection. At the visit, Mr. Flisk complained of neck pain that radiates into his shoulders and upper arms. *Id.* Mr. Flisk was kept off work at this time. *Id.* On December 26, 2017, he followed up with Dr. Fisher again complaining of neck pain, left side greater than right in the cervical spine. *Id.* The record notes that Mr. Flisk was finally approved for injection followed by additional physical therapy. (Pet. Ex. 2, p. 39 of 52).

On March 9, 2018, Mr. Flisk underwent a cervical epidural steroid injection at the C7-T1 level under Fluoroscopy. (Pet. Ex. 6, p. 1). The procedure was performed at Hyde Park Same Day Surgicenter by Thomas Pontinen, M.D. *Id.* Following the injection, Mr. Flisk testified that he began therapy again and went to Athletico. He testified that it took a while for the City to approve the therapy. He testified that the therapy did not help alleviate his symptoms. The records indicate that Mr. Flisk began therapy at Athletico on April 2, 2018. (Pet. Ex. 5, p. 1). The records show that Mr. Flisk underwent several sessions over the next several weeks. (Pet. Ex. 5). Mr. Flisk testified that the therapy was not helping and that it was making his symptoms worse.

On March 19, 2018, Mr. Flisk was sent for a Section 12 examination with Avi Bernstein, M.D. (Res. Ex. 1). Dr. Bernstein notes that Mr. Flisk was a candidate for surgery due to his pain, in the form of extension of the fusion to the cervical thoracic junction. (Res. Ex. 1, p. 3). Dr. Bernstein opined that the Petitioner's condition is not causally related to his work incident of July 3, 2017, but instead related to his prior surgery of June 2, 2016. *Id.* Further, he opined that Mr. Flisk was capable of light duty work at that time. *Id.*

Mr. Flisk testified that he saw Dr. Fisher again on June 20, 2018, the day prior to the hearing. He testified that he did not improve following the therapy and the injection. Mr. Flisk was kept off work at this time. (Pet. Ex. 7). The Petitioner testified that Dr. Fisher recommended surgery. Further, he testified that that following the Section 12 examination, he stopped receiving disability benefits. He testified that he attempted to return to work in order to pay his bills and was able to work from April 14, 2018 to June 1, 2018. He testified that he stopped working again because of the pain and difficulty doing his job. He testified that he has remained off work since.

The Arbitrator makes the following Conclusions of Law:

In support of the Arbitrator's decision relating to (F), whether the petitioner's present condition of ill-being is causally related to the injury, the Arbitrator finds the following facts:

Based upon the totality of the evidence, the Arbitrator finds Petitioner's current condition of ill-being is causally related to his work injury of July 3, 2017. Accordingly, based on the credible testimony of the petitioner as well as the medical records and opinions of Theodore Fisher, M.D., Stephen Anderson, D.O.. and Thomas Pontinen, M.D., which includes the MRI results of the cervical spine and the CT scan results of the cervical spine, the Arbitrator finds that the petitioner has affirmatively demonstrated a causal relationship between his work-related injury on July 3, 2017 and his current condition of ill-being. The Arbitrator adopts in total the medical opinions of Dr. Theodore Fisher of IBJI in this case at bar.

Immediately prior to his injury, Petitioner did not have any issues with his cervical spine. Even though the Petitioner had prior neck injuries, including fusion procedures in 2001 and 2015, evidence was presented through testimony of the Petitioner that shows approximately 8 months where the Petitioner did not complain of any neck pain and worked full duty as a laborer.

Further, the Respondent did not present any evidence that showed that the Petitioner remained symptomatic during that time frame. The mechanism of injury described is a competent cause for a herniated disc to occur. The Petitioner injured his neck while attempting to move heavy material with both arms when he had an immediate onset of pain. The injury caused an immediate disability to Petitioner's neck. Further, the prior neck injuries and surgeries that the Petitioner had placed him at higher risk to sustain another injury to his neck. The Petitioner complained of neck pain consistently at each medical visit. Further, the MRI and CT scan taken of the cervical spine showed a herniated disc at the C7-T1 level. This is the precise level that both Dr. Fisher and Section 12 Examiner Dr. Bernstein stated was affected. Both Dr. Fisher and Dr. Bernstein agree that Mr. Flisk is a candidate for that procedure.

The Arbitrator places great weight on the diagnostic studies that were taken of the Petitioner's cervical spine. The Arbitrator adopts and underscores the MRI and CT which clearly shows a herniated disc at the C7-T1 level. Further, the Arbitrator notes that the prior surgeries that the Petitioner had to his neck did not include the C7-T1 level. Further, the Arbitrator does not adopt but rejects Dr. Bernstein's opinion that the Petitioner's condition of ill-being is related to the prior surgery. As stated above, the prior surgeries involved different disc levels. Neither of the prior surgeries involved intervention at C7-T1. No evidence was presented Petitioner suffered a C7-T1 herniated disc prior to the July 3, 2017. No evidence was presented Petitioner had any complaints of neck pain from the time he was released in November of 2016 following the prior injury up until he re-injured his neck on July 3, 2017. No evidence was presented by Respondent that the pathology on the MRI was pre-existing.

Again, the Arbitrator also places great weight on the opinion of orthopedic surgeon Theodore Fisher, M.D. After review of the medical chart, the Petitioner's complaints are consistent throughout his treatment. The objective physical examination findings correlate with the Petitioner's subjective complaints. Further, the physical examination findings correlate with the pathology seen on the MRI and CT scan of the cervical spine. Further, the Arbitrator notes that the treatment plan recommended by the doctor is appropriate based upon the adopted evidence. He recommended conservative management of physical therapy. The therapy did not alleviate the Petitioner's symptoms. Therefore, the next available treatment option to attempt to treat the Petitioner's symptoms was a cervical epidural injection, which Mr. Flisk had without benefit.

On March 19, 2018, Mr. Flisk was sent for a Section 12 Examination with Dr. Avi Bernstein regarding his neck. Dr. Bernstein agreed with Dr. Fisher that Mr. Flisk is a candidate for a Fusion extending to the C7-T1 level. However, Dr. Bernstein believes that his condition is not causally related to his alleged work incident but instead related to his prior surgery of June 2, 2016. This opinion is not persuasive for many reasons. First, looking at Dr. Bernstein's report as well as Dr. Fisher's records, the prior fusion that Mr. Flisk underwent in 2016 was performed at C3-C7. That procedure did not involve C7-T1 intervention. Therefore, his opinion that the prior surgery is the cause of the current C7-T1 problem lacks merit. Secondly, Dr. Bernstein concedes that appropriate treatment for Mr. Flisk's current condition of ill-being would be an extension fusion to the T1 level yet does not explain his opinion of why the prior surgery is what is causing the problem at a level of the cervical spine that was not included in the prior fusion.

Finally, Dr. Bernstein's opinion that Mr. Flisk's pain is consistent with loose hardware and pseudarthrosis of at the C6-7 level also lacks merit. Dr. Bernstein opined that Mr. Flisk is a candidate for an extension fusion to T1. If the above opinion regarding source of pain were credible, his treatment recommendation would have been a correction surgery to address the level of the prior fusion, which stopped at C6-7. However, he clearly recommended the same procedure Dr. Fisher did which would be to extend the fusion to the T1 level. If the C6-7 level were truly causing his pain, then there would be no need to include the C7-T1 level.

It is well settled that employers take their employees as they find them. Therefore, even though an employee may have a pre-existing condition which may make him more susceptible to an injury, compensation for the injury will not be denied as long as it can be shown that the employment was also a causative factor. *Caterpillar Tractor Co., v. Industrial Comm'n*, 92 Ill. 2d 30, 36, 440 N.E.2d 861 (1982). Furthermore, an accidental injury need not be the sole causative factor, or even the primary causative factor as long as it was a causative factor in the resulting condition of ill-being. *Rock Road Construction Co., v. Industrial Comm'n*, 37 Ill. 2d 123, 127, 227 N.E.2d 65 (1967). Although this is well settled law in the state of Illinois, the petitioner's work related injury was the primary causative factor in the resulting condition of ill-being. If a pre-existing condition was asymptomatic prior to the injury and then became symptomatic as a result of the injury, aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Id* at 67-68.

Upon close examination of the medical records, this Arbitrator finds no inconsistent history, nor any evidence of any intervening cause for the petitioner's current condition.

In support of the Arbitrator's decision relating to (J), were the medical services that were provided to petitioner reasonable and necessary, the Arbitrator finds the following facts:

On September 6, 2017 the Petitioner began treating at Illinois Bone and Joint with Theodore Fisher, M.D. and continues to treat with that provider. At the time of the hearing on June 21, 2018, the petitioner presented medical bills from the provider. (Pet. Ex. 4). The Arbitrator finds that the treatment rendered by the treating physician was reasonable and necessary to treat the Petitioner for the work-related injury he sustained. The Arbitrator also finds that since the Petitioner's condition of ill-being was causally related to his injury on July 3, 2017, the respondent is responsible for the aforementioned medical charges and that such charges were generated as a result of treatment that was reasonable and necessary as well as usual and customary. The Arbitrator finds that the related bills on Petitioner's Exhibit 4, totaling $230.00 are to be paid by Respondent according to the medical fee schedule.

In support of the Arbitrator's decision relating to (K), is the Petitioner entitled to any prospective medical treatment, the Arbitrator finds the following facts:

Based upon the totality of the evidence, The Arbitrator finds that the Petitioner requires additional medical treatment and is entitled to prospective medical treatment. The Arbitrator finds that the respondent is responsible for follow up care with Dr. Fisher including the surgery recommended. The MRI taken of the Petitioner's neck shows a herniated disc at the C7-T1 level. (Pet. Ex. 27 of 52). Further, the records show that Mr. Flisk has already exhausted conservative treatment of physical therapy and cervical epidural injection. Further, the records from Dr. Fisher as well as the Petitioner's credible testimony show that the injuries were causally related, and that additional treatment is needed. (Pet Ex. 2). T

he Arbitrator finds that the respondent must authorize the remaining treatment, including the fusion surgery to extend the fusion to the C7-T1 level. The Arbitrator finds that payment for the treatment is also the responsibility of the respondent. Once the current recommended treatment regimen decided by the Petitioner's treating physician is rendered and complete, the petitioner's condition will be re-evaluated to ascertain whether additional treatment is necessary.

In support of the Arbitrator's decision relating to (L), is the Petitioner entitled to any TTD benefits, the Arbitrator finds the following facts:

Having found an accident that arose out of and in the course of Petitioner's employment, and that Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator awards temporary total disability benefits to the Petitioner. The payment is to be made to the Petitioner and his attorney of record. The medical records show that Mr. Flisk was kept off work from the date of injury to the present time. (Pet. Ex. 2). However, Mr. Flisk testified that he attempted to return to work after the Section 12 exam since his benefits were terminated and he worked from April 14, 2018 through June 5, 2018. Further, he testified that work was too difficult for him and the pain was too severe, so he stopped working again. He did not work from June 5, 2018 up through the hearing date of June 21, 2018. The arbitrator finds that Mr. Flisk is owed temporary total disability benefits from July 7, 2017 through April 13, 2018 and June 6, 2018 through June 21, 2018, for a total of 42 1/7 weeks.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARY ANNE HIGGINS,
Petitioner,

v. NO: 11 WC 31456

MATTESON ELEMENTARY SCHOOL DISTRICT,
Respondent.

20IWCC0157

DECISION AND OPINION ON REMAND

This matter coming before the Commission on an Order pursuant to Rule 23 from the Appellate Court, First District Workers' Compensation Commission Division dated February 23, 2018 wherein the Court affirmed the decision of the circuit court thereby affirming the decision of the Commission dated June 6, 2016 save the denial of penalties and fees and further remanded the matter to the Commission with directions to consider the issue of penalties and attorneys' fees. The Commission affirms and adopts its prior decision of June 6, 2016 which is attached hereto and made a part hereof and further finds Petitioner failed to prove entitlement to penalties pursuant to Sections 19(l) and (k) of the Illinois Workers' Compensation Act and attorneys' fees pursuant to Section 16 of the Illinois Workers' Compensation Act and denies the same.

Procedural History

This matter proceeded to hearing before Arbitrator Simpson on January 29, 2015 concerning issues of causal relationship, medical benefits, temporary total disability benefits, permanent partial disability benefits, penalties and fees, and credit due Respondent. The arbitrator issued her decision on May 5, 2015 finding Petitioner proved entitlement to certain benefits which were awarded accordingly and denying Petitioner's request for penalties and fees.

Petitioner filed a timely Petition for Review. On June 6, 2016, the Commission issued its decision reversing the May 5, 2015 decision of the Arbitrator finding Petitioner entitled to additional benefits and awarding the same. The Commission in its decision failed to make specific findings as to Petitioner's request for an award of penalties and fees.

Respondent filed a timely review to the Circuit Court of Cook County. On May 8, 2017, the Circuit Court issued its decision confirming the decision of the Commission and finding Petitioner not entitled to an award of penalties and fees. Although a review was filed solely by Respondent, Petitioner continued to raise the issue of penalties and fees. See *Hurt v. Industrial Commission*, 191 Ill. App. 3d 733, 738, 548 N.E.2d 122 (1989) ("It was never intended that a 'cross writ of *certiorari*' should be necessary in order for the opposing party to preserve his right to object to any questions arising on the record or involved in the decision reviewed").

Respondent and Petitioner filed timely appeals to the Appellate Court, First District Workers' Compensation Commission Division. On February 23, 2018, the Court issued an order pursuant to Rule 23 wherein the Court "affirm that portion of the circuit court's judgment which confirmed the Commission's decision; vacate that portion of the circuit court's judgment which found that the claimant is not entitled to an award of penalties pursuant to sections 19(k) and 19(l) of the Act of an award of attorney fees pursuant to section 16 of the Act; and remand this matter back to the Commission with directions to address the claimant's request for an ward of penalties and attorney fees. *Higgins v. the Illinois Workers' Compensation Commission*, 2017 IL App (1st) 170798WC-U, ¶ 2. [1]

Conclusions of Law

The rationale for the Act's penalties provisions is well known. The Act "provides an income stream to an injured worker, who is typically left without income while he is disabled. [Citation omitted]. The penalty sections attempt to prevent bad faith and unreasonable withholding of compensation benefits from employees. (*Board of Education v. Industrial Com.* (1982), 93 Ill. 2d 1, 442 N.E.2d 861.)" *Ford Motor Co. v. Illinois Industrial Commission*, 140 Ill. App. 3d 401, 405, 488 N.E.2d 1296 (1986). It is equally clear, however, those sections are "not intended to inhibit contests of liability or appeals by employers who honestly believe an employee not entitled to compensation; they are intended to promote the prompt payment of compensation where due and to deter those occasional employers or insurance carriers who might withhold payment from other than legitimate motives. A failure to pay because of a good faith belief that no payment is due will not warrant a penalty." *Avon Products v. Industrial Commission*, 82 Ill. 2d 297, 301-2, 412 N.E.2d 468 (1980). "The employer, therefore, bears the burden of justifying the delay if the employee challenges it, and the employer is held to a standard of objective reasonableness in order to avoid the severe sanctions of *sections 19(k)* and *(l)* and the attorneys' fees and costs provisions

[1] During the pendency of the appeal, Petitioner died due to unrelated causes. No substitution has been filed before the Commission as to the current representative of the Estate of Mary Anne Higgins. Pursuant to the holding of *Illinois State Treasurer v. Estate of Kormany*, 2019 IL App (1st) 180644WC, a question exists as to whether the Commission retains jurisdiction to enter a decision. As the Appellate Court issued its mandate directing the Commission to rule, we have so complied.

of section 16 of the Act (see 820 ILCS 305/19(k), (l), 16 (West 1998))." *R. D. Masonry v. Industrial Commission*, 215 Ill. 2d 397, 408-409, 830 N.E.2d 584 (2005). "When the employer acts in reliance upon responsible medical opinion or when there are conflicting medical opinions, penalties are not ordinarily imposed. [citation omitted]. As long as the insurer 'had a legitimate doubt, from a legal standpoint, of its liability, its conduct [refusing payment] was not unreasonable.' [citation omitted]." *Avon Products* at 302.

The Petitioner argues penalties and fees should be imposed as it was unreasonable for Respondent to rely on the opinions of Dr. Suchy, Respondent's retained expert pursuant to Section 12 of the Act. On May 27, 2011, Dr. Suchy evaluated Petitioner and subsequently authored a report. RX1. Thereafter, Dr. Suchy provided his testimony pursuant to a deposition undertaken on June 25, 2013. RX5. Dr. Suchy was of the opinion that Petitioner's lumbar spine condition was temporarily aggravated by the work accident, and she reached maximum medical improvement as of November 5, 2011. Dr. Suchy further opined Petitioner's continued need for treatment for her lower back including but not limited to surgery was unrelated to her accident and solely due to her pre-existing degenerative condition. Relative to Petitioner's left knee condition, Dr. Suchy opined arthroscopic surgery was reasonable and necessary and anticipated Petitioner to reach maximum medical improvement within three to four months following surgery. Consistent with this opinion, on December 12, 2011, Dr. Mehl, Petitioner's treating physician, placed Petitioner at maximum medical improvement relative to her left knee.

Although Petitioner's treating physicians, Drs. Mehl and Hurley (PX18 & PX19), offered differing opinions to those advanced by Dr. Suchy and such opinions were ultimately more persuasive to the Commission, Respondent's reliance on Dr. Suchy's opinions was objectively reasonable. Respondent paid benefits in accordance with Dr. Suchy's opinion as it related to the left knee and denied benefits as it related to the lower back. In doing so, Respondent acted in a reasonable manner and penalties pursuant to Section (l) of the Act are not warranted.

In *McMahan v. Industrial Commission*, 183 Ill. 2d 499, 702 N.E.2d 545 (1998), the Supreme Court of Illinois explained the compensation authorized by §19(l) is in the nature of a late fee:

> The statute applies whenever the employer or its carrier simply fails, neglects, or refuses to make payment or unreasonably delays payment "without good and just cause." If the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay, an award of the statutorily specified additional compensation is mandatory. *McMahan*, 183 Ill. 2d at 515.

Section 19(k) of the Act provides, "In case[s] where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation *** then the Commission may award compensation additional to that otherwise payable under the Act equal to 50% of the amount payable at the time of such award." *820 ILCS 305/19(k)* (West 2012). In contrast to Section 19(l), Section 19(k) provides for substantial penalties, imposition of which are discretionary rather than mandatory and "is intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose. This is apparent in the statute's use of the terms 'vexatious,' 'intentional' and 'merely frivolous.'" *McMahan*, 183 Ill. 2d at 515. Section 16 of the Act provides for an award of attorney fees when an award of additional compensation under 19(k) is appropriate. *820 ILCS 305/16* (West 2012).

20IWCC0157

As Petitioner was unable to prove entitlement to penalties under Section 19(l) of the Act which requires a lower standard of proof for imposition of penalties than is required by Section 19(k) and Section 16, it follows Petitioner's request for penalties and fees pursuant to those sections is hereby denied. See *USF Holland, Inc. v. Industrial Commission*, 357 Ill. App. 3d 798, 806, 829 N.E.2d 810 (2005) ("Given our determination that the lower standard of proof required to impose section 19(l) penalties was not met, we further conclude that the Commission's assessment of section 19k) penalties and section 16 attorney fees was against the manifest weight of the evidence").

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Commission filed June 6, 2016 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for penalties pursuant to Sections 19 (k) and (l) of the Act and attorneys' fees pursuant to Section 16 of the Act is hereby denied.

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

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

Under Section 19(f)(2), no "county, city, town, township, incorporated village, school district, body politic, or municipal corporation" shall be required to file a bond. As such, Respondent is exempt from the bonding requirement. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 5 - 2020

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

Stephen J. Mathis

Stephen J. Mathis

D. Douglas McCarthy

D. Douglas McCarthy

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STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARY ANNE HIGGINS,

Petitioner,

16IWCC0374

vs.

NO: 11 WC 31456

MATTESON ELEMNTARY SCHOOL DISTRICT 159,

Respondent.

DECISION AND OPINION ON REVIEW

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

Findings of Fact and Conclusions of Law

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23. In June of 2012, two lumbar epidural steroid injections were administered.

24. A CT taken on August 26, 2011 was compared to the April 2011 MRI. It showed overall stability with grade I spondylolisthesis secondary to facet degeneration and mild stenosis.

25. On October 11, 2012, Dr. Hurley noted that Petitioner had suffered a fall on ice in February of 2011 which aggravated her preexisting degenerative disc disease. An MRI showed degenerative disc disease at L4-5 and L5-S1 with grade I spondylotic changes with neuroforaminal stenosis. Petitioner failed conservative treatment and presented for surgery. Dr. Hurley performed L4-5 posterior interbody fusion with instrumentation and autograft and bilateral L4-5 screw fixation and bone arthrodesis.

26. Petitioner did not progress well after surgery, On August 9, 2013, she reported to Dr. Hurley that she fell the previous day when her knee buckled and was complaining of low back pain radiating into her legs bilaterally. Dr. Hurley noted that she appeared "very uncomfortable." He did not think she could return to work due to persistent back and knee issues.

27. On October 9, 2013, Petitioner returned to Dr. Hurley and indicated she was told to return to work by her lawyer after a Section 12 examination. However, she had to call off work because her low back pain got worse. She now also complained of pain in the right leg as well as left leg pain. Dr. Hurley did not agree with her returning to work and indicated she needed a new MRI.

28. On December 30, 2013, Petitioner reported her condition worsened when she had returned to work. Dr. Hurley indicated the MRI showed new L3-4 lateral recess stenosis and what he thought was slightly worse stenosis at L5-S1, though the radiologist interpreted the MRI to be similar to the previous study. Dr. Hurley believed Petitioner fulfilled the criteria for failed back surgery syndrome, but he did not believe additional surgery would likely alleviate the problem. Her worsening condition might all be due to her being forced to return to work for three months. They discussed going back to the pain clinic.

29. On March 28, 2014, Dr. Hurley noted Petitioner was still not doing well. Her right leg pain was now actually worse than her chronic left leg pain. She went to another pain clinic and was taking Lyrica, which was not effective and stopped the previous day. They were considering a trial of injections. Petitioner also informed him that she was "told that due to her fall her knee has deteriorated" and she will need a knee replacement. Dr. Hurley concerned that her new right leg pain likely showed L5 nerve involvement. He recommended surgery and Petitioner agreed.

30. On May 12, 2014, Dr. Hurley performed L3-4 posterior interbody fusion with instrumentation and autograft, L5-S1 laminectomy and complete facetectomy and foraminotomy, and bilateral L3-4 screw fixation and bone arthrodesis for adjacent degeneration L3-4 and L5-S1 with L3-4 herniated disc, facet arthropathy, spinal stenosis, and L5-S1 facet arthropathy and neural foraminal stenosis.

31. On June 27, 2014, Dr. Hurley noted that Petitioner was doing better with reduced back and right leg pain. However, the left leg pain persisted. X-rays showed good alignment and fusion. Dr. Hurley thought she could start physical therapy.

32. On September 25, 2014, Petitioner returned to Dr. Hurley and reported that she still had low back and left leg pain. She had not made much progress in physical therapy. Dr. Hurley was disappointed that the surgery did not help Petitioner's left leg pain. They again discussed going to a pain clinic. He noted that the FDA had changed the rules about prescribing Norco and she would have to pick up written prescriptions. He encouraged her to "use it less and less."

33. Dr. Suchy was deposed by Respondent on June 25, 2013. He testified he is a board certified orthopedic surgeon and independent medical examiner. He examined Petitioner on May 27, 2011 and reviewed medical records at Respondent's request. That was the only time he examined her. On his examination he noted no atrophy or effusion in her leg. His examination of her back appears to have been normal except for pain with hyperextension and subjective complaints of pain generally.

34. An MRI of the knee showed high-grade chondromalacia of the patellofemoral joint with mild to moderate arthritic changes. An MRI of the lumbar spine showed diffuse disc bulging at multiple levels with spinal stenosis and spondylolisthesis of L4 on L5 with facet arthroplasty but no acute abnormality.

35. Dr. Suchy diagnosed left knee contusion with exacerbation of pre-existing chondromalacia patella, and lumbar strain with exacerbation of pre-existing degenerative disc disease and spondylolisthesis. Dr. Suchy concluded the chondromalacia was pre-existing because the knee MRI showed an advanced condition and there was no effusion. Similarly the lumbar MRI showed a long-standing degenerative process of the facet joints and bulging discs and spondylolisthesis would be acute only from a severe trauma.

36. In his Section 12 medical examination report, Dr. Suchy recommended arthroscopic evaluation of the knee with chondroplasty of the patella. She should be able to return to work as a special education teacher in two to three weeks and would be at maximum medical improvement in three to four months. He only recommended six to eight weeks of physical therapy for Petitioner's lumbar condition at which time she should have returned to her pre-exacerbation condition. He did not believe that back surgery was indicated at that time because he found no neurological deficits. If surgery was eventually needed it would not be the result of her February 16, 2011 injury.

37. Dr. Suchy testified that subsequent to his initial report, he received additional medical records and on November 5, 2011 he reached the conclusion that Petitioner had reached maximum medical improvement with regard to the February 16, 2011 aggravation of the pre-existing condition of her back. At that time he offered no opinion regarding Petitioner's knee condition.

38. On cross examination, Dr. Suchy testified he found no atrophy in Petitioner's left leg. He reiterated that he initially found a causal relationship between the work accident and an exacerbation of Petitioner's pre-existing knee and lumbar conditions. A simple slip and fall on buttocks can aggravate anterolisthesis but cannot cause it. He had no documentation indicating that the condition was present prior to the accident.

39. On redirect, Dr. Suchy testified that after reviewing Dr. Hurley's records, his opinion did not change that any need for fusion surgery was caused by the natural progression of Petitioner's degenerative disc disease and not the February 16, 2011 injury.

40. Dr. Hurley was deposed by Petitioner on November 1, 2013. He testified that he is board certified in neurological surgery. He first saw Petitioner on October 9, 2007 when he saw her for a cervical herniated disc for which he treated conservatively. He last saw Petitioner regarding her cervical spine in December of 2009. At that time she had never complained of low back pain.

41. Dr. Hurley saw Petitioner again on April 21, 2011, at which time she reported slipping and falling on ice in February and had back and left knee pain since. He ordered an MRI for her back. It showed several degenerated discs and evidence of grade I spondylolisthesis at L4-5 with moderate neuroforaminal stenosis. That condition is a common cause for low back pain.

42. Dr. Hurley opined that "certainly with her history" "the fall somehow caused the onset of back pain." He disagreed with the opinion of Dr. Suchy that the only way such a condition could be aggravated was from a fall from about 20'. He thought Dr. Suchy might have been referring to traumatic spondylolisthesis from a fracture. Low impact injuries can aggravate spondylolisthesis from facet disease.

43. Dr. Hurley also testified that he agreed that about 85% of back pain is related to muscle injury. However, he disagreed with the assessment of Dr. Suchy that Petitioner's condition was temporary in nature because her symptoms lasted longer than a simple exacerbation and "more importantly, she had a structural issue to her spine."

44. Initially, Dr. Hurley prescribed physical therapy and epidural steroid injections. However, that treatment did not help and Petitioner continued to have back pain radiating into her buttocks and legs. Therefore, he performed L4-5 interbody fusion surgery. He kept her off work from September of 2011 "until very recently when she was required to return to work."

45. Dr. Hurley had her off work exclusively due to her back injury. He opined that Petitioner was off work from September 2011 to the beginning of the 2013 school year "because of her persistent and chronic pain" caused by her February 16, 2011 injury. Petitioner was not at maximum medical improvement. He normally follows up with fusion patients for two years to ensure that the bone graph was in proper place and solidifies. Because she still had pain a year past surgery he anticipated referral to a pain specialist.

46. On cross examination, Dr. Hurley testified the first time Petitioner complained to him about low back pain was on April 21, 2011. He did not see any records of her treating with another doctor for her back but he thought she had a general practitioner. He agreed that Petitioner's spondylolisthesis existed prior to her accident but the accident aggravated the condition.

47. Dr. Hurley also testified that Petitioner reported no previous back pain prior to the accident. Dr. Hurley did not formally take Petitioner off work until September of 2011 because that was when she asked him. He was under the impression that she was off work due to her knee condition. The CT was taken on August 26, 2011 to rule out a fracture. It showed the spondylolisthesis but did not show acute changes. He agreed that spondylolisthesis changes occur over time.

48. Dr. Mehl was deposed by Petitioner on June 2, 2014. He testified he is board certified in orthopedic surgery. He practices general orthopedics and does "a lot of surgery on knees, hips and shoulders." He does minor surgery on extremities but does not treat the spine.

49. Dr. Mehl first saw Petitioner on March 23, 2011. X-rays taken on the date of the accident showed only mild degenerative changes. She continued to work but continued to have knee pain. On examination, Dr. Mehl found reduced range of motion, tenderness, and crepitus. She had a positive "McMurray's stressing the medical meniscus, but no knee instability." Petitioner did not indicate she had any problem with her left knee prior to her accident. He diagnosed pre-existing mild degenerative joint disease and a medial meniscus tear from the fall at work. He provided a knee brace, told her to continue the Vicodin as needed, and ordered an MRI. The MRI was denied; "they wanted physical therapy before anything else." In his practice Dr. Mehl would want an MRI before prescribing PT to avoid risk of additional injury to a possible torn cartilage.

50. Petitioner had physical therapy but reported "absolutely no improvement in her pain." She also indicated that the therapist thought she had a meniscus tear, which was Dr. Mehl's initial impression as well. Thereafter, an MRI was approved.

51. The MRI was interpreted as showing a high grade chondromalacia of the patellofemoral joint with no definite meniscal tear. He performed arthroscopic surgery on August 12, 2011, in which he found there was indeed a torn meniscus, which he repaired, as well as performing a diffuse chondroplasty. The meniscal surgery was "substantial" and he had to remove "a moderate amount of the torn medial meniscus."

52. Petitioner progressed slowly after surgery. She continued to have pain, reduced range of motion, and weakness. He administered cortisone injections. The cortisone injections helped with the pain but did not appear to improve her strength. Dr. Mehl kept her off work until he released her to full duty with regard to her knee on December 12, 2011.

53. Dr. Mehl had absolutely no opinion on whether Petitioner could resume working with regard to her back condition. Petitioner mentioned back pain to him but he never examined her back. He administered a Synvisc injection in January of 2012 after the cortisone injection was wearing off. He wanted authorization for another Synvisc injection all further injections were denied. X-rays showed a progression of her degenerative joint disease so he administered another Synvisc injection under her group health insurance.

54. Dr. Mehl opined that Petitioner had pre-existing degenerative joint disease which was exacerbated by the injury. In addition, the injury caused a medial meniscus tear and traumatic injury to anterior cartilage. All the treatment that he provided was necessitated by the work injury. He last saw Petitioner on February 26, 2014. At that time she had "severe degenerative disease which had significantly progressed since the first x-ray comparison taken at the time of her injury." That degeneration was posttraumatic and her ongoing problem was related to her injury of February 16, 2011.

55. On cross examination, Dr. Mehl testified chondromalacia can be either degenerative or traumatic in nature or a combination of both. He thought Petitioner had moderate pre-existing chondromalacia in all compartments prior to the accident. He disagreed with Dr. Suchy's assessment that Petitioner suffered a left knee contusion with an exacerbation of chondromalacia patella; she had traumatic damage to the articular cartilage and medial meniscal tear. Her back condition affected her functionality but did not contribute to her knee pain itself.

56. Dr. Mehl placed her at maximum medical improvement on December 12, 2011, except for occasional injections, and released to full-duty work. He did not impose any restrictions because of her knee since and would not currently place any now. The five degree varus deformity he noted on February 26, 2014 progressed too quickly to be degenerative. At his last visit he recommended another Synvisc injection but not additional surgery.

57. On redirect examination, Dr. Mehl testified he did not recommend total knee replacement, but if the Synvisc injection did not relief her arthritic pain such surgery may be indicated. If the surgery was performed she would be off work for about three months.

58. Dr. Suchy issued an addendum Section 12 medical report on May 5, 2014, after his deposition testimony. He had reviewed additional medical records and answered interrogatories. He opined that treatment rendered to Petitioner for her back after November 5, 2011 was not related to her February 26, 2011 work injury. The October 11, 2012 fusion surgery was medically indicated but the need for such surgery was not related to her work injury. Similarly, treatment of the left knee since November 5, 2011 was medically indicated but not related to the work accident. He agreed that she needed permanent restrictions after the diagnosis of failed back syndrome, which would include no lifting over 10-15 lbs with no excessive standing, walking, bending, or squatting. However, those restrictions were necessitated by her underlying condition and not her work injuries.

In finding Petitioner had not proved causation of her current conditions of ill-being of her knee and lumbar spine, the Arbitrator noted that Petitioner was able to work the rest of the school year and there was no knee effusion found in the emergency department. She also stressed that the tests taken within temporal proximity of the accident all appeared to be normal, her initial injuries were relatively benign, and that it was "undisputed that Petitioner had significant pre-existing degenerative issues in both her left knee and back."

The Commission reverses the Decision of the Arbitrator and finds that Petitioner did sustain her burden of proving the stipulated work-related injury of February 16, 2011 caused the conditions of ill being of both her left knee and lumbar spine, respectively. The Arbitrator is correct that Petitioner did have pre-existing conditions of ill being of both her left knee and lumbar spine, according to both her current treating doctors, Dr. Hurley and Dr. Mehl, as well as Respondent's Section 12 medical examiner, Dr. Suchy. However, there is no indication that these conditions were symptomatic prior to the accident. There is absolutely no evidence of any previous complaints or treatment of her knee whatsoever. While there are mentions of low back complaints twice, once in 2004 and once in 2006, there is no indication that she received any treatment for her lumbar spine at that time, or any other time, prior to the current accident.

In addition, the Commission finds the opinions of Petitioner's treating doctors more persuasive than that of Respondent's Section 12 medical examiner. Dr. Mehl and Dr. Hurley were able to monitor condition through the years of treatment and to note the persistence of her symptoms. On the other hand, Dr. Suchy only examined Petitioner once, within three and a half months of the accident, and therefore was not able to observe the extent and persistence of her symptoms. Regarding Petitioner's knee condition, Respondent's Section 12 medical examiner, Dr. Suchy, actually recommended arthroscopic evaluation of the knee with chondroplasty of the patella. Then when Dr. Mehl actually performed the arthroscopic evaluation, he noted that through surgery he realized that the meniscal surgery was "substantial" which was more pathology than originally anticipated and more pathology than seen in the MRI. Therefore, he had to remove "a moderate amount of the torn medial meniscus."

The Commission also finds the causation opinion of Dr. Mehl more persuasive that that of Dr. Suchy. Dr. Mehl opined that although Petitioner had moderate pre-existing chondromalacia in all compartments prior to the accident, she also she had traumatic damage to the articular cartilage and medial meniscal tear. He also testified that it was the aggravation from the accident which necessitated all of his treatment of her knee. Dr. Suchy's opinion that she suffered only a contusion is not persuasive because Dr. Mehl did not explain why such a simple contusion, causing only a temporary exacerbation, would result in persistent and ongoing symptoms for more than five months leading up to surgery.

Similarly, the Commission finds the causation opinion of Dr. Hurley more persuasive than that of Dr. Suchy. Dr. Hurley's opinion that the work injury caused an aggravation of Petitioner's pre-existing back condition necessitating treatment is supported by the medical records which are completely devoid of any previous treatment for her lumbar spine. On the other hand, once again Dr. Suchy did not adequately explain how a temporary exacerbation of Petitioner's pre-existing lumbar condition would result in many months of continuous symptoms without her ever returning to her pre-exacerbation status. Therefore, based on the sequence of events evidenced by the onset of symptoms after the work-related accident, the lack of evidence that Petitioner had any treatment for her knee or back prior to the work injury, the credible testimony of Petitioner, and the persuasive opinions of her treating doctors, Dr. Hurley and Dr. Mehl, the Commission concludes that Petitioner sustained her burden of proving the conditions of ill being of her left knee and lumbar spine were caused by the work accident of February 16, 2011.

The Arbitrator awarded Petitioner temporary total disability benefits of 17&4/7 weeks from August 12, 2011 through December 12, 2011, terminating temporary total disability on the date that Dr. Mehl initially found her at maximum medical improvement and released her to full duty relating to her knee condition. Because the Commission finds that Petitioner's work-related conditions of ill being extended beyond December 12, 2011, we modify the award of temporary total disability benefits.

The Commission awards temporary total disability benefits from August 12, 2011, the date Dr. Mehl performed knee surgery and took her off work, to August 13, 2013, when she returned to work on the advice of her lawyer after Dr. Suchy's Section 12 medical examination report. Thereafter, the Commission reinstates temporary total disability benefits commencing on November 15, 2013, the date on which she testified she could no longer work. That inability was corroborated by Dr. Hurley's opinion that she should not have been returned to work in August.

The Commission finds that an appropriate date to terminate temporary total disability benefits to be September 25, 2014. That was the last treatment note in the record representing the last time Petitioner was seen by Dr. Hurley. The Commission concludes that Petitioner's conditions largely stabilized as of September 25, 2014. Accordingly, the Commission awards temporary total disability benefits of 149&2/7 weeks.

The Commission finds all the medical treatment provided to Petitioner to date were reasonable and necessary to treat her conditions of ill being of her left knee and lumbar spine. Therefore, the Commission awards all the medical expenses Petitioner submitted into evidence, including direct reimbursement to Petitioner for all out-of-pocket expenses.

Regarding the issue of prospective medical treatment, the Commission notes that while Petitioner preserved the issue of prospective treatment in her Petition for Review, she does not request any specific prospective treatment in her brief. It is certainly possible that Petitioner may seek treatment in the future, which could include Synvisc injections or arthroplasty for her knee, *per* Dr. Mehl, and/or pain management for her back, *per* Dr. Hurley. If Petitioner does elect to have such treatment she could return to the Commission through a petition under Section 8(a) of the Act to seek an award of these and associated expenses.

Although the Arbitrator found Petitioner did not prove that her current conditions of ill being of her left knee and lumbar spine were not caused by her work-related accident, she nevertheless awarded her a total of 91.25 weeks of permanent partial disability benefits representing the loss of 25% of the left leg and 7.5% loss of the person as a whole for her lumbar condition, respectively.

Petitioner seeks a finding by the Commission that she is permanently and totally disabled. The Commission does not find that Petitioner is permanently and totally disabled. No doctor has opined that Petitioner is permanently and totally disabled from employment, Petitioner did not have a functional capability evaluation, she did not conduct a job search, and she did not request vocational rehabilitation.

In looking at the entire record before us, the Commission concludes that an appropriate permanent partial disability award is loss of 30% of the left leg, due to her knee condition, and loss of 40% of the person as a whole for her lumbar condition. In arriving at this award, the Commission notes that Petitioner was 61 years of age at the time of the accident and turned 67 years of age on April 16, 2016. Therefore, Petitioner has not proven a substantial loss of future earning potential. In addition, as noted above regarding prospective medical expenses, Petitioner may return to the Commission and seek additional benefits in a petition under Sections 8(a)and 19(h) of the Act if she suffers a change in her condition or needs additional medical care.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator issued May 5, 2015 is reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,129.41 per week for a period of 149&2/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $669.64 per week for a period of 264.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of the use of 40% of the person as a whole and loss of 30% of her left leg, respectively.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay medical expenses submitted into evidence, including direct reimbursement for out-of-pocket expenses under §8(a) of the Act pursuant to the applicable medical fee schedule. Respondent is entitled to credit for any payments it paid on the awarded bills either directly under the Workers' Compensation Act or through a group policy that qualifies under Section 8(j) of the Act

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

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

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

JUN 6 - 2016

DATED:

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-5/25/16
46

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Danilo Perez,

Petitioner,

vs.

NO. 12 WC 41277

Alpine Demolition Services, LLC,

Respondent.

20IWCC0158

DECISION AND OPINION ON REVIEW

This matter came before the Commission on Petitioner's Petition for Review of the Arbitrator's denial of reinstatement of the case. The Commission, after being advised of the facts and law, finds as follows.

On November 29, 2012, Petitioner through his counsel, Horwitz, Horwitz & Associates, filed an Application for Adjustment of Claim alleging work-related injuries on October 6, 2012. On November 13, 2017, Horwitz, Horwitz & Associates filed a Motion to Withdraw as Petitioner's attorneys of record, which was ultimately granted on January 29, 2018.

On April 30, 2018, the case was dismissed for want of prosecution by Arbitrator Steffenson as Petitioner, *pro se*, did not attend the hearing. The Commission mailed the dismissal order to Petitioner at the address on file.

Petitioner filed a petition to reinstate his case styled "Notice of Motion to Reinstate" on February 6, 2019, which was scheduled to be heard on February 20, 2019. Petitioner did not present his Motion as scheduled on February 20, 2019. He then filed a second Notice of Motion to Reinstate the following day. Petitioner indicated that he had been released from incarceration a few days prior to filing the first Notice of Motion and did not "remember all the processes" at the time of this filing.

Eventually, the second Notice of Motion to Reinstate was presented to the Arbitrator on May 30, 2019. Respondent objected to reinstatement of Petitioner's case based on the untimeliness of the petition. Petitioner confirmed his decision not to attend the April 30, 2018 hearing, the date of dismissal. He also indicated that he had received notice of the April 30, 2018 dismissal, but stated that he was subsequently incarcerated and lost all his paperwork. After a hearing on the issues, the Arbitrator denied Petitioner's Motion to Reinstate.

In consideration of the record as a whole, the Commission denies Petitioner's Petition to Reinstate as it failed to comply with the requirements of Section 9020.90 of the Commission's Rules. In so concluding, the Commission is not unaware that Petitioner's circumstances at the

time his claim was dismissed on April 30, 2018 were complicated. However, Petitioner was admittedly not incarcerated on April 30, 2018 when he failed to appear for the hearing on his case. Pursuant to the *Rules Governing Practice Before the Illinois Workers' Compensation Commission* (hereinafter "Rules"), Petitioner's claim was dismissed. *See* 50 Ill. Adm. Code §9030.20.

The dismissal notice was mailed to him at the address on file at the Commission. Petitioner admitted to receiving the dismissal order. Upon filing for reinstatement on February 6, 2019, Petitioner used this same address, which was also the address used at the time of filing his Application for Adjustment of Claim in 2012. When Petitioner did appear for a hearing on May 30, 2019, he failed to show compliance with the Commission's Rules and failed to establish that his petition to reinstate was timely filed when it was filed over nine months after the dismissal order was entered by the Commission on April 30, 2018. The Rules outline that, when a case is dismissed for want of prosecution, the parties shall have 60 days from receipt of the dismissal order to file a Petition to Reinstate the cause to the arbitration call. *See* Id. §9020.90.

Having found the foregoing failure to adhere to legal requirements, the Commission hereby affirms the Arbitrator's denial of Petitioner's Motion.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Petitioner's Motion to Reinstate is hereby denied.

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

DATED: MAR 5 - 2020
BNF/wde
2/ 20 /20
045

Barbara N. Flores

Deborah L. Simpson

Deborah L. Simpson

Marc Parker

Marc Parker

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 Choose direction	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANDRE HARPER,

Petitioner,

vs. NO: 17 WC 020142

CITY OF PEORIA,

Respondent.

20IWCC0159

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, permanent partial disability, and the Arbitrator's inclusion of facts not in evidence, and being advised of the facts and law, affirms with the following changes the Decision of the Arbitrator, which is attached hereto and made a part hereof.

I. Evidentiary Objection

Respondent raises an initial evidentiary issue. Respondent maintains that the Arbitrator erred in admitting treating surgeon Dr. Li's notes of June 21, July 11, and August 1, 2017 into evidence. Respondent contends that these notes were inadmissible under Section 16 of the Act, claiming that his opinions on causation contained therein were prepared for use in litigation because his notes also refer to obtaining a workers' compensation claim number and the subsequent denial of the authorization. See 820 ILCS 305/16 (West 2018).

Respondent attempts to distinguish this case from *RG Construction Services v. Illinois Workers' Compensation Comm'n*, 2014 IL App (1st) 132137WC, which rejected a similar argument grounded in both due process and hearsay objections. *Id.* ¶¶ 37-43. The Illinois Appellate Court observed: "It stands to reason that the records and reports of a treating physician are likely to contain medical opinions relating to a variety of aspects in the care, treatment, and

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evaluation of the employee. As a result, we are not persuaded by the employer's position that the simple inclusion of medical opinions within a treating physician's records is sufficient to exclude it from admission pursuant to section 16." *Id.* ¶ 39. Accordingly, a treating doctor's awareness of whether treatment is being processed under workers' compensation or through other insurance does not necessarily render that doctor's medical opinions inadmissible.

More significantly, in *dicta*, the appellate court discussed a "To Whom it May Concern" letter from one of the treating doctors, which provided an opinion that did not appear to have been relevant or necessary to his treatment of claimant as it concerned claimant's inability to work during a period of time prior to when his own treatment and evaluation of claimant began. *Id.* ¶ 41. The court concluded that because the letter was not relied upon by the Commission, the employer did not suffer prejudice and any error was harmless. *Id.* In this case, the Arbitrator relied on the chain of events to establish causation and thus any error in admitting those portions of Dr. Li's notes was similarly harmless.

II. Accident

The Arbitrator found Petitioner proved by a preponderance of evidence that he sustained an accident that arose out of and in the course of his employment which resulted in a disabling injury. 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 his employment. *Baggett v. Industrial Comm'n*, 201 Ill. 2d 187, 194 (2002). An injury "arises out of" one's employment if it originated from a risk connected with, or incidental to, the employment and involved a causal connection between the employment and the accidental injury. *Id.* "In the course of" refers to the time, place, and circumstances of the accident. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483 (1989). Both elements must be present at the time of the claimant's injury to justify compensation under the Act. *Id.*

Respondent argues that the preponderance of credible evidence does not establish an accident because Petitioner's testimony was inconsistent with the medical histories and other documentary evidence, including eight different accident histories and seven separate mechanisms of injury. In the context of an acute-trauma injury, a claimant must show that an injury is traceable to a definite time, place, and cause. *International Harvester Co. v. Industrial Comm'n*, 56 Ill. 2d 84, 89 (1973); *Elliott v. Industrial Comm'n*, 303 Ill. App. 3d 185, 188 (1999). The Commission may determine that a claimant failed to prove accidental injuries arising out of and in the course of his employment where the claimant's testimony at hearing is "grossly inconsistent with the more trustworthy contemporaneous medical histories." See *Sleeter v. Industrial Comm'n*, 346 Ill. App. 3d 781, 784 (2004); see also *Elliott,* 303 Ill. App. 3d at 189 ("The arbitrator noted that, although the testimony related to a 'bump,' the application for adjustment of claim referred to mid-air turbulence and concluded the history in the application for adjustment of claim was inaccurate and an attempt by claimant's attorney to relate claimant's problems to an incident of sufficient force to cause the injury.")

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In this case, the claimant's testimony was not grossly inconsistent with the more contemporaneous medical histories or other documentary evidence. Petitioner testified that he initially injured himself while carrying his basic life services (BLS) bag and attempting to navigate hazards quickly in the front yard of the site of the emergency call. This account is essentially consistent with Petitioner's Form 45 dated June 7, 2017, which stated Petitioner was carrying a medical bag and stepping around trash in the front yard. It is consistent with his application for adjustment of claim dated July 7, 2017, which stated he injured his right knee while walking across the yard wearing a BLS bag during a call. It is consistent with the history Petitioner provided to Dr. Moody on July 12, 2017, which stated Petitioner was on a call carrying a BLS bag across a lawn when he experienced sharp pain in his right knee. It is consistent with the history he provided in the physical therapy evaluation on August 14, 2017, which stated Petitioner was carrying a heavy life support bag when he stepped in a hole in the grass and injured his right knee. It is further consistent with the undated statement Petitioner provided to Respondent's Human Resources department, which stated Petitioner was carrying a medical bag to the address of the BLS call when he first tweaked his right knee.

Petitioner testified that he first experienced knee pain as he entered the house and again as he provided service during the emergency call. This account is broadly consistent with the Form 45, which referred not only to the front yard, but also to trash, furniture, and bad footing in the house. It is also consistent with Petitioner's statement to the physical therapist that he ascended stairs and had pain in his right knee, then had to navigate around furniture which continued to cause pain. It is even broadly consistent with Captain Allen's report of the incident, which Petitioner did not write, but which refers to the bad footing experienced by all personnel while lifting the patient. Moreover, neither Captain Allen nor any of the other personnel present on the emergency call testified at the arbitration hearing.

Petitioner's basic account was inconsistent with the history he first provided Dr. Li on June 14, 2017, which stated Petitioner felt pain after pulling a hose during a training exercise some days before the visit. Yet Petitioner explained that he had told Dr. Li that it was this pain that finally prompted him to seek medical treatment for his knee. This explanation is similar to the account Petitioner provided to Respondent's Human Resources department, *i.e.*, that he first tweaked his right knee on June 1, 2017, but the pain became more consistent after crawling during training on June 7, 2017 (which also happens to be the date of the application for adjustment of claim).[1] The fact that Petitioner attributed this worsening of symptoms to one part of his training rather than another is not a gross discrepancy, particularly in light of contemporaneously filed Form 45 and the undisputed evidence that Petitioner reported an injury related to the emergency call to Captain Allen on June 1, 2017.

[1] Respondent produced records showing that Petitioner did not work on June 11 or 12, 2017 to argue that Petitioner's account to Dr. Li of being injured "a couple of days" before the visit was inconsistent. Given that Petitioner informed Respondent that his June 1, 2017 injury was aggravated by training on June 7, 2017, prompting him to seek the advice of his doctor, the "couple of days" remark is not grossly inconsistent.

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In sum, the weight of the evidence indicates that Petitioner injured himself while carrying his BLS bag and rushing across an apparently hazardous front lawn during the emergency call on June 1, 2017. The symptoms of that injury first became evident to Petitioner or were immediately aggravated by additional injuries as he ascended the stairs to the house, navigated the clutter therein, and assisted the patient. Petitioner hoped that the pain would recede over time, but instead it worsened during training in the days after the injury, causing him to seek medical treatment.

These facts distinguish this case from *Sleeter* and *Elliott*, where the claimants' records indicated their symptoms may have stemmed from incidents unrelated to the alleged work accident. In *Sleeter*, the claimant did not provide details of a work accident for five months and provided testimony which directly contradicted his medical histories. See *Sleeter*, 346 Ill. App. 3d at 784-85. In *Elliott*, the claimant had claimed he was injured on an airplane after providing a medical history of an injury at a hotel and a prior injury in college. See *Elliott,* 303 Ill. App. 3d at 188. Here, there are no unrelated incidents which might have caused Petitioner's injury, which was corroborated at the time.

Moreover, each of the activities at issue, from the initial injury while rushing toward the house, to experiencing the knee pain during the emergency call, to the subsequent aggravation of that pain during training, occurred in the course of employment when considering time, place, and circumstances. Furthermore, each phase related to a risk of employment, from rushing to the site of the emergency while carrying a BLS bag, to navigating the hazards of the site, to lifting the patient, to crawling or pulling a hose in training exercises.

Given the record as a whole, the Commission concludes that Petitioner established by a preponderance of the evidence that his injury is traceable to a definite time, place, and cause, regardless of whether the focus is on Petitioner's initial injury or encompasses aggravating injuries occurring almost immediately thereafter during the emergency call. Petitioner sustained a work-related accident on June 1, 2017 that was eventually sufficiently aggravated by Petitioner's work duties that Petitioner sought treatment on June 14, 2017.

III. Causal Connection

The Arbitrator ruled that Petitioner proved a causal connection between the accident and his current condition of ill being, based on a "chain of events" analysis. Respondent argues this ruling is in error, relying primarily on its arguments regarding the accident issue, which the Commission has rejected.

Respondent also argues that Petitioner lacked a medical opinion on causation because Dr. Li's opinion was predicated on a report of knee pain after pulling a hose during firefighter training. Of note, Dr. Li was not deposed and no objection was made to his opinion. Inasmuch as Petitioner reported to Dr. Li an aggravation of the knee pain resulting from the June 1, 2017 accident, this does not matter. Moreover, Respondent does not address the Arbitrator's reliance on the chain of

events in this case. The Arbitrator observed that there was no evidence of prior treatment or symptoms in the right knee between 2013 and June 1, 2017, with a steady stream of symptoms from the accident date until the August 2017 surgery. Given this record, the preponderance of the evidence indicates a causal connection between the accident and Petitioner's current condition of ill-being.

IV. Medical Expenses

Respondent next contends that the Arbitrator erred in finding a preponderance of the evidence supported the award of medical expenses reflected in Petitioner's Exhibits 4, 5, and 6. Respondent primarily relies on its arguments regarding accident and causal connection, which the Commission has rejected.

Respondent argues in the alternative that if the Commission awards such medical expenses, Respondent should receive a credit for amounts Respondent paid through its group insurance. The Arbitrator found that Respondent was entitled to that credit under section 8(j) of the Act; Petitioner does not dispute the point in his brief. Accordingly, the Commission affirms the Arbitrator's award of this credit.

Respondent also argues that the Arbitrator specifically erred by not addressing Respondent's dispute of the reasonableness and necessity of Ireland Grove Center's surgery charges of $3,213.42 and $2,296.00. Respondent notes these were charges for "Arthrocentesis, Aspiration And/or Injection," which Respondent claims are not mentioned in Dr. Li's operative note. Respondent acknowledges the operative note refers to an injection of Marcaine for anesthesia but claims there is no reference to an injection into the right knee joint. A review of Dr. Li's operative note, however, indicates Petitioner was put under general anesthesia, while Marcaine appears to be a local or regional anesthetic. Petitioner maintains that Respondent's argument is just an argument without supporting evidence. Respondent has failed to demonstrate that the award of medical expenses is against the preponderance of the evidence.

V. Permanent Partial Disability

Respondent argues that the Arbitrator erred in finding Petitioner sustained a permanent 15% loss of the right leg pursuant to section 8(e)12 of the Act. Respondent initially relies on its arguments regarding accident and causal connection, which the Commission has rejected. However, Respondent argues in the alternative that the award was excessive.

Subsection (b) of section 8.1b of the Act lists five factors upon which the Commission must base its determination of the level of permanent partial disability benefits to which a claimant is entitled, including: (i) the level of impairment contained within a permanent partial disability impairment report; (ii) the claimant's occupation; (iii) the claimant's age at the time of injury; (iv) the claimant's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b(b) (West 2018). However, "[n]o single

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enumerated factor shall be the sole determinant of disability." *Id.* § 305/8.1b(b)(v). The relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. *Id.* § 305/8.1b(b).

Respondent points to Petitioner's three-month treatment history, his successful recovery and return to full duty without restrictions, and lack of continuing care from Dr. Li as reasons to deny Petitioner benefits, but these circumstances bear indirectly on the analysis of the statutory factors. A more rigorous analysis of the factors is delineated herein.

Regarding factor (i), the level of impairment contained within a permanent partial disability impairment report, as the Arbitrator noted, no AMA impairment rating was presented in this case. Accordingly, the Commission gives this factor no weight.

Regarding factor (ii), the claimant's occupation, the Arbitrator correctly noted that a firefighter is required to be active, including crawling and bending, activities which continue to cause Petitioner pain. Petitioner testified that he is also required to exercise for his job; as the Arbitrator observed, Petitioner testified that it takes time for him to warm up on duty days and treats his symptoms with ointments, heat and ice treatments, and a supportive band. Accordingly, the Commission gives this factor considerable weight.

Regarding factor (iii), the Arbitrator also noted that Petitioner was 53 years old at the time of the accident. Petitioner has returned to his job. Accordingly, it may be inferred that Petitioner will continue to work in his physically demanding job for a significant period of time. The Commission gives this factor some weight.

Regarding factor (iv), the claimant's future earning capacity, the Arbitrator properly noted that Petitioner did not produce any evidence of future wage loss. Petitioner also testified that he was promoted to captain at approximately the time he returned to Respondent. Accordingly, the Commission gives this factor some weight.

Regarding factor (v), the evidence of disability corroborated by the treating medical records, the Arbitrator noted Petitioner testified that he continues to take Tramadol twice daily. Petitioner testified that squatting and kneeling remained more difficult now, even after employing the aforementioned ointments and other treatments. The Arbitrator found Petitioner's current complaints were corroborated by the medical records. Petitioner reported his pain at 4/10 as reflected in his final physical therapy note, dated August 24, 2017. Accordingly, the Commission gives this factor greater weight.

Following a consideration of the statutory factors, particularly the fact that Petitioner is working full duty in the demanding position of a firefighter through continuing knee pain after surgery, the Commission concludes that the Arbitrator's ruling is supported by the weight of the evidence.

VI. The Arbitrator's Inclusion of Facts Not in Evidence

Lastly, Respondent argues that the Arbitrator erred by including facts not in evidence in his Decision and relying upon them in reaching his conclusions of law. Petitioner replies that he proved his case and that any such reliance on facts not in evidence is harmless error.

Respondent observes that the Arbitrator found that Petitioner testified that his BLS bag weighed approximately 25-30 pounds, when Petitioner did not so testify. Respondent is correct, but the record indicates Petitioner previously reported to his physical therapist that he was carrying a heavy life support bag when he stepped in a hole in the grass and injured his right knee. Moreover, Petitioner had previously recommended to Respondent's Human Resources department that the BLS bag should be made less heavy to avoid similar accidents. "Heavy" is a general term that may easily encompass a weight of 25-30 pounds and quite possibly more. Accordingly, any error in mentioning a weight of 25-30 pounds is harmless.

Respondent observes that the Arbitrator found that Petitioner testified he was unable to see the hole or other hazard in the yard "because the grass was high and there were toys in the yard." Respondent is again correct, particularly as to the presence of tall grass. However, Respondent acknowledges that Petitioner testified that the yard had "toys and other stuff" that impeded his path to the house. Petitioner additionally testified that the firefighters "are trying to get in there as quick as possible because you have somebody down and you don't know what the situation is." Petitioner further testified that he "just crossed over just getting around that obstacle, [he] stepped into something which [he] thought was maybe a hole or something like that," but kept pushing forward. The record thus clearly indicates that Petitioner did not observe the hazard due to toys or other obstacles in the yard and the emergency nature of the situation. Accordingly, the reference to high grass is harmless.

Respondent observes that the Arbitrator found Petitioner had testified that he "felt a tweak in his knee" but proceeded into the house, "where his right knee buckled," causing him to slip again because the interior floor of the house was covered with debris and unstable. Petitioner did not testify that he initially felt a tweak in his knee, but Petitioner previously had informed Respondent that "As I was carrying the medical bag at the above address it was the first time I tweaked my right knee ***." Thus, the Arbitrator's use of the term was harmless at most. The transcript of the hearing also includes the following testimony from Petitioner:

> "Q. I think you said you felt more pain when you entered the house. You indicated the house was kind of in disarray, did you slip again or just feel more pain?
>
> A. Well, even talking with my captain about it, you know, the surfaces wasn't stable."

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Captain Allen's own report of the incident indicated: "We were all on unsecure footing and we were all sliding as we lifted patient to a chair." Given this record, the Arbitrator's inference that Petitioner's knees buckled in the house is harmless.

Petitioner further notes that the Arbitrator sustained an objection to Petitioner testifying that he initially hoped the pain in his knee would resolve with rest but included this testimony in the findings of fact. However, Petitioner also testified without objection that he initially was limping a bit but thought his knee would be alright once he applied ice to it. Petitioner also testified prior to the objection that in discussing the injury with Captain Allen, he said he "thought it was something that would pass, you know, I will be all right." Accordingly, the finding is harmless.

Petitioner observes that the Arbitrator found that Petitioner "testified he felt pain in his knee when he was pulling a fire hose on June 13 and decided to seek medical treatment." Respondent is correct that Petitioner did not specify June 13, 2017, but Respondent also acknowledges that Petitioner did refer to pulling a hose in early June and provides no explanation of how the difference affected the Arbitrator's ruling on causal connection, which relied on the chain of events. Accordingly, the finding is harmless.

Respondent observes that the Arbitrator found Petitioner testified that "he is required to do [CPR training] at least two to three times a year," when Petitioner did not so testify. However, Petitioner was asked how often he was required to do CPR training and answered: "Um, a refresher like yearly, a yearly refresher, and just daily training at times when it comes to CPR." The Arbitrator's inference that Petitioner thus engaged in CPR training more than once annually was harmless, particularly when the subject was one small part of the larger issue of how the lingering symptoms from his accidental injury affected his ability to work.

Respondent additionally argues that the Arbitrator improperly concluded that Petitioner hurriedly walked across a front yard in disrepair while carrying a 25- to 30-pound life support bag when he stepped in a hole "or something" with his right leg and felt immediate pain in his right knee. Petitioner contends there was no testimony that Petitioner was in a hurry, that the bag weighed 25 to 30 pounds, that he stepped into the hole with his right leg, or that he felt immediate pain. As the above discussion indicates, however, the record indicates that Petitioner was trying to reach the house as quickly as possible, carrying a heavy BLS bag. Respondent does not explain why whether Petitioner stepped in the hole with his right leg or his left leg matters more than the result of that step on the condition of his right knee. The record further indicates that Petitioner felt pain ascending the steps to the house, which may be fairly described as immediately or almost immediately after stepping into the hole. Any inaccuracy in the Arbitrator's description in these respects is harmless.

Finally, Respondent argues that it was prejudiced where the Arbitrator assumed that Petitioner's undated statement to Respondent was filed around the time that Petitioner sought medical care. Respondent introduced the undated statement and did not question Petitioner about

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when it was filed, which is a fact that should be known to Respondent quite apart from the fact that Petitioner did not date his signature. Indeed, given Respondent's argument that more contemporaneous reports are more reliable, Respondent's use of the statement for impeachment suggests Respondent believed it to be more reliable. Respondent argues that the date the statement was filed is material because Petitioner provided differing accounts of his injury. Yet Petitioner's early dated statements – the Form 45 and the application for adjustment of claim – both report he injured his right knee while walking across the yard wearing a BLS bag during a call. For all of these reasons, the Arbitrator's presumption is harmless.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 20, 2018, is hereby affirmed and adopted with the changes noted above.

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

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

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

DATED: MAR 5 - 2020
d: 2/6/20
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HARPER, ANDRE
Employee/Petitioner

Case# **17WC020142**

CITY OF PEORIA
Employer/Respondent

20IWCC0159

On 8/20/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% 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:

4589 BACH LAW
JEFFREY R BACH
110 S W JEFFERSON AVE SUITE 41
PEORIA, IL 61602

0980 HASSELBERG GREBE SNODGRASS
JOE PISHGHADAMIAN
401MAIN ST SUITE 1400
PEORIA, IL 61602

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

Andre Harper
Employee/Petitioner

v.

City of Peoria
Employer/Respondent

Case # **17** WC **20142**

Consolidated cases: _____

20IWCC0159

An *Application for Adjustment 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 McCarthy**, Arbitrator of the Commission, in the city of **Peoria** , on **July 19, 2018** . After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of 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 **June 1, 2017**, Respondent ***was*** operating under and subject 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 $**82,445.88**; the average weekly wage was $**1,563.88**.

On the date of accident, Petitioner was **53** 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 $ for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

Respondent is entitled to a credit under Section 8(j) of the Act for all medical bills paid under its group insurance.

ORDER

ACCIDENT

The Arbitrator finds that the Petitioner proved he sustained accidental injuries arising out of and in the course of his employment with Respondent occurring on or about June 1, 2017.

CAUSATION

The Arbitrator finds that the Petitioner proved that a causal connection exists between his current condition of ill-being and the accidental injuries arising out of and in the course of his employment with Respondent occurring on or about June 1, 2017.

MEDICAL

The Arbitrator finds Petitioner proved entitled, by a preponderance of the evidence, to payment for medical, surgical, hospital, or prescription expenses, pursuant to Section 8(a) of the Act as found in Petitioner's Exhibits 4, 5,and 6 in evidence, and payable pursuant to the provisions of Section 8.2 of the Act.

PERMANENT DISABILITY

The Arbitrator finds that Petitioner proved he sustained permanent partial loss of use of his right leg under Section 8(E)1 of the Act to the extent of 15% thereof (32.25 weeks at $775.18 per week).

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

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

Aug. 14, 2018
Date

STATE OF ILLINOIS)
) SS
COUNTY OF PEORIA)

20IWCC0159

BEFORE THE ILLINOIS INDUSTRIAL COMMISSION

ANDRE HARPER,)
Employee/Petitioner,)
)
v.) Case No.: 17 WC 20142
)
CITY OF PEORIA,)
Employer/Respondent.)

FINDINGS OF FACT

The Arbitrator finds the following facts with regard to (C) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent and (F) Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner, Andre Harper, is a 54-year-old firefighter who has been employed by Respondent for twenty six or twenty seven years. At the time of the accident, he testified that he was employed as an engineer. He testified that in addition to fire suppression, he was also required to respond to medical and lift assist calls, during which he was required to render assistance to individuals in medical emergencies.

Andre testified that on June 1, 2017, he was working at station 4. On that day, he was required to go to a life support call on Idaho St. He testified that when he arrived, his captain, Tim Allen, got off the truck first and proceeded into the residence. Andre testified that he picked up a basic life support bag, which weighed approximately 25 to 30 lbs, and attached the bag to his person using a one shoulder strap. He testified that he walked across the yard to enter the residence, and as he was walking across the yard, he stepped into a hole or something in the yard, which he was unable to see because the grass was high and there were toys in the yard. He testified that he felt a tweak in his right knee, and felt pain as he continued to walk into the house.

Andre testified that he proceeded into the house, where his right knee buckled, causing him to slip again because the surface of the interior was covered with debris and was unstable. He testified that he again felt pain in his knee, but attended to the patient in the house until an ambulance arrived. He testified that he felt pain in his right knee as he was attending to the patient.

Andre testified that he felt a catch in his knee and that the knee was generally unstable after the accident of June 1, 2017. He testified that he mentioned his injury to his captain, Tim Allen, after the incident and filled out a report of injury on June 6 or June 7. He further testified that he did not seek immediate medical treatment because he was hoping his knee would heal on its own.

He testified that he felt pain in his knee when he was pulling a fire hose on June 13 and decided to seek medical treatment.

Andre testified that he first sought treatment with Dr. Lawrence Li, an orthopedic surgeon, on June 14, 2017. He testified that he was familiar with Dr. Li from a previous automobile accident that occurred four years prior to his work related accident. He testified that he had no symptoms from the automobile accident on the date of his work related accident. Andre testified that he told Dr. Li he injured his knee at work during early June, and that his knee was painful and catching at work. He testified that Dr. Li diagnosed him with a knee sprain and referred him for an MRI.

Andre testified that an MRI was performed on June 15, 2017, which revealed degeneration in the lateral and medial meniscus and mild to moderate chondromalacia. He testified that he saw Dr. Li on June 21, and that Dr. Li noted swelling on examination and diagnosed him with a right knee lateral meniscus tear. He testified that Dr. Li performed a cortisone injection in his knee and recommended that he follow up in three weeks.

Andre testified that he next saw Dr. Li on July 11, 2017, and reported that the steroid injection had helped him for a week, but that the pain in his knee returned. He testified that Dr. Li again found swelling on examination and recommended surgery.

Andre testified that he saw the city doctor, Dr. Edward Moody of OSF Occupational Health on June 12, 2017 and that there was a mix up about his accident date, as his poor handwriting caused Dr. Moody to believe that the accident occurred on January 1, 2017. Dr. Moody placed Andre on restricted duty.

Andre testified that he again saw Dr. Li on August 1, where Dr. Li found swelling on examination and noted that Andre's claim had been denied by worker's compensation so Andre's health insurance would be billed for his surgery. He testified that surgery was performed on August 8, 2017, and consisted of an arthroscopy with partial lateral meniscectomy and abrasion chondroplasty of femoral trochlea. He testified that the post-operative diagnosis was a lateral meniscus tear with a Grade 2 chondral injury to the femoral trochlea. He testified that Dr. Li did not perform shoulder or hip surgery that day.

Andre testified that he underwent therapy for four weeks after the accident and was released to work on September 6. He testified that he currently experiences symptoms in his knee with squatting and kneeling. He testified that he also experiences pain in his knee during CPR training, which he is required to do at least two to three times per year. He testified that it takes time to warm his knee up on duty days and that he treats his current symptoms with ointments, sauna, hot tub and cold packs. He testified that he still takes tramadol twice a day, every day for pain and that he wears a knee brace on his duty days. He testified that he always gets on and off his fire engine carefully to avoid injury to his knee.

On cross-examination, Andre confirmed that he had given seemingly inconsistent histories of how and when the injury to his knee occurred. Specifically, he was asked about his supervisor, Captain Tim Allen's, report of injury that indicated that Andre had slipped on loose material inside the house on June 1, 2017. Andre testified that he did not instruct Captain Allen what to write on

the report and noted that he first told Captain Allen of his injury while inside the house. He agreed that the history of injury given to Dr. Li was that Andre was pulling a fire hose when he felt pain in his knee. He also agreed that he had written that he had pain in his knee after crawling when completing his employee statement on June 7, 2017.

On re-direct examination, Andre testified that he had been required to crawl and pull fire hose multiple times from January 1, 2017 to the date he was injured, June 1, 2017, but had never experienced pain with either activity. He further testified that the cause of cause of his knee injury was the accident that occurred on June 1, 2017.

Andre's records from OpenMRI Center were admitted as Petitioner's Exhibit 1. The records show that Andre underwent an MRI on June 15, 2017, which revealed degeneration of the medial meniscus, fraying and degeneration of the lateral meniscus, and mild to moderate chondromalacia of the medial femoral condyle.

Andre's records from OSF Center for Occupational Health were admitted as Petitioner's Exhibit 2. The records show that Andre first saw Dr. Edward Moody on July 12, 2017 complaining of right knee pain with instability and catching. The records show that Dr. Moody recorded the date of the accident which caused these symptoms as January 1, 2017. Dr. Moody placed him on restricted duty on that day. The records show that on July 26, 2017, Dr. Moody authored a note indicating that Andre had provided a statement that noted that the date of injury was actually June 1, 2017, not January 1, 2017. The records show that Andre was released back to work on September 6, 2017.

Andre's records from Dr. Li were admitted as Petitioner's Exhibit 3. The records show that Andre saw Dr. Li on June 14, 2017 and gave a history of a knee injury that occurred while he was working. However, the note indicates that the history provided by the Petitioner was that he was pulling a hose during training and felt right knee pain. He further said that since then he had experienced multiple episodes of the knee catching while at work. He reported knee pain and instability. Dr. Li referred him for an MRI. Andre next saw Dr. Li on June 21, at which time Dr. Li administered a cortisone injection and diagnosed Andre with a right knee lateral meniscus tear. On the same day, Dr. Li indicated that it was his opinion to a reasonable degree of medical certainty that Andre's work injury caused his knee condition. Dr. Li saw Andre on July 11 and recommended surgery after Andre reported that the cortisone injection only helped for a week. Dr. Li saw Andre on August 1 and the records indicate that Andre informed Dr. Li that his worker's compensation claim had been denied and that he would be proceeding under group health insurance. Dr. Li performed a right knee arthroscopy with partial medial meniscectomy and abrasion chondroplasty of femoral trochlea. The records indicate that the post-operative diagnosis was a lateral meniscus tear with a grade 2 chondral injury to the femoral trochlea. Dr. Li last saw Andre on August 16, and noted that Andre was complaining of typical post-operative pains with swelling and bruising.

The Petitioner's post surgical therapy records were also admitted into evidence as part of the records from Dr. Li's facility. At his first therapy visit on August 14, 2017, the history from the Petitioner was that he was carrying a heavy life support bag when he stepped in a hole in the grass and injured his right knee. He further said that he then went up some stairs and had to navigate

around furniture, both of which continued to cause him pain. He said that he tried to keep working but still had significant pain after a couple of weeks. Accordingly, he reported it at that time. (PX 3)

Petitioner's Exhibit 4 consisted of medical bills from OSF Center for Occupational Health. The bills include all treatment rendered to Andre for his work-related injuries. The bills total $109.51 and indicate that a balance of $109.51 is outstanding.

Petitioner's Exhibit 5 consisted of medical bills from Orthopedic and Shoulder Center. The bills include all treatment rendered to Andre for his work-related injuries. The bills total $9,282.61 and indicate that a balance of $1,570.03 is outstanding.

Petitioner's Exhibit 6 consisted of medical bills from Ireland Grove Center for Surgery, LLC. The bills include all treatment rendered to Andre for his work-related injuries. The bills total $17,891.13 and indicate that a balance of $14,144.13 is outstanding.

Respondent's Exhibit 4 consisted of the Illinois Form 45 from this accident, which indicates that Andre was injured while stepping around trash in the front yard and inside the house.

Respondent's Exhibit 5 consisted of the Supervisor's Accident Investigation Report from this incident. Captain Tim Allen indicates that the house was extremely cluttered and very inaccessible. He indicated that everyone was on unsecure footing and was sliding as the patient was lifted.

Respondent's Exhibit 6 consisted of Andre's employee statement. The statement indicates that Andre injured his knee while carrying a basic life support bag by stepping in a hole in the yard on June 1, 2017. It indicates that Andre experienced knee pain while crawling on his knee for training on June 7, 2017.

CONCLUSIONS OF LAW

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

The Petitioner has the burden to prove that his employment was a causative factor of his physical disability. Respondent contends that he failed to satisfy this burden because of the inconsistencies concerning the accident history contained in the various exhibits admitted into evidence. The Petitioner acknowledged the inconsistencies, but maintained that his knee was injured while performing all of the activities at work between June 1 and June 13, 2017.

Petitioner testified that on or about June 1, 2017, while on a life support call, he was hurriedly walking across a front yard in disrepair while carrying a 25 to 30 lb. life support bag in order to perform a rescue on an individual at the residence. He said he stepped in a hole or

something with his right leg. He testified that he felt immediate pain in his right knee. In his employee statement which was presumably filed around the time he sought medical care, he said that he "tweaked" the knee. He testified that he proceeded into the house and felt right knee pain when going up some stairs. He said he felt more pain inside the house when he approached the patient. It was on that day when he told Captain Allen that he was having pain in the knee. He continued to perform his job. He indicated that his symptoms were exacerbated while crawling and pulling a fire hose during the two weeks after his accident. He further indicated that he was able to crawl and pull a fire house without experiencing pain during the five months prior to the accident.

After reviewing the various medical reports along with histories contained in the employee statement, the application for adjustment of claim, the supervisor's report and the Form 45, the Arbitrator concludes that the Petitioner's histories were in fact consistent with what he testified to at arbitration. He did not say that he injured himself all at once while carrying his medical bag across the yard. He said that he tweaked it at that time. He said that noticed additional or ongoing pain when performing the various subsequent work activities which are referenced in the histories provided. Nothing in those histories was shown to be false. It is clear that he performed a number of activities at work between the time of the initial tweak and June 14 when he saw Dr. Li. The fact that he did not tell everyone that he saw about every time his knee pain increased does not mean that he did not injure the knee at work as alleged. The Arbitrator finds that the evidence shows an initial injury on June 1 while the Petitioner was hurrying across the lawn to answer an emergency call, and subsequent injuries or manifestations of the initial injury over the following two weeks while performing his work duties.

The Arbitrator also fins a causal link between the initial accident and the injuries for which he treated. There was no evidence of any prior treatment or symptoms in the right knee from 2013 to June 1, 2017. There was evidence of a steady stream of symptoms from that date forward until surgery in August of 2017. The chain of events supports causation.

Based upon the above, the Arbitrator finds that the Petitioner sustained an accident arising out of is employment on June 1, 2017 which is causally related to the condition for which he was treated.

In support of the Arbitrator's decision relating to **(J) Has Respondent paid all appropriate charges for all reasonable and necessary medical services?**, the Arbitrator finds the following facts and conclusions of law:

The Arbitrator finds that the evidence shows that Petitioner's knee injury was caused by the accident that occurred on or about June 1, 2017. Therefore, the medical bills, set forth in Petitioner's Exhibit 4-6 are awarded. Respondent is ordered to pay each of the medical bills, pursuant to the Fee Schedule. Respondent is entitled to credit under Section 8 (j) of the Act for bills it paid through the Petitioner's group insurance policy.

In Support of the Arbitrator's decision relating to **(L) What is the nature and extent of the injury?**, the Arbitrator finds the following facts and conclusions of law:

Petitioner testified that while he was able to return to work on a full duty basis, he notices that his knee is still symptomatic as a result of the accident. Petitioner's occupation as a firefighter requires him to be active, crawling and bending, which causes pain in his knee. Petitioner has returned to his regular job and did not produce any evidence of a future wage loss. When last seen by Dr. Li on September 6, 2017, the Petitioner reported that he was doing very well. On exam, he did have some mild atrophy of the quadriceps muscle in the right leg. (PX 3) Petitioner testified that it takes time to warm his knee up on duty days and that he treats his current symptoms with ointments, sauna, hot tub and cold packs. He testified that he still takes tramadol twice a day, every day for pain and that he wears a knee brace on his duty days. The Arbitrator finds Petitioner's testimony about his current complaints credible, and notes that the symptoms he complained of were corroborated by Petitioner's medical records. Petitioner was 53 years old at the time of the accident, and his testimony indicates that he is still experiencing symptoms approximately a year after his knee surgery. No evidence was presented that Petitioner's future earning capacity was affected by this accident, and no AMA impairment rating was presented.

After considering the factors above which are enumerated in Section 8.1 of the Act, the Arbitrator awards the Petitioner 15 % of the right leg under section 8 (e) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Kanka,
Petitioner,

vs.

20IWCC0160

NO: 14 WC 29010

Edson Group Corp. and Illinois Workers' Benefit Fund,
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 employer-employee relationship and temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 10, 2019, is hereby affirmed and adopted.

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

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.

20IWCC0160

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 6 - 2020
o2/20/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0160

KAKDA, DAVID
Employee/Petitioner

Case# **14WC029010**

EDSON GROUP CORP AND IWBF
Employer/Respondent

On 1/10/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.47% 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:

2553 McHARGUE & JONES LLC
BRENTON M SCHMITZ
123 W MADISON ST SUITE 1800
CHICAGO, IL 60602

0000 EDSON GROUP CORP
WALDEMAR HERDZIG
9656 GOLF TERRACE #2S
DES PLAINES, IL 60016

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

20IWCC0160

STATE OF ILLINOIS)
)SS.
COUNTY OF MCHENRY)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

David Kanka
Employee/Petitioner

v.

Edson Group Corp. and IWBF
Employer/Respondent

Case # **14** WC **29010**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty** Arbitrator of the Commission, in the city of Woodstock on **December 5, 2018.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☒ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of 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 25, 2014** Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

Petitioner earned $2,712.50; the average weekly wage was $226.04. SEE DECISION

On March 25, 2014, Petitioner was **42** 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 **$0.00** for nonoccupational indemnity disability 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

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $220.00/week for 38 3/7 weeks, commencing March 25, 2014 through December 18, 2014, as provided in Section 8(b) of the Act. Respondent is entitled to a credit of $0.00 in TTD.

Medical Benefits

Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of his causally related right eye injury pursuant to Sections 8 and 8.2 of the Act.

Permanent Partial Disability

Respondent shall pay Petitioner permanent partial disability benefits of $220.00/week for 162 weeks, because the injuries sustained caused the 100% loss of use of the right eye, as provided in Section 8(e) of the Act.

Injured Workers' Benefit Fund

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.

Carolyn M. O'Neill

Signature of Arbitrator

1/8/19

Date

JAN 10 2019

FINDINGS OF FACT

Petitioner David Kanka pursued this action under the Workers' Compensation Act and sought relief from the Respondent-Employer Edson Group and its owner, Waldermar Herdzik, and, in turn, the Injured Workers' Benefit Fund as Petitioner alleges that named Respondent-Employer did not maintain workers' compensation insurance at the time of the accident. (PX 6). On December 5, 2018, the parties appeared for trial. ARB EX 1. Petitioner and the IWBF were represented by counsel. Mr. Waldermar Herdzik appeared in his capacity as the owner of Edson Group and was also present on behalf of Respondent-Employer Edson Group at trial. Mr. Herdzik and the Edson group were not represented by counsel. Mr. Herdzik testified via interpreter of the Polish language. All issues were placed in dispute.

At trial, Petitioner testified that he was born on November 4, 1971. On the date of accident, March 25, 2014, Petitioner was unmarried with no dependent children. Petitioner testified that on March 25, 2014, he was employed by the Edson Group which he indicated was owned by Mr. Herdzik. Petitioner is a roofer by trade, and testified that he is usually laid off during the winter. Petitioner lived in the same building as Mr. Herdzik, and Mr. Herdzik knew Petitioner was laid off. Petitioner testified that Mr. Herdzik offered Petitioner a job working on a remodeling project at a home near Woodstock, IL. Petitioner testified he was told he would be paid $14.00 per hour, and working 40-45 hours per week. He further testified he was paid once a week via a check, on which the drawer was named as Edson Group Corp.

The job started in early January 2014, and was scheduled to take several months. Petitioner testified that he worked from approximately 8am until 4pm. He left his house every day at approximately 6am in a van owned by and driven by Mr. Herdzik. Another neighbor and Edson Group employee, Robert Blasko, was also transported in this manner. The work consisted of renovation and construction. Tools used ranged from basic hammers and screwdrivers up to a pneumatic nail gun. Petitioner testified that the tools were provided by Mr. Herdzik. Mr. Herdzik was present at the job site most days, and supervised the work of Petitioner and Mr. Blasko.

On March 25, 2014, Petitioner was nailing up rafters, using a nail gun. The nail gun and the nails were provided by Mr. Herdzik. On this date, while nailing rafters, a nail struck a piece of metal on the rafter and ricocheted into Petitioner's right eye. Mr. Herdzik immediately began driving Petitioner to a nearby hospital. On the way, they encountered police, who requested a flight-for-life helicopter. The records of the EMS providers on the helicopter are consistent with Petitioner's testimony. The helicopter took Petitioner to Advocate Condell Medical Center. PX 1.

At Condell, Petitioner was admitted. X-ray scans confirmed a right eye globus rupture. PX 2. A trapdoor fracture of the right orbital bone floor was also noted. Petitioner had no vision out of his right eye. Id. Dr. Emily Velotta performed a repair of the ruptured globe and also repaired corneal and scleral lacerations. Id. Petitioner was released from the hospital on March 26, with instructions to follow-up with a specialist. Id.

Petitioner was seen on April 9, 2014 y Dr. John Galasso of Retina Consultants, on referral from Dr. Velotta. Petitioner reported light perception out of the right eye, but no vision out of the eye on this date. PX 4. He was also seeing "occasional floaters" in the right eye. Id. Dr. Galasso stated "if there is any hope of salvaging this eye, he needs a vitrectomy with possible use of the endoscope. We will repair whatever can be repaired at that time. I would like to schedule this within the next week and no later." Id. This surgery was performed by Dr. Galasso at Advocate Lutheran General Hospital on April 15, 2014. Id. Dr. Galasso's operative report indicated

a significant corneal tear, along with a large break in the retina, which was totally detached. Id. Sutures from the prior surgery were removed. Id. In follow-up on April 16, Petitioner reported he could see light, but not colors, shapes, or objects. Id. He was instructed to remain as much as possible in a face-down position, and advised that further surgery would be needed. Id. As of April 28, 2014, the cornea was looking better, and Dr. Galasso was able to begin considering further retinal repair. Id. This was confirmed on May 5, 2014, and surgery was scheduled for May 6, 2014, on the understanding that "the overall prognosis is quite poor, and that this may not be repairable."

On May 6, 2014, the third surgery was performed. Id. In post-op the next day, Petitioner still could not see colors or objects in his right eye. Id. Petitioner was instructed again to remain as much as possible in a face-down position, and further keratoprosthesis and retinotomy would be needed. Id. On May 22, 2014, a fourth surgery was recommended, specifically a keratoprosthesis to repair the complex retinal detachment. Id. This was performed on June 10, 2014. As of July 2, 2014, Dr. Galasso believed there was "not a lot of visual potential in this eye." Id. On July 23, Dr. Galasso noted a dense white membrane growing around the pupil, and was concerned about phthisis. Id. This was worsening as of August 6, and Dr. Galasso was beginning to consider total enucleation. Id. Dr. Galasso confirmed this as of October 1, 2014, and was recommending total enucleation at that time. Id. This recommendation continued as of December 18, 2014, but Petitioner was unable to have the enucleation "given his limited options with no insurance." Id.

Petitioner last saw Dr. Galasso for a long term follow-up on August 23, 2018. He reported that he had no vision in the right eye, and had 4/10 pain in the right eye. He stated his left eye was getting worse, consistent with sympathetic ophthalmia. Dr. Galasso recommended shatter-proof lenses in the left eye to protect it, and again recommended enuclation of the right eye, possibly at Cook County Hospital.

Petitioner testified that none of his medical bills have been paid. He testified that he is completely blind in his right eye. Prior to the accident, Petitioner had no vision problems and did not wear glasses. He is able to drive during the day in clear weather, but not in darkness. He testified that he was unable to return to his regular profession as a roofer after his release to work in December 2014. Per the medical records, Petitioner was released to full duty with the suggestion that he wear safety glasses. Petitioner testified that he told Mr. Herdzik that he could not work but that he did not attempt to return to work for Mr. Herdzik or Edson and that he did not supply any off work slips to Herdzik. He further testified that he tried to return to work in other areas of the construction trade but was not successful. He has not worked since the accident. Petitioner testified that he is unable to use a computer and that his left eye is stressing due to over compensation for the right eye which has not been removed.

Petitioner was cross-examined by Mr. Herdzik. On cross, Petitioner admitted that he worked for Mr. Herdzik from January to March 2014. He further admitted that approximately half of the money paid to him by Mr. Herdzik was meant for the other employee, Mr. Blasko. Petitioner believed this was done to save Mr. Herdzik money on checks. Petitioner also testified that Mr. Herdzik gave him $100 per week in cash to buy supplies as an advance on the salary. Petitioner further testified that he was hired to work three months in total and that he was to return to his regular season roofing job as a company foreman thereafter.

Mr. Herdzik then testified in his own behalf. He testified that he hired Petitioner and Mr. Blasko to work with him on this job for a lump sum of $4,500.00 combined regardless of the number of hours worked on the job. He further estimated that he provided Petitioner approximately $500.00 in cash over the three month job for expenses. He confirmed that he was only working with Petitioner and Mr. Blasko. He confirmed that the nail gun was his, as were most of the tools and the van. He confirmed he instructed Petitioner and Mr. Blasko on

what to do and how to do it and that he set the work hours. Mr. Herdzik introduced Respondent's Exhibit 1, consisting of several checks stubs drawn on an account in the name of Edson Group Corp and made payable to Mr. Kanka. The nine checks total $4,425.00 Mr. Herdzik testified this money was to be split between Kanka and Blasko. He further testified that RX1 consists of all the checks that were paid to Mr. Kanka over the course of his employment.

Mr. Herdzik also testified that Petitioner and Mr. Blasko had worked for him before on two or three jobs as "subcontractors." His defense at trial was that Petitioner was not an employee but a subcontractor. Mr. Herdzik testified that he did not have workers' compensation insurance in his name or in the name of the Edson Group on the date of the accident.

CONCLUSIONS OF LAW

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

A. WAS RESPONDENT OPERATING UNDER AND SUBJECT TO THE ILLINOIS WORKERS' COMPENSATION ACT?

The Arbitrator finds that on March 25, 2014, the Respondent Herdzik and Edson was operating under and subject to the Illinois Workers' Compensation Act. Pursuant to Section 3 of the Illinois Workers' Compensation Act, the Act automatically applies to a Respondent who meets any one of the seventeen listed "ultra-hazardous" activities. Testimony at trial established that Respondent engaged in the maintenance of structures (1), was involved in construction (2), used sharp edged cutting tools (8), and power driven equipment (15). No evidence was presented by the Respondent to dispute this issue. Therefore, the Arbitrator finds that Respondent was operating under and subject to the Illinois Workers' Compensation Act on March 25, 2014.

B. WAS THERE AN EMPLOYER-EMPLOYEE RELATIONSHIP?

The Arbitrator finds that there was an employer-employee relationship between Petitioner and Respondent on March 25, 2014. Petitioner credibly testified that Mr. Herdzik set the work hours and provided all of the tools used at the site. Petitioner worked under the supervision and control of Respondent and was paid by Edson. Petitioner was driven to the job site every day by Mr. Herdzik and was given instructions on the work to be done when they arrived at the site. Respondent Herdzik agreed with the testimony about supervision and tools. The Arbitrator finds that the preponderance of the credible evidence supports a finding of an employer-employee relationship between Petitioner and Respondent Herdzik and Edson on March 25, 2014.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT? D. WHAT WAS THE DATE OF THE ACCIDENT?

The Arbitrator finds that an accident did occur that arose out of and in the course of Petitioner's employment by Respondent. The Petitioner credibly testified that on March 25, 2014, he was struck in the eye by a ricocheting nail while nailing up rafters. The medical histories given to all medical providers are consistent. Respondent Herdzik was present at the scene and did not dispute Petitioner's account. Based on the credible testimony of the Petitioner as buttressed by the medical records and the testimony of Mr. Herdzik, the Arbitrator finds that the Petitioner suffered an accident, arising out of and in the course of his employment with Respondent, on March 25, 2014.

E. WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT?

Petitioner testified that immediately after the accident, Mr. Herdzik started driving him to the hospital. Mr. Herdzik did not dispute this account. Therefore, the Arbitrator finds that the Petitioner gave timely notice of the accident to Respondent.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

The Arbitrator finds that Petitioner's condition of ill-being, namely total blindness of the right eye, is causally connected to his March 25, 2014 accident at work. In so finding, the Arbitrator relies on the credible testimony of the Petitioner, taken together with the records of his treating medical physicians. No medical evidence was presented by the Respondent. Petitioner underwent four surgeries in an attempt to preserve the sight in his right eye. Dr. Galasso at multiple points confirmed that the chances of success were poor, and he was ultimately proved correct. He has recommended enucleation of the eye, which Petitioner has not yet undergone for financial reasons.

G. WHAT WERE PETITIONER'S EARNINGS?

Petitioner testified that he was paid $14.00 per hour, and worked 40-45 hours per week. Respondent Herdzik disputed this testimony, and testified that Petitioner and Mr. Blasko were to be paid a combined $4,500.00 for the entire three month job to be split evenly between them regardless of the number of hours worked. This arrangement is supported by the checks submitted by Mr. Herdzik. He presented a total of nine checks, totaling $4,425.00 in corroboration of his testimony. RX 1. The Arbitrator further notes that Petitioner agreed that Mr. Herdzik made checks payable to him and the money would be split between Petitioner and Mr. Blasko. Further, testimony indicates that Petitioner was paid $500.00 in cash for expenses during the course of the job. Accordingly, based on the credible evidence submitted at trial, the Arbitrator finds that Petitioner earned $2,712.50 towards the work completed on the roofing project during the agreed upon and finite job period of January 1, 2014 to March 25, 2014. Based on the foregoing, the Arbitrator finds that Petitioner's average weekly wage is $226.04 ($2,712.50/12 weeks or January 1, 2014 – March 25, 2014).

H. WHAT WAS PETITIONER'S AGE AT THE TIME OF THE ACCIDENT? I. WHAT WAS PETITIONER'S MARITAL STATUS AT THE TIME OF THE ACCIDENT?

Petitioner testified that his date of birth is November 4, 1971. The Arbitrator has no reason to doubt the Petitioner's testimony on this issue. Petitioner's medical records also confirm this. Therefore, the Arbitrator finds that Petitioner was 42 years old on the date of accident. Petitioner testified that at the time of the accident he was unmarried with no dependent children. The Arbitrator has no reason to discount this undisputed testimony. Therefore, the Arbitrator finds Petitioner was unmarried with no dependent children 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?

The Arbitrator finds that the medical services rendered to the Petitioner were reasonable and necessary, and that Respondent has paid none of the charges for medical services. Petitioner was taken by helicopter to Advocate Condell Medical Center. One surgery was performed there, followed by three more procedures by Dr. Galasso at Advocate Lutheran General Hospital. Respondent presented no medical evidence to dispute the opinions of Petitioner's treating physicians. Therefore, the Arbitrator finds that the medical services rendered to the Petitioner were reasonable, necessary and causally related as presented. The Arbitrator finds that Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in connection with the care and treatment of his causally related right eye injury pursuant to Sections 8 and 8.2 of the Act.

K. WHAT TEMPORARY BENEFITS ARE DUE?

The Arbitrator finds that Petitioner is entitled to Temporary Total Disability Benefits from March 25, 2014 through December 18, 2014, a period of 38-3/7 weeks. The Arbitrator relies on the credible testimony of the Petitioner, taken together with the records of his treating physicians. Petitioner was unable to work immediately following his first surgery, and was placed on restrictions of remaining face-down whenever possible following his next three surgeries. This restriction was last mentioned on June 25, 2014, however Dr. Galasso never formally cleared Petitioner to return to work. The Arbitrator therefore awards TTD through the date the condition stabilized and reached maximum medical improvement, the last regular follow-up with Dr. Galasso on December 18, 2014.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Based upon the evidence in its entirety, the Arbitrator finds that Petitioner has been permanently disabled to the extent of 100% loss of use of the right eye. The Arbitrator bases this finding on the Petitioner's credible testimony and the records of the treating physicians. Petitioner has no sight in his right eye. Enucleation has been recommended.

N. IS RESPONDENT DUE ANY CREDIT?

Petitioner testified that Respondent paid no benefits. Respondent presented no evidence that it paid any benefits and claimed no credit. Therefore no credit is awarded to Respondent.

O. OTHER – LIABILITY OF INJURED WORKERS' BENEFIT FUND

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, because of the *per se* failure of Respondent-Employer to pay the benefits due and owing the Petitioner.

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

Robert Loehr,

Petitioner,

20IWCC0161

vs.

NO: 18 WC 25903

Forest Preserve District of Cook County,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary disability and medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 6, 2019, 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.

There is no bond for the removal of this cause to the Circuit Court by Respondent pursuant to §19(f)(2) of the Act. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 6 - 2020
o2/20/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

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

20IWCC0161

LOEHR, ROBERT
Employee/Petitioner

Case# **18WC025903**

FOREST PRESERVE DISTRICT OF COOK COUNTY
Employer/Respondent

On 8/6/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.95% 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
ERIN M SIEVERS
505 E HAWLEY ST SUITE 240
MUNDELEIN, IL 60060

0000 GILDEA COGHLAN & REGAN LTD
EDWARD COGHLAN
901 W BURLINGTON AVE SUITE 500
WESTERN SPRINGS, IL 60558

20IWCC0161

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)

Robert Loehr
Employee/Petitioner

v.

Forest Preserve District of Cook County
Employer/Respondent

Case # **18** WC **25903**

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

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **June 14, 2019 and June 20, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **July 13, 2018**, Respondent ***was*** operating under and subject 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 $**102,429.60**; the average weekly wage was $**1,969.80**.

On the date of accident, Petitioner was **62** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**38,345.44** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**38,345.44**.

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

ORDER

AT THE HEARING OF JUNE 20, 2019, THE PARTIES AGREED THE CLAIM CAPTION SHOULD BE AMENDED SO AS TO REFLECT RESPONDENT'S PROPER TITLE, I.E., THE FOREST PRESERVE DISTRICT OF COOK COUNTY.

Medical Benefits
Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $672.87 to Southwest Center for Healthy Joints and $2,553.80 to ATI Physical Therapy, as provided in Sections 8(a) and 8.2 of the Act.

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $1,313.20/week for 38 1/7 weeks, commencing September 21, 2018 through June 14, 2019, as provided in Section 8(b) of the Act, with Respondent receiving credit for its stipulated payment of $38,345.44.

Prospective Care
Respondent shall authorize and pay for prospective medical treatment as prescribed by Dr. Chaudri in the form of a right knee arthroplasty.

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.

20IWCC0161

Molly C Mason

Signature of Arbitrator

8/6/19
Date

ICArbDec19(b)

AUG 6 - 2019

Robert Loehr v. Forest Preserve District of Cook County
18 WC 25903

Summary of Disputed Issues

The parties agree that Petitioner, a plumber, sustained an accident on Friday, July 13, 2018, while working in a trench. Petitioner testified he injured his right knee after the trench began to collapse. He was facing away from the collapsing earth when a co-worker shouted out a warning to him. He turned to his left but his feet remained stuck in the mud. He fell. He reported the accident to a scheduler that day. He testified his right knee pain worsened over the weekend. On Monday, July 16, 2018, he went to work and reported the accident to his supervisor. He underwent care at Loyola's Emergency Room later the same day. He subsequently came under the care of Dr. Chaudri, who imposed restrictions. Respondent provided Petitioner with work within those restrictions until September 20, 2018. Following an MRI and various conservative measures, including a series of gel injections, Dr. Chaudri recommended a right total knee replacement. At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Karlsson on February 21, 2019. Dr. Karlsson opined that the work accident merely temporarily aggravated an underlying degenerative condition. He agreed that a right knee replacement was reasonable but he did not link the need for this surgery to the work accident. He found Petitioner capable of full duty.

The disputed issues include causal connection, medical expenses, temporary total disability from September 20, 2018 through the initial hearing of June 14, 2019 (with Respondent stipulating Petitioner was disabled from September 24, 2018 through April 9, 2019) and prospective care. Arb Exh 1.

Procedural Note

When the parties closed proofs, on June 20, 2019, they agreed the caption of the claim should be amended so as to reflect Respondent's proper title, i.e., Forest Preserve District of Cook County. The Arbitrator allowed this amendment.

Arbitrator's Findings of Fact

Petitioner testified he began working as a plumber for Respondent in June 2017. T. 10. His job is physical. It involves kneeling, squatting and crawling. His tasks range from minor sink and pipe repairs to sewer and water line installations. Some of his assignments involve working in trenches that can be as deep as 8 feet. T. 11. Once a trench has been dug, either by machine or by hand, the workers gain access to it via a ladder. T. 11. The surface of a trench is typically very uneven and composed of grassy areas, dirt and/or stone. T. 12.

Petitioner denied experiencing right knee pain or undergoing any right knee treatment prior to the accident of July 13, 2018. T. 26. He had no problems performing his regular work tasks before the accident. He denied experiencing any right knee pain while climbing ladders, kneeling, crawling or squatting before the accident. T. 26.

Petitioner testified his accident of Friday, July 13, 2018 occurred while he and others were working in Busse Forest Preserve in Elk Grove Village, repairing a sewer that had been broken for three years. T. 12. The repair initially involved working in a trench that was 7 ½ feet deep. T. 13. The adjacent ground was extremely unstable. Dirt was constantly falling into the trench. T. 13.

Petitioner testified he and a co-worker were working inside the trench immediately before the accident. The trench began to collapse but Petitioner did not see this because he had his back to the area where the collapse was taking place. T. 13. His co-worker shouted a warning to him. He turned to the left but his feet stayed where they were because they were stuck in mud and there was a piece of pipe on top of his feet. T. 14. He fell forward, with dirt landing on top of him. T. 14. He felt pain but was able to get out of the trench. T. 14. His immediate supervisor was not available but he reported the accident to an individual who handed out assignments each day. He told this person he was in pain but would "play it by ear." T. 15. He testified his pain worsened over the weekend. The pain was in his right knee. T. 15-16. On Monday, July 16, 2018, he went to work and reported the accident to his supervisor. He completed a report and then went to the Emergency Room at Loyola. [In the report, Petitioner indicated he was working in a 6-foot deep trench at 2 PM on July 13, 2018 when a portion of the trench caved in. He indicated he "moved quickly but [his] feet were stuck in the mud and [he] twisted [his] knee." In response to a question asking him to describe all of the injured body parts, he wrote: "right knee." He denied previously injuring his right knee. He identified two witnesses, Bruce Pendleton and Chris Psinka. RX 3.]

The Emergency Room records of July 16, 2018 set forth a consistent history of the work accident, with Petitioner reporting he twisted his right knee when he got stuck in mud while working in a trench. PX 1, p. 7. On examination, the Emergency Room physician, Dr. Sterk, noted no significant effusion, mild medial joint line tenderness to palpation, full flexion and extension and questionably positive McMurray testing. PX 1, p. 8. Right knee X-rays showed a mild joint effusion and atherosclerotic calcifications. PX 1, pp. 9, 13. The doctor diagnosed a knee sprain. He released Petitioner to restricted work with no ditch work or activities requiring climbing pending an orthopedic evaluation. PX 1, pp. 23, 30.

Petitioner testified he next underwent treatment on August 2, 2018, when he saw Dr. Chaudri. T. 16. A patient report form in the doctor's chart reflects that the visit was related to a work-related twisting injury of the right knee occurring on July 13, 2018. PX 2, pp. 46-47. On right knee examination, the doctor noted tenderness on palpation of the medial aspect and patellofemoral region, positive McMurray's, positive Apley's, negative drawer testing and negative Lachman's. He reviewed the X-rays taken at the Emergency Room, noting arthritic changes with joint space narrowing and osteophyte formation. He diagnosed localized primary osteoarthritis of the right knee, an acute peripheral tear of the right medial meniscus and chondromalacia of the right patella. He recommended a right knee MRI. PX 2, pp. 41-42. He imposed restrictions of no ditch work and no ladder usage. PX 2, p. 44.

Petitioner testified Respondent was initially able to provide him with accommodated duty. He performed lighter repair tasks that did not involve climbing or working in trenches, while continuing to receive his regular salary. T. 17, 25-26.

Petitioner testified he returned to Dr. Chaudri on September 20, 2018. By then, his right knee pain had increased. T. 18.

Dr. Chaudri's note of September 20, 2018 sets forth a history of the work accident. The doctor recorded the following complaints:

> "The patient states he continues to have constant pain in the right knee and states the left knee has also been giving

him pain again. He states they both hurt at time of injury but right was worse than left. He states the left has been locking up more often and giving more pain. He states he would like an MRI order[ed] for the left knee."

PX 2, p. 37. In a separate note, the doctor addressed the issue of causation:

"Patient continues to have significant pain and locking in his right knee. The patient does have arthritic changes and I believe he has a meniscal tear. We are still awaiting approval for the MRI which was requested on 8/2/2018 for the right knee. Patient states that he also injured his left knee and [sic] his initial injury in July but his pain has resolved so he never expressed this on his last visit. His left knee now is starting to hurt him as well as lock up. He states he has never had this pain before his injury in July and I believe his left knee is related to his July 13, 2018 work injury."

Dr. Chaudri again recommended a right knee MRI. He took Petitioner off work. PX 2, pp. 37-40.

Petitioner underwent the recommended right knee MRI on October 9, 2018. T. 19. The MRI, performed without contrast, showed tricompartmental degenerative arthritis, predominantly in the medial femorotibial joint, an extrusion of the body meniscus and degenerative thinning, with high speed intensity changes in the anterior horn of the meniscus, with no definitive tearing, preservation of the lateral meniscus and a small to moderate joint effusion. PX 2, pp. 59-60.

On October 15, 2018, Dr. Chaudri reviewed the MRI results with Petitioner and re-examined the right knee. On this date, the doctor described Lachman, McMurray and Apley's testing as negative. He diagnosed localized primary osteoarthritis of the right knee. He administered a right knee intraarticular injection. He again addressed causation:

"Patient MRI was reviewed which shows no meniscal tears. He does have significant arthritic changes of the knee. I explained to him that the arthritic changes are most likely chronic in nature however he was not having pain before his work injury. I believe he aggravated a pre-existing condition but his pain is related to his work injury."

Dr. Chaudri prescribed physical therapy and home exercises. He released Petitioner to desk work, with no bending, twisting, squatting, jumping, climbing or kneeling and limited stair usage. PX 2, pp. 32-34.

On October 31, 2018, Petitioner underwent an initial physical therapy evaluation at ATI. Petitioner testified the therapy helped in terms of strengthening the muscles around the knee. T. 20. The evaluating therapist recorded the following history of the work accident:

"The patient reports that while he was at work on 7/13/18 while he was doing a plumbing job the ground was muddy and caving in. He twisted B knees which progressively gotten

[sic] worse in B knees."

PX 3, p. 58. The therapist also noted that, before the accident, Petitioner's heavy physical demand level plumber job involved lifting up to 100 pounds, walking approximately 5 miles per day and constant kneeling, crawling and climbing. She indicated that the therapy "may be extended longer than expected due to BLE involvement." PX 3, p. 58.

Petitioner continued attending therapy thereafter.

Petitioner returned to Dr. Chaudri on November 12, 2018. The doctor noted a complaint of bilateral knee pain. He indicated he was still waiting for gel injection approval. He again recommended the gel injections, noting that Petitioner was experiencing right knee pain with stair usage. He also recommended continued therapy. PX 2, pp. 25-26.

A therapy note dated November 14, 2018 reflects that Petitioner was deriving benefit from a cream his doctor had prescribed. PX 3, p. 39. Subsequent notes reflect complaints of weather-related right knee pain and stiffness. PX 3, pp. 24-25.

A therapy progress note dated December 7, 2018 reflects that Petitioner was still experiencing bilateral knee pain but that this had "improved moderately since starting PT." The therapist also noted that Petitioner reported experiencing a lot of right knee pain "when he was at work after injury." Petitioner indicated he was awaiting the first of five gel shots. PX 3, p. 20.

On December 10, 2018, Dr. Chaudri noted ongoing bilateral knee pain, with Petitioner reporting some improvement secondary to therapy. The doctor re-examined the right knee and administered a right knee Orthovisc injection. He recommended that Petitioner continue therapy. He continued the previous desk work restriction. T. 21. PX 2, pp. 20-23.

Subsequent therapy notes reflect improvement following the first injection. PX 3, pp. 16-19.

Dr. Chaudri administered additional Orthovisc injections on December 17 and 26, 2018. PX 2, pp. 15-19. T. 21.

Subsequent therapy notes reflect Petitioner's pain increased markedly after the second Orthovisc injection, with that pain persisting despite the third injection. PX 3, pp. 3, 6-7.

A therapy progress note dated December 28, 2018 reflects that Petitioner reported ongoing bilateral knee pain, right worse than left. The therapist noted that Petitioner had experienced initial improvement with therapy but "had a return to severity of pain in R knee since the second injection in R knee just over a week ago", with that pain persisting after the third injection. PX 3, p. 6.

Petitioner was discharged from therapy on January 7, 2019, with the therapist noting he had last attended therapy on December 29th and was being discharged "due to being denied authorization." PX 3, p. 3.

Petitioner testified he returned to Dr. Chaudri on January 24, 2019. His right knee pain had not subsided. T. 22. He asked the doctor if he could perform exercises at a gym. The doctor agreed. The

doctor also indicated that, since conservative care had not relieved Petitioner's symptoms, the next step would be surgery. T. 23.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Karlsson on February 21, 2019. RX 1, p. 6. Petitioner testified that Dr. Karlsson examined his knee. The examination lasted for about 15 to 20 minutes.. T. 24-25.

Dr. Karlsson testified by way of evidence deposition on April 8, 2019. RX 1. Dr. Karlsson testified he has been licensed to practice medicine in Illinois since 1993. He is board certified in orthopedic surgery. He most commonly deals with problems involving the knees, shoulders and hips, in that order. RX 1, pp. 4-5. He has privileges at Edward, Good Samaritan and Central DuPage Hospitals. RX 1, p. 6.

Dr. Karlsson testified he examined Petitioner on February 21, 2019, at Respondent's request. RX 1, p. 6. He has only a "minimal" independent recollection of the examination. RX 1, p. 7. He referred to his report while testifying. Petitioner told him he injured both knees on July 13, 2018, while working in a trench for Respondent. Petitioner indicated he turned quickly to his left, in response to a warning from a co-worker concerning a cave-in, twisting both knees in the process because both of his feet were partially stuck in mud at the bottom of the trench. RX 1, p. 8. Petitioner reported being in pain right away but the accident occurred on a Friday and his left knee pain subsided over the weekend. RX 1, p. 9.

Dr. Karlsson testified that Petitioner described his current right knee pain as worse than his left. He rated his right knee pain at 1 out of 10 at its best and 10 out of 10 at its worst. He rated his left knee pain at 0 out of 10 at its best and 5 out of 10 at its worst. RX 1, p. Petitioner reported being sent to the Emergency Room on the Monday following the accident and later seeing Dr. Chaudri. Petitioner reported having undergone MRIs of both knees, with the right knee MRI showing a probable meniscal tear and some arthritis and the left knee MRI showing some edema but no tears. RX 1, pp. 10-11. He described undergoing bilateral knee injections and being told he would probably need an arthroscopic surgery to the right knee. RX 1, p. 11. Petitioner reported taking Tramadol every other day and Meloxicam twice weekly for his knee symptoms. RX 1, p. 11.

Dr. Karlsson testified he reviewed an employee accident report, Emergency Room records, MRI reports, some physical therapy notes and Dr. Chaudri's records in connection with his examination. RX 1, pp. 12-13. He indicated the accident report mentioned only the right knee and there was no mention of left knee problems prior to Dr. Chaudri's note of September 20, 2018. RX 1, pp. 12-13.

Dr. Karlsson testified he examined both of Petitioner's legs, including the knees, and also checked the hip range of motion. He watched Petitioner walk and described his gait as normal. He noted a slight varus alignment to both knees. Petitioner's right knee range of motion was good but slightly decreased, at 0 to 120 degrees. The left knee range of motion was 0 to 130. Petitioner had no effusion to either knee. His bilateral leg strength was 5/5. He had some medial joint line tenderness bilaterally, worse on the right, and lateral joint line tenderness on the right only. McMurray testing was positive only on the right. RX 1, pp. 14-15.

Dr. Karlsson testified he obtained bilateral standing knee X-rays. Petitioner had "complete loss of the medial clear space on the right knee, actually bone to bone" and moderate loss on the left. He also had some loss behind both kneecaps and bone spurs throughout all three compartments of both knees, slightly worse on the right. Overall, the findings were consistent with "severe bone on bone

arthritis of the right knee and moderate osteoarthritis in the left knee." There was also some wear on the thigh bone on the right knee "where it had gone beyond wearing through the cartilage and actually some wear on the bone underneath." RX 1, pp. 16-17.

Dr. Karlsson testified that Petitioner reported working after the accident until September 21, 2018, at which point his treating physician took him off work. RX 1, p. 17.

Dr. Karlsson opined that Petitioner's bilateral knee osteoarthritis "is not related to the work accident." The osteoarthritis is a "longstanding lifelong wear of the cartilage." There were no acute findings, such as fractures, loose bodies or tears, in either knee. At most, the work accident caused a temporary exacerbation of the underlying severe osteoarthritis in the right knee. RX 1, p. 18. Dr. Karlsson did not believe there was any injury whatsoever to the left knee, citing the accident report Petitioner completed three days after the accident, the Emergency Room records and Dr. Chaudri's initial note. RX 1, pp. 18-19. Based on his review, "the first medical record that listed any problem with the left knee was over two months after the date of injury." RX 1, p. 19.

Dr. Karlsson testified that Petitioner's complaints were consistent with the level of arthritis he had in both knees. RX 1, p. 19. He did not view Petitioner as a candidate for an arthroscopy, given the MRI findings. He felt a right total knee arthroplasty was reasonable. He did not relate the need for the arthroplasty to the work accident, since there was "no permanent structural change in [the] knee." RX 1, p. 20. The lifetime wear, particularly given the bow-leggedness, put Petitioner at greater risk of developing arthritis. RX 1, pp. 20-21. Since Petitioner had been performing full duty with this level of arthritis before the accident, he felt Petitioner could continue performing full duty. RX 1, p. 21. He viewed Petitioner's treatment to date as reasonable and necessary. Gel injections are "not likely to be successful in someone who has this level of arthritis but there is certainly some hope of it" so it was reasonable to proceed. RX 1, p. 22. In his view, there is nothing inconsistent about finding gel injections to be an appropriate measure for a temporary flare-up and finding that the need for the knee replacement did not stem from the accident. RX 1, p. 23. Even relatively minor trauma can cause a temporary exacerbation of arthritis symptoms. RX 1, p. 23. His opinion would be different if there was something like a fracture at the joint line, a large piece of cartilage that had been knocked off and there had been good cartilage space beforehand. RX 1, pp. 23-24. An accident can certainly lead to something that causes an arthritic knee to need replacement but that is not what happened here. RX 1, p. 24.

Under cross-examination, Dr. Karlsson testified he did not recall Petitioner's counsel previously asking him whether a physician was present during his examination of Petitioner. RX 1, p. 24. [Arbitrator's note: it is apparent this deposition was bifurcated (see RX 1, p. 31) but no transcript of the first part is in evidence.] He and Petitioner were the only two people present during the examination. RX 1, p. 24. Petitioner was asked to bring I.D. to the examination. His front desk staff would have checked this I.D. so he assumes they had Petitioner's address. RX 1, p. 25. He directed his report to Corvel Corporation. There is no indication that copies were sent to other people. RX 1, p. 26. He cannot point to any evidence indicating he sent his report to Petitioner or Petitioner's counsel. RX 1, p. 27. He can say for a fact this was not done. RX 1, p. 28. [Arbitrator's note: at this point in the deposition, Petitioner's counsel moved to strike the doctor's direct examination testimony. He went on to stipulate he received a copy of the report from Respondent's counsel, with that counsel indicating he transmitted the report via E-mail on March 8, 2019. RX 1, pp. 28-29. RX 1, pp. 28-29.]

Dr. Karlsson testified he did not retain the records he reviewed. He further testified he did not have paper copies of the reports of the knee X-rays he obtained but he could pull up the images on his computer. Petitioner's counsel moved to strike the doctor's testimony, alleging he was being denied the right to properly cross-examine the doctor. RX 1, p. 30. Dr. Karlsson testified he feels it is unlikely Petitioner was asymptomatic before the accident. RX 1, p. 32. Respondent has not provided him with any affidavit indicating Petitioner complained of knee pain or was seen to be limping during the period of employment preceding the accident. RX 1, pp. 32-33. He did not include any of Petitioner's subjective complaints from a health survey in his report. He did indicate that Petitioner denied any prior history of problems with either knee. RX 1, p. 40. There is nothing he knows of showing Petitioner underwent knee care before the accident. Respondent did not provide him with any pre-employment physical. RX 1, p. 41. He reviewed the October 9, 2018 right knee MRI report but not the MRI itself. RX 1, p. 42. The radiologist who interpreted the July 16, 2018 knee X-rays did not use the term "bone on bone." The views he obtained on that date were non-weight-bearing. Such views do not typically show "bone on bone" changes. RX 1, p. 43. The reports listed lateral patellar subluxation. RX 1, p. 44. Arthritis does not always show up on X-ray. Joint space narrowing often will not show up on non-standing views. RX 1, p. 45. The October 9, 2018 MRI report does not contain the term "bone on bone." RX 1, p. 45. On September 20, 2018, Dr. Chaudri noted that Petitioner's left knee was also giving him problems again. RX 1, p. 46. It is possible Petitioner's left knee started bothering him on August 3, 2018, long before he returned to Dr. Chaudri on September 20th. RX 1, p. 48. On October 15, 2018, Dr. Chaudri noted that Petitioner was still experiencing pain in both knees. RX 1, p. 49. Since the accident, Petitioner has had continuous right knee care. There is no evidence indicating Petitioner underwent right knee care before July 13, 2018. An asymptomatic patient does not present for care. RX 1, p. 51. A knee replacement is one of the treatment options. It would alleviate Petitioner's pain and make the knee more functional. RX 1, p. 52. He would agree that Petitioner failed conservative care. RX 1, p. 52. He does not believe Petitioner required any work restrictions. RX 1, p. 53. It is up to Petitioner to decide whether he wants to have his knee replaced. RX 1, p. 54. Some activities might cause pain for Petitioner. Different patients have different symptoms. Dr. Chaudri has seen Petitioner on more occasions than he has. RX 1, p. 55. Depending on a person's body habitus, a normal range of knee flexion can be between 120 and 140 degrees. RX 1, pp. 55-56. He performs at least two examinations and at most four to five examinations per week. He devotes 5% of his practice to record reviews and examinations. RX 1, p. 56. Between holidays and vacations, he is typically away from his office four weeks each year. RX 1, p. 56. More than 90% of the record reviews he performs are in workers' compensation claims. More than 95% of the examinations he performs are in workers' compensation claims. 95% or more of the reviews and examinations he performs are for employers or insurance carriers. RX 1, p. 57. He believes his charge for an examination, including a records review, is $1200. He charges $1200 per hour for deposition time, with a one hour minimum. RX 1, pp. 57-58.

Petitioner filed a Section 19(b) petition on May 15, 2019. PX 5.

Petitioner testified he last saw Dr. Chaudri on May 23, 2019. The doctor continued to recommend a right knee replacement on that date. T. 24.

Dr. Chaudri testified by way of evidence deposition on June 10, 2019. PX 4. Dr. Chaudri is an osteopath who is board certified in orthopedic surgery and sports medicine. He underwent fellowship training in sports medicine at the Los Angeles Orthopeaedic Institute. PX 4, p. 5.

Dr. Chaudri testified he independently recalls some of his interaction with Petitioner but needs to refer to his chart as to the details. PX 4, p. 6. He first saw Petitioner on August 2, 2018. His assistant

obtained Petitioner's history. He then reviewed this history. Petitioner described twisting and injuring his right knee on July 13, 2018, when he was trying to exit a trench during a cave-in. Petitioner indicated his feet got caught. PX 4, pp. 7-8. Dr. Chaudri testified he noted tenderness along the patella, positive McMurray's and Apley's testing and a positive Clarke's sign on initial right knee examination. The positive McMurray's and Apley's were indicative of meniscal tears. The positive Clarke's sign was more diagnostic of patellofemoral syndrome. PX 4, p. 8. He reviewed X-rays taken at Loyola. These X-rays showed some arthritic changes, joint space narrowing and osteophyte formation. PX 4, p. 8. He assessed Petitioner as having arthritis of the right knee and a possible meniscal tear, along with chondromalacia of the right patella. PX 4, p. 9. He imposed restrictions, including no use of ladders and no work in ditches. He ordered an MRI and prescribed Meloxicam. PX 4, p. 9.

Dr. Chaudri testified that, on September 20, 2018, he was still awaiting approval of the MRI. Petitioner's clinical picture was the same. He changed the work restrictions to no use of the right leg. PX 4, p. 9. He believed Petitioner's symptoms stemmed from the July 13, 2018 work accident. PX 4, p. 11. After undergoing the MRI, Petitioner returned to him on October 15, 2018. At this visit, Petitioner was "still complaining of both knees having pain." The examination findings were largely the same. The MRI did not show a meniscal tear. It just showed arthritic changes within the right knee. PX 4, p. 11. Based on Petitioner's denial of pre-accident knee pain, he opined that the work accident aggravated Petitioner's underlying arthritis. PX 4, p. 12. He discussed treatment options, including a cortisone injection, therapy and gel shots. PX 4, p. 12. Patients with arthritis lose synovial fluid and can experience pain. The gel shots, which are either avian- or bacteria-based, are intended to supplement the patient's natural synovial fluid. PX 4, pp. 14-15. He restricted Petitioner to desk work. PX 4, p. 13.

Dr. Chaudri testified that Petitioner "was still having pain in both knees" as of the next visit, on November 12, 2018. His examination findings were unchanged. PX 4, pp. 13-14. He did not document any relief from the cortisone injection. PX 4, p. 14. He again restricted Petitioner to desk work. PX 4, p. 15.

Dr. Chaudri testified that, as of the next visit, on December 10, 2018, Petitioner had undergone about 17 physical therapy sessions. His examination findings were unchanged at that visit. He administered a gel shot and continued to restrict Petitioner to desk work. PX 4, pp. 15-16. He administered additional gel shots on December 17 and 26, 2018. He next saw Petitioner on January 24, 2019. Petitioner reported only mild relief from the gel shots at that time. PX 4, pp. 16-17. He recommended more therapy. Petitioner informed him that he had been performing only home exercises during the preceding month because formal therapy had been denied. PX 4, p. 17.

Dr. Chaudri testified that, at the next visit, on March 28, 2019, Petitioner indicated his knee might be getting worse. Petitioner also reported having undergone an independent medical examination. PX 4, p. 18. He imposed a restriction of no use of the right leg and told Petitioner to continue his home exercise program pending receipt of the examiner's report. PX 4, p. 18.

Dr. Chaudri testified that Petitioner again reported worsening of his symptoms on April 25, 2019. He added work restrictions on that date. PX 4, p. 19. When he last saw Petitioner, on May 23, 2019, Petitioner reported some benefit from therapy but indicated the therapy had been "cut off again." PX 4, p. 19. He discussed two options: restarting therapy versus surgery, "most likely a total knee arthroplasty." PX 4, p. 20. He is recommending an arthroplasty based on the MRI, which showed arthritis, and Petitioner's failure to respond to months of conservative measures. PX 4, p. 20.

Dr. Chaudri testified it is possible for someone to have knee arthritis that is asymptomatic and to have that arthritis become symptomatic following an injury. He believes this is what happened in Petitioner's case. PX 4, p. 21.

Dr. Chaudri testified he agrees with Dr. Karlsson's opinion that Petitioner's overall prognosis is poor due to his severe right knee osteoarthritis. He disagrees with the doctor's opinion that Petitioner's current symptoms are not related to the work accident of July 13, 2018. PX 4, pp. 21-22.

Dr. Chaudri testified that, to his knowledge, Petitioner's job is rather physical in nature. He imposed restrictions based on Petitioner's reported symptoms and his examination findings. Petitioner did not report having any problems performing his job before the July 13, 2018 accident. PX 4, p. 22.

Under cross-examination, Dr. Chaudri testified he first saw Petitioner on August 2, 2018. He does not know whether he treated any of Petitioner's family members before that date. PX 4, p. 24. At the initial visit, he reviewed X-rays taken at Loyola on July 16, 2018. He saw the images. He did not review any of the Loyola records. PX 4, pp. 25-26. He had no difficulty communicating with Petitioner at the time of the initial visit. PX 4, p. 26. Petitioner described twisting his right knee while trying to exit a ditch. Petitioner did not voice any left leg or left knee complaints on August 2, 2018. PX 4, p. 26. He diagnosed osteoarthritis and a potential tear in the right knee. PX 4, p. 27. The history Petitioner provided at the next visit, on September 20, 2018, was different in that he reported injuring both knees on July 13, 2018. His September 20, 2018 note reflects that Petitioner continued to have constant right knee pain and reported that his left leg had been giving him pain "again." He does not know whether Petitioner complained of left knee pain to him before September 20, 2018. PX 4, p. 29. There is nothing in his chart before September 20, 2018 to support Petitioner's statement that he was having a recurrence of left knee pain. PX 4, p. 29. If Petitioner used the word "again," that is what his medical assistant would have recorded. PX 4, pp. 29-30. That same note reflects that Petitioner reported injuring both of his knees on July 13, 2018, with the right knee injury "worse" than the left. PX 4, p. 30. Up to that point, there was no documentation of Petitioner having injured his left knee on July 13, 2018. PX 4, p. 30. After he reviewed the right knee MRI, he was able to rule out a meniscal tear. PX 4, pp. 30-31. His only diagnosis as of October 15, 2018, was localized primary osteoarthritis of the right knee. PX 4, p. 31. To his knowledge, Petitioner has not undergone any additional MRIs since October 9, 2018. PX 4, p. 31. If he looked solely at the X-rays, he would assume the patient would be a candidate for a knee replacement but he treats patients, not X-rays. PX 4, p. 32. If a patient has pain associated with the changes seen on the X-rays, he would recommend replacement surgery. PX 4, p. 32. He is charging for his deposition time but he has no idea how much he is charging. His office manager has arranged a "set rate" for deposition time. PX 4, p. 33.

On redirect, Dr. Chaudri testified it is common for patients with multiple injured body parts to complain only of the body part that hurts the most. PX 4, p. 33. The fact a patient does not initially mention the other injured body parts does not mean those body parts do not hurt. PX 4, p. 34.

Under re-cross, Dr. Chaudri testified he does not limit any of his patients to one complaint. He wants to know everything that is wrong with a patient so that he can fashion a treatment plan. PX 4, pp. 34-35.

Petitioner testified he wants to undergo the recommended knee replacement and would undergo the surgery if it was awarded. T. 30. The injury has affected both his work and recreational abilities. He has not attempted to mow his lawn because this task would involve more walking than he

can tolerate. He no longer hunts because that activity involves climbing and walking on uneven terrain. He worked out constantly before the accident and was able to squat while holding weights but he avoids this activity now because his right knee feels unstable. T. 28-29. He denied experiencing feelings of instability in his right knee before the accident. T. 29.

Petitioner testified he would readily resume performing light duty if Respondent could accommodate his restrictions. T. 30.

Under cross-examination, Petitioner testified he is now 63 years old. He is 5 feet, 11 inches tall and weighs 245 pounds. T. 31. Respondent hired him in June 2017. T. 31. He has worked as a plumber for 41 years. During that period, his duties remained relatively similar. T. 32. He owned a plumbing business at one point. T. 31. Before beginning to work as a plumber, he worked as a welder for 1 to 2 years. T. 32. He identified RX 3 as an accident report he completed and signed on Monday, July 16, 2018. He was truthful in this report. T. 33. He reported his accident to Pat Jones on that date. Jones functions as a dispatcher. T. 34. He is not sure whether Jones completed a report. [Petitioner's counsel stipulated Petitioner is not pursuing a claim for a left knee injury at this time. T. 35.] Dr. Martinez was his family physician before he began working for Respondent. Respondent has an HMO but Dr. Martinez "didn't take HMO." T. 36. He had to find another doctor. T. 36. Before the accident, he did not see Dr. Martinez for any right knee problems. T. 37. Following the accident, he first sought treatment on July 16, 2018, when he went to Loyola. T. 37. He was diagnosed with a right knee sprain at Loyola. T. 37. He began a course of care with Dr. Chaudri on August 2, 2018. T. 37. At Respondent's request, he underwent an examination by Dr. Karlsson. T. 38.

Patrick Jones, Sr. testified on behalf of Respondent. Jones testified he has worked for Respondent for 28 years. T. 40-41. His current job title is Engineering Assistant 2, Grade 18. He has held this title since 1994. T. 41. He hands out work assignments each morning and visits jobsites to supervise work. T. 41.

Jones testified he knows Petitioner through work. He is aware of Petitioner's accident. T. 42-43. If a worker reports an accident to him, he completes forms, determines whether there are any witnesses and provides the forms to his own supervisor. T. 43. Jones identified RX 4 as a report he completed and signed concerning Petitioner's accident. T. 43. He completed this report on July 16, 2018. T. 44. In this report, Jones indicated he did not examine the accident area because he was working elsewhere at the time. He listed two witnesses to the accident. In response to a question asking how the accident happened "in employee's own words," he wrote: "dirt fell and he got stuck in mud twisting his right knee." In response to a question asking what body part was injured, he wrote: "right knee." He indicated Petitioner began working for Respondent on June 23, 2017. RX 4.

Under cross-examination, Jones testified he has worked with Petitioner throughout Petitioner's tenure with Respondent. Petitioner is a good and honest employee. T. 44.

In addition to Dr. Karlsson's deposition transcript and the two accident reports, Respondent offered into evidence a print-out of the temporary total disability benefits it paid to Petitioner, the payments it made to CorVel Corporation, Disability Management Network and Adco Billing Solutions and the medical bills it paid. RX 5.

Arbitrator's Credibility Assessment

Petitioner came across as an individual who wants to improve and return to the workplace. His willingness to resume light duty, were Respondent to offer it, enhanced his credibility. Patrick Jones, Sr., who has worked for Respondent for 28 years, characterized Petitioner as a good and honest employee. T. 44.

Arbitrator's Conclusions of Law

Did Petitioner establish causal connection?

During the hearing, Petitioner's counsel indicated she was not addressing any potential left knee claim at that time. T. 35-36.

The Arbitrator finds that Petitioner established a causal connection between the undisputed work accident of July 13, 2018 and his current right knee condition of ill-being. The Arbitrator further finds that Petitioner established causation as to the need for the replacement surgery contemplated by both Dr. Chaudri and Respondent's examiner, Dr. Karlsson. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible denial of any pre-accident right knee pain or treatment; 2) the treatment records, which do not reference any pre-accident right knee conditions or care; 3) the fact that Petitioner successfully performed a variety of physically demanding tasks for Respondent between his hiring in June 2017 and the accident; and 4) Dr. Chaudri's causation-related opinions. Respondent's sole witness, Patrick Jones, Sr., did not refute Petitioner's testimony that he regularly performed kneeling, crawling, squatting, climbing and trench work while working as a plumber for Respondent before the accident.

Overall, the Arbitrator found Dr. Karlsson's causation-related opinions less persuasive than those voiced by Dr. Chaudri. Dr. Karlsson expressed doubt as to whether Petitioner was truly asymptomatic before the accident but he acknowledged the treatment records contain no mention of pre-accident right knee problems. On direct examination, he conceded that an accident can bring about the need for a knee replacement, although he did not believe this is what happened in Petitioner's case. Under cross-examination, he acknowledged that 95% of the record reviews and examinations he performs are for employers or insurance carriers. He admitted that certain activities could be painful for Petitioner but saw no need for restrictions.

Well-established Illinois law supports a finding of causation in this case. The appellate courts have long held that a claimant seeking benefits under the Act need only establish that a work accident was a cause of his condition. He is not required to prove that the accident was the sole, or even a significant, cause. Nor is he obligated to eliminate all other possible contributing causes. See, e.g., Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193, 205 (2003) and Schroeder v. IWCC, 2017 Ill.App. LEXIS 350 (4th Dist. 2017). The facts of the instant case are considerably more compelling than those of Schroeder. In Schroeder, the Appellate Court reversed the Circuit Court and reinstated the Commission's finding of causation, even though the claimant declined a recommended third back surgery in March 2013, only two months before she resumed working for the respondent, following a hiatus, and only nine months before the same physician again recommended surgery following a slip and fall accident occurring in December 2013. The Appellate Court found that the Commission properly applied the "chain of events" principle and that this principle does not apply only where the claimant is in a condition of absolute good health. In the instant case, in contrast, there is no evidence suggesting Petitioner had right knee problems, let alone required right knee surgery, before the undisputed accident.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims unpaid medical expenses from Southwest Orthopedics (Dr. Chaudri) and ATI Physical Therapy. PX 6.

The Arbitrator has previously found in Petitioner's favor on the issue of causation. Respondent's Section 12 examiner, Dr. Karlsson, characterized Petitioner's care, including the gel injections, as appropriate, although he did not link the need for the care to the work accident. RX 1, pp. 21-22.

The Arbitrator awards the claimed medical expenses, totaling $3,553.90, subject to the fee schedule.

Is Petitioner entitled to temporary total disability benefits from September 20, 2018 through the initial hearing of June 14, 2019?

Petitioner claims he was temporarily totally disabled from September 20, 2018 through the initial hearing of June 14, 2019. Respondent agrees Petitioner was temporarily totally disabled from September 24, 2018 through April 9, 2019 but disputes the claim for additional benefits. Respondent discontinued paying benefits on April 9, 2019, the day after its Section 12 examiner testified the accident caused only a temporary aggravation and Petitioner was capable of full duty. RX 1. The parties agree Respondent paid $38,345.44 in temporary total disability benefits prior to the hearing. Arb Exh 1.

The Arbitrator has found in Petitioner's favor on the issue of causation. The Arbitrator also finds in Petitioner's favor as to the need for restrictions pending the recommended arthroplasty. Respondent's examiner agrees that Petitioner is a candidate for the arthroplasty, although he does not link the need for this surgery to the work accident. Petitioner credibly testified that, following the accident, he performed light duty, while receiving his full salary, until September 20, 2018, when Dr. Chaudri took him off work. T. 17. Dr. Chaudi later released Petitioner to desk work. Petitioner credibly testified he asked Respondent to accommodate him but was told no light duty was available. T. 21. Respondent's witness, a longtime employee, did not refute this testimony. The Arbitrator finds that Petitioner was temporarily totally disabled from September 21, 2018 through June 14, 2019, with Respondent receiving credit for its stipulated payment. Petitioner's causally related right knee condition remained unstable as of the hearing, given the need for the arthroplasty. Interstate Scaffolding, 236 Ill.2d 132 (2010). Based on the stipulated average weekly wage of $1,969.80, the Arbitrator finds the temporary total disability rate to be $1,313.20 per week.

Is Petitioner entitled to prospective care?

The Arbitrator has previously found that Petitioner established causation as to his current right knee condition of ill-being and the need for the recommended replacement surgery. The Arbitrator awards prospective care in the form of the right knee arthroplasty recommended by Dr. Chaudri. The Arbitrator again notes that Respondent's examiner agreed this surgery would be appropriate, although he did not link the need for the procedure to the work accident.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Randall Dunaj,
Petitioner,

vs.

Chicago Transit Authority,
Respondent.

20IWCC0162

NO: 16 WC 18242

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 expenses and 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 October 31, 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.

There is no bond for the removal of this cause to the Circuit Court by Respondent pursuant to §19(f)(2) of the Act. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 6 - 2020
o2/20/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0162

DUNAJ, RANDALL
Employee/Petitioner

Case# **16WC018242**

12WC000949

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

On 10/31/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0146 CRONIN PETERS & CCOK
JOHN CRONIN
221 N LASALLE ST SUITE 1454
CHICAGO, IL 60601

0515 CHICAGO TRANSIT AUTHORITY
ELIZABETH L MEYER
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

20IWCC0162

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

Randall Dunaj
Employee/Petitioner

v.

Chicago Transit Authority
Employer/Respondent

Case # **16** WC **018242**

Consolidated cases: **12 WC 0949**

An *Application for Adjustment 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 **August 8, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of 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 _____

20IWCC0162

FINDINGS

On **7/20/2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$63,731.20**; the average weekly wage was **$1,225.60**.

On the date of accident, Petitioner was **59** years of age, ***single*** with **0** dependent children.

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

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

All lost time benefits regarding this claim were paid regarding the consolidated case, Case No. 12 WC 0949.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $735.37/week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner all compensation benefits that have accrued from 7/20/2014 to 8/8/2018 in a lump sum and shall pay the remainder of the award, if any, in weekly benefits.

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

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

Signature of Arbitrator

October 31, 2018
Date

OCT 31 2018

FINDINGS OF FACT

The Findings of Fact in consolidated Case No. 12 WC 0949 shall operate as the Findings of Fact in this matter.

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)

Petitioner's testimony is found to be credible.

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

Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on July 20, 2014, when he felt a sharp pain climbing into a truck at work.

This finding is based upon the unrebutted testimony of Petitioner and the medical records.

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

Petitioner's current condition of ill-being regarding his cervical spine is causally related to the injury.

This finding is based upon Petitioner's testimony and the medical records.

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 claimed bill from Palos Community Hospital is not awarded, as no bill was submitted into evidence and the ER records from Palos are incomplete.

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

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

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

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

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

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. Therefore, this factor is given no weight in determining PPD.

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 mechanic at the time of the accident and that he was not able to return to work in his prior capacity as a result of the 10/28/2011 injury. Petitioner did not return to the mechanics job with restrictions that he was working at the time of this injury. This factor is given some weight in determining PPD.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 59 years old at the time of the accident. This factor is given some weight in determining PPD, as Petitioner will continue to experience pain and stiffness in his neck and right arm as a result of the injury.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner's earnings capacity is considered in the Award in case No. 12 WC 0949. Accordingly, this factor is given no weight in determining PPD.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner's subjective complaints are consistent with the records of Dr. Fardon. This factor is given substantial weight in determining PPD.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jasmine Santos,
Petitioner,

vs. No: 18 WC 08501

20IWCC0163

Android 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, causal connection, medical expenses, temporary total disability, and prospective medical, and being advised of the facts and law, reverses the August 7, 2018 Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator found that Petitioner failed to prove that she sustained an accident that arose out of and in the course of employment on February 2, 2018 and denied all benefits. He found Petitioner to be not credible and denied her claim on the ground that she was engaged in horseplay at the time of her injury.

After considering the entire record, and for the reasons set forth below, the Commission reverses the August 7, 2018 decision of the Arbitrator and awards medical expenses and prospective medical benefits.

I. FINDINGS OF FACT

A. Background and Accident

Petitioner was hired by Respondent as an assembler on December 16, 2016. She worked different positions on the production line assembling Chrysler engines. The line was oval-shaped, and the engines were moved by four-wheeled carts from station to station, with additional parts being affixed to the engines at each stop. The engines were moved to and from the carts by means of a hoist attached to two bridles, consisting of metal pieces screwed into the engine for that purpose.

On the date of her accident, February 2, 2018, Petitioner was assigned to the tear down position. She removed salvageable parts from defective engines which had been returned to Respondent by Chrysler. She then disseminated the parts to the appropriate stations on the line for re-use. In order to reach some of the engine parts, she was required to stand on a metal piece above the wheel on the cart and stretch out her arms over the top of the engine. When she had removed all usable parts, she used a hoist and the bridles to move the stripped-down engine to the green rack in front of the auto loader platform.

Petitioner testified that on February 2, 2018, she had completed work on an engine and was prepared to remove the engine from the cart and lift it onto the green rack to be returned to Chrysler. She realized at that time that she would require two bridles to make the transfer, as the bridles on her engine had been removed during the prior shift. Bridles were kept in bins on the auto loader platform and at two other stations along the production line. The auto loader bin was closest to her station.

Respondent's plant manager, Frederick Swain, testified that Respondent had installed multiple video cameras in the auto-loader system. The cameras are wide-lens, so the video shows more than just the engines, operator, and platform. Respondent has used the videos to show customers what is done or is not done to the product.

Respondent introduced a video filmed on the date of Petitioner's accident (RX5) that showed her co-worker, Richard Barragan, who was working the auto-loader position. He appears to speak with someone on the floor below his platform. Petitioner testified that she was asking Mr. Barragan to hand her two bridles from the bin on his platform at that time. Mr. Barragan recalled that Petitioner was returning two bridles to the bin, rather than requesting additional bridles. Petitioner testified that Mr. Barragan declined to hand her the bridles and advised her to obtain what she needed for herself. The exchange was friendly.

Petitioner stepped onto the metal plate above the wheel of an empty cart on the line and from there to the auto-loader platform. Although there were stairs from the factory floor to the top of the platform, they were located on the side farthest from the tear down area. Petitioner spoke with Mr. Barragan again when she had ascended the platform, but before she could obtain a bridle from the bin, she realized that the cart in front of the platform was getting ready to move along the track. She testified that she moved to allow Mr. Barragan room to maneuver the incoming engine. She stepped back onto the top of the cart she had used to ascend to the platform, planning to hop down the 28 inches to the floor to return to the tear down area. However, the cart began to move down the line, causing Petitioner to lose her balance and fall onto her right knee.

Petitioner testified that she felt immediate knee pain and could not stand up. Co-worker Mr. Barragan, team leader Rubin Alonzo, and supervisor Danny Gutierrez all came to her aid. No one admitted to actually witnessing her fall, although Mr. Barragan was facing that direction at the time.

20IWCC0163

Petitioner reported her accident that day. She testified that because she was concerned about losing her job as a result of her work injury, she misrepresented the mechanism of her injury to her supervisor, on the first report of injury, and to her treating physicians. To each of these, she indicated that she tripped on a cart or the cart knocked into her as she was walking away. However, Brian Brown, Respondent's human resources manager, testified that he learned of the true mechanism of injury within eight to nine days of the accident, when Respondent became aware of the videotape (RX5) made on the date of accident.

The videotape shows Petitioner walking toward the auto-loader platform and talking to Mr. Barragan. Although his back is toward the camera, he appears to be engaging in a friendly conversation with Petitioner. As they talk, she climbs onto the step above the wheel of a cart stopped in front of the platform and steps up onto the same level as Mr. Barragan. They chat briefly, then she notices the carts beginning to move on the track and steps back down onto the top of the cart she had used to ascend to the platform. Her back is toward Mr. Barragan, but he is facing her direction. As she is stepping down, Mr. Barragan reaches out to a control pad and presses a button. Both Petitioner and Mr. Barragan testified that the button released the cart to continue down the production line. While Petitioner was on top of the cart, it began to move, causing her to lose her balance, jump from the cart top, and land on her right knee.

Respondent submitted "Personnel Meeting Notes" dated February 27, 2018 into evidence. (RX3). Petitioner was disciplined for riding on the cart top on the date of accident, but no evidence regarding possible discipline of Richard Barragan was presented. Petitioner's behavior was characterized as "horseplay" by Respondent's personnel committee.

B. Medical Treatment

Petitioner was evaluated that same day by Dr. Borchardt at OrthoIllinois, where she told the doctor that she had twisted her knee when she tripped on a cart. X-rays of her right knee showed normal alignment, and Dr. Borchardt diagnosed Petitioner with a sprained right knee. He recommended that she wear a hinged brace but did not prescribe any work restrictions. He did advise Petitioner to notify her employer and his office if she had to miss work due to her injury.

Petitioner followed up with Dr. Borchardt on February 12, 2018 due to continued pain and an inability to flex her knee. She reported pain with prolonged standing and descending stairs. At this appointment, Petitioner reported working with the restriction of sit down work only. Dr. Borchardt ordered an MRI and continued her work restrictions.

On March 27, 2018, Petitioner underwent an MRI, which revealed a complete ACL tear. At her March 29, 2018 appointment with Dr. Borchardt, Petitioner's main complaints were pain and tightness, and Dr. Borchardt referred her to Dr. Whitehurst, also at OrthoIllinois, for surgical repair of her torn ACL.

Petitioner told Dr. Whitehurst that she was injured when she jumped off an engine cart and tripped over a cart. Petitioner reported that she was in pursuit of her normal duties at work when she stepped off a moving platform and suffered the injury. She received conservative treatment from the medical staff at work. Due to her age and activity level, the doctor recommended surgery to avoid the development of arthritis as a young adult.

Dr. Whitehurst performed the surgery on May 17, 2018 and Petitioner followed up on May 24, 2018 and was prescribed physical therapy twice a week for 12-14 weeks. At the time of hearing, Petitioner was completing her course of physical therapy.

Petitioner's claim was denied by Respondent on the ground that she was engaged in horseplay at the time of her injury. Respondent concluded that Petitioner's accident did not arise out of her employment because she had willfully removed herself from the performance of her assigned duty.

C. Additional Information

On appeal, Petitioner seeks medical expenses, temporary total disability and prospective medical expenses. She argues that she was the victim of a practical joke perpetuated by a co-worker and was engaged in a business purpose when she was injured.

II. CONCLUSIONS OF LAW

A. Accident

The Arbitrator found Petitioner was not credible and cited to inconsistencies in her reports of the mechanism of her injury. In denying the claim, the Arbitrator noted that Petitioner and Mr. Barragan gave conflicting testimony as to the purpose of her visit to the auto loader platform: Petitioner testified that she needed additional bridles to complete her assigned task, and Mr. Barragan testified that she was bringing unneeded bridles to the bridle bin on the platform. The Arbitrator determined that Petitioner stepped onto a cart that is intended to hold an engine block, knew that those carts moved along the assembly line, and fell when she lost her balance attempting to jump off the moving cart. The Arbitrator then noted that "... it is apparent [P]etitioner had no business purpose in being on the auto loader platform or the top of the cart at the time of injury. This was an inherently dangerous risk and had nothing to do with her assigned duties of tear down on the date of injury. ... Petitioner assumed a personal and inherently dangerous risk unrelated to her employment duties."

After careful review of the evidence proffered at the hearing, including the video of the incident itself, the Commission views the evidence differently than the Arbitrator and concludes that Petitioner did sustain a compensable accident at work.

Petitioner explained that she was initially hesitant to provide an accurate report of her accident, because she did not believe that she was seriously injured. She also feared she might lose her job for being hurt at work. Petitioner reported the mechanism of her injury in different ways: as a result of tripping over a cart; being caught between two carts; and tripping when she hurried to get from between them and talking with a co-worker and not paying sufficient attention to the movement of the carts. Petitioner's concerns regarding her continued employment were founded given that she was subjected to

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discipline for violation of Respondent's "horseplay" policy. No evidence was submitted to show that Richard Barragan was disciplined for his participation in the "horseplay." However, Respondent's internal safety policy is not dispositive relative to whether Petitioner was engaged in horseplay that would render her claim non-compensable under the law.

An employee who engages in horseplay resulting in injury is said not to have sustained the injury within the scope of the employment. *Payne v. Industrial Comm'n*, 295 Ill. 388, 391 (1920). Liability only attaches "where at the time of the accident the employee is performing service growing out of and incidental to his employment." *Payne*, 295 Ill. at 392. However, a non-participating victim of horseplay may recover. *Murray v. Industrial Comm'n*, 163 Ill. App. 3d 841, 843 (1987) (also citing *Health & Hospital Governing Comm'n v. Industrial Comm'n*, 62 Ill.2d 28 (1975) (injury compensable even where it is uncertain whether the act was horseplay or simply an act of negligence)).

The Arbitrator found that at the time of her accident, Petitioner was engaged in horseplay with Mr. Barragan and concluded that her accident did not arise out of her employment. He deemed her conduct "an unexpected and unnecessary deviation from her assigned duties of tear down" and denied all benefits. The Commission disagrees.

It is clear from the testimony of witnesses and the photos, video, and diagrams submitted by both parties that the tear down area to which Petitioner was assigned on the date of her accident was adjacent to the auto-loader platform. Petitioner testified that she had completed work on one engine and was preparing to move it to the green rack in front of the auto loader platform when she realized that her torn down engine was missing bridles. She would need to obtain two bridles and attach them to her engine before she would be able to use the hoist to move her engine to the appropriate rack. Petitioner testified that, although bridles were available at other stations along the production line, she was closest to the auto loader platform and elected to obtain a bridle from the bin at that location. Petitioner testified that she had climbed onto the auto loader platform, using a cart as a step up rather than the stairs provided, for the purpose of obtaining a bridle.

While Petitioner did not follow Respondent's prescribed manner of performing her work, and she was engaged in some type of conversation with Mr. Barragan while at her station and on the platform, the video also shows that Mr. Barragan was not innocent in the dialogue on the floor or on the platform. The Arbitrator noted, "Mr. Barragan testified that [P]etitioner brought some bridles to him, while [P]etitioner testified that she went on the auto loader platform to get bridles." However, the video directly controverts this testimony. Petitioner did not bring anything to Mr. Barragan or onto the platform. The foregoing supports Petitioner's version of events that she approached the platform to obtain bridles and was engaged in a service growing out of or incidental to her employment.

Moreover, the bridle bin is located on one side of the platform, along with two other bins. The video shows the bridle bin on a shelf on the left side of the platform. Petitioner testified that after she had reached the platform, she spoke briefly with Mr. Barragan and then noticed that the carts on the line appeared ready to move. It is at this point that the video reflects Mr. Barragan facing Petitioner's direction, holding the control mechanism with his right hand, and pressing a release button causing the cart to begin to move. Notably, Petitioner was already on the cart at shoulder level with the bridle bin to her left. Had Petitioner had the opportunity to reach into the bin and retrieve the bridles she went to get, the accident may not have occurred. However, Mr. Barragan pressed a release button and the cart began

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to move down the line. It was at this point that Petitioner stepped down from the cart falling to the factory floor and injuring her right knee.

Mr. Barragan also testified that he did not realize he placed Petitioner in danger when he hit the release button, allowing the cart on which Petitioner was standing to move forward down the channel. The video shows quite the contrary. Mr. Barragan's head and face are tilted downward toward Petitioner and the cart. Simultaneously, Mr. Barragan's right hand held the control mechanism, and he pressed the release button causing the cart to move. Mr. Barragan's testimony is not credible and, paradoxically, supports Petitioner's explanation for the inconsistencies in her reports about the mechanism of her injury that the Arbitrator found persuasive to deny her claim. It is apparent that both Petitioner and Mr. Barragan had an interest in being untruthful to Respondent regarding their conduct at the time so that they would not be subjected to discipline for violation of Respondent's safety policy.

Given the foregoing, the Commission cannot conclude that Petitioner was a willing participant in horseplay rendering her claim non-compensable. Petitioner should have obtained bridles as directed by Respondent's policies, but she was nonetheless engaged in an employment activity that brought her to the platform. The person with the ability to operate the cart was Mr. Barragan, and he did so while Petitioner's back was turned to him. Petitioner was an unwilling participant in this horseplay or Mr. Barragan's negligent act.

Based upon its determination that Petitioner's accident occurred in the course of and arose out of her employment, and that she was not a willing participant in horseplay, the Commission concludes that Petitioner's accident is compensable under the Act.

B. Causal Connection

The Commission next considers whether Petitioner's current condition of ill-being is causally related to the accident. As explained herein, the medical records establish that Petitioner did sustain a work-related accident as claimed that resulted in a current condition of ill-being of her right knee. Given this record, the Commission concludes Petitioner's condition of ill-being is causally related to the accident.

C. Medical Benefits & Prospective Medical Treatment

As a result of her accident, Petitioner suffered an ACL tear that was surgically repaired. At the time of hearing, Petitioner had undergone surgical repair by Dr. Whitehurst of OrthoIllinois and was completing a course of physical therapy. Dr. Whitehurst's April 11, 2018 office note recites the mechanism of injury as "Patient states that she was jumping off an engine cart, and tripped over a cart" (PX1, 4/11/18), resulting in a complete ACL tear and sprains of the medial and lateral collateral ligaments of the right knee.

Respondent did not have Petitioner examined and did not dispute that her treatment thus far was reasonable and necessary. Dr. Borchardt provided a hinged knee brace and ordered an MRI before referring Petitioner to Dr. Whitehurst, who performed a surgical ACL repair after concluding the following:

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> Due to the patient's age and activity level, I discussed that the natural history of nonoperative treatment with [sic] likely lead to arthritis as a young adult. The patient has some collateral ligament injury, however I recommend that these be treated conservatively prior to surgical intervention. Ultimately I recommend surgical intervention for a right knee arthroscopy, ACL reconstruction with autograft, possible partial meniscectomy versus meniscal repair.

PX1, 4/11/18.

Based upon the MRI results, the absence of any prior knee complaints, and Dr. Whitehurst's recommendation for surgical repair of the ACL tear, the Commission finds that Petitioner proved that her current condition is causally related to her accident on February 2, 2018 and that her treatment to the time of hearing was reasonable, necessary, and causally related to her work accident. According to Petitioner's Exhibit 1, Respondent's insurer paid for the conservative treatment and testing rendered by Dr. Borchardt, although not for the hinged brace or MRI prescribed by the doctor. Respondent paid nothing toward Dr. Whitehurst's treatment, beginning on March 30, 2018 up through the date of hearing. PX1.

Based on the foregoing, the Commission awards Petitioner the medical expenses related to her treatment for her right knee injury. The bills are for reasonable and necessary treatment to alleviate Petitioner from the effects of her accident at work.

The Commission further finds that the post-operative physical therapy recommended by Dr. Whitehurst and being completed at the time of hearing is reasonable and necessary to alleviate Petitioner from the ongoing effects of her injury at work.

D. Temporary Total Disability

On the Request for Hearing, Petitioner claimed she was entitled to 11 and 4/7ths weeks of temporary total disability (TTD). Respondent denied liability for any and paid no TTD. Petitioner was denied short term disability benefits due to the insurer's determination that the injury was work-related.

Petitioner was injured on February 2, 2018. She saw Dr. Borchardt of OrthoIllinois that same day and returned to work the following day with her knee in a hinged brace. On February 12, 2018, Dr. Borchardt restricted her to sit-down work only. Petitioner's March 27, 2018 MRI revealed a complete ACL tear, and Dr. Borchardt on March 29, 2018 noted Petitioner was working full-time with restrictions and referred her for surgery to Dr. Whitehurst, an orthopedic surgeon in his practice. Dr. Borchardt continued her restrictions, but at that point, Respondent discontinued Petitioner sit-down position. Dr. Whitehurst first saw Petitioner on April 11, 2018 and performed her surgery on May 17, 2018. At the time of hearing, Petitioner was still undergoing post-operative physical therapy. She had not worked or collected any temporary total disability or short-term disability from March 29, 2018 to the date of hearing. Thus, the Commission finds that Petitioner is entitled to the claimed temporary total disability benefits.

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IT IS THEREFORE ORDERED BY THE COMMISSION that the August 7, 2018 Decision of the Arbitrator is reversed. The Commission finds Petitioner sustained an accident on February 2, 2018 that arose out of and in the course of her employment, and Petitioner proved by a preponderance of the evidence that her current condition of ill-being is causally related to the accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay temporary total disability for a period of 11 4/7 weeks from March 29, 2018 to June 18, 2018. Respondent stipulated that it had not paid either temporary total disability or non-occupational indemnity disability benefits for which credit may be allowed under Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable and necessary medical expenses contained in Petitioner's Exhibit 1 pursuant to §8(a) and §8.2 of the Act. Respondent shall receive a credit for medical bills, if any, paid through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay for prospective medical treatment, as recommended by Dr. Whitehurst.

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 Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injuries.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980), but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

DATED: MAR 9 - 2020

Marc Parker

Deborah L. Simpson

Barbara N. Flores

mp/dak
o-01/23/20
68

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

SANTOS, JASMINE
Employee/Petitioner

Case# **18WC008501**

ANDROID INDUSTRIES
Employer/Respondent

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On 8/7/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% 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:

0000 GESMER & REYNOLDS PC
BRAD A REYNOLDS
526 E JEFFERSON ST STE 118
ROCKFORD, IL 61107

2027 WIEDNER & McAULIFFE LTD
JEFF SALISBURY
2990 N PERRYVILLE RD STE 4300
ROCKFORD, IL 61107

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
19(b)

Jasmine Santos
Employee/Petitioner

v.

Android Industries
Employer/Respondent

Case # 18 WC 0008501

Consolidated cases: None

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An *Application for Adjustment 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 **Rockford**, on **June 18 and 19, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of 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 _____

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FINDINGS

On the date of accident, **2-2-2018**, Respondent ***was*** operating under and subject 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 **$39,860.08**; the average weekly wage was **$766.54**.

On the date of accident, Petitioner was **25** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$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 she sustained accidental injuries arising out of and in the course of her employment on February 2, 2018.

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 7, 2018
Date

AUG 7 - 2018

ICArbDec19(b)

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FINDINGS OF FACT

Frederick Swain testified for Respondent that before becoming Plant Manager, he was Operations Manager for six years and was responsible for production, safety and quality of team members and leadership staff. Approximately 70-80% of his time was spent on the manufacturing floor. (T. 2-22)

Mr. Swain testified that Android Industries manufactures engines for Fiat Chrysler Automobiles (FCA). The manufacturing process involves an oval assembly line consisting of metal "carts" which travel along a channel in the floor to various stations. The carts contained "tooling" or metal supports on top where the engine module sits, and operates as a foundation for the engine. Each cart measures 28 inches from the floor and has two axles and wheels, covered by orange bumpers or skirting surrounding the wheels that contain sensors within them that identify where each cart is located in the assembly process. The last station in the assembly line where the completed engines are removed from the carts is known as the "autoloader." The completed engines are hoisted or lifted onto a racking system with the aid of bridles, which are pieces of metal attached to the side of the engine where the hoist attaches. (T. 2-27) The racks of engines are then transported to the customer, FCA.

Part of the assembly process includes an area known as "tear down" where fully-built engine modules arrive on a rack and the person performing the tear down uses the bridles to attach the hoist and move the engine to a cart. Removed bridles are to be taken to one of two bridle locations, farther down the assembly line where they could be reattached. (T. 2-31)

Petitioner testified that she became employed as an assembly line worker with Android Industries on December 16, 2016. (T. 10) She testified that between 8:00 a.m. and 9:00 a.m. on February 2, 2018 she was working in the tear down area. He job duties included bringing bad engines—model GMET4—from the assembly line and taking off and separating good parts from bad, and taking the good parts back to the assembly line. (T. 11) At times, petitioner would stand on the orange bumpers at the bottom of the carts in order to reach the top of the engine to remove hoses or wiring harnesses that she could not reach from the ground.

Petitioner testified that on the date of injury, she needed to obtain a bridle in order to hoist an engine from the rack. Petitioner testified that she walked over to the autoloader station and asked Richard Barragan, an autoloader operator, for a bridle. After he refused, she climbed on top of a cart and mounted the autoloader platform herself. Petitioner admitted that she could have gone to other stations at ground level to get a bridle, but claimed that the autoloader was the closest station. (T. 2-84) She also testified that there were stairs near the autoloader that she could have used, but chose not to use the stairs. (T. 19) Petitioner testified that once on top of the autoloader, she briefly spoke to co-employee Richard Barragan. She testified that there was no physical contact between herself and Mr. Barragan. (T. 25) After a brief interaction with Mr. Barragan, petitioner testified that she turned around and stepped on top of another cart. She testified that she did not realize Mr. Barragan had activated the button to advance the carts down the line. Once she was on the cart and realized it was moving she "hopped down like I normally do." (T. 36) She landed on the ground she felt a "pop" in her right knee and felt immediate right knee pain. (T. 17)

Mr. Swain testified that when an employee reports an injury, it is the policy of Android Industries to investigate every incident. The process includes all team members involved in the incident in order to investigate

and determine the root cause of the injury and to put safety measures in place to prevent a reoccurrence. The final stage of the investigation resulted in compiling information so that long-term preventative measures or corrective action could be implemented.

Mr. Swain testified that following petitioner's injury on February 2, 2018, the resultant investigation lead to the discovery of a video which captured the incident. The camera that took the video was located on the autoloader platform, facing outwards. It was designed to capture team members loading engines to ensure that the engines were built correctly and are placed on the finished rack in sequential order. The camera was connected to a DVR system which stores footage for approximately 30 to 60 days. After viewing the video, Mr. Swain requested that the footage be taken from the source and saved. An IT member saved the approximately 1.5 minute video footage. Mr. Swain testified that RX5 was a true and accurate copy of the video clip he originally observed which included a date and time stamp. (T. 2-44) RX5 was admitted into evidence without objection.

Mr. Swain testified that on February 2, 2018 petitioner was working at the tear down station, which was completely performed on the floor level, and she would not have had any business purpose for being on the autoloader platform. He testified that RX5 did not show petitioner performing any business-related tasks on the autoloader. (T. 2-53)

Petitioner admitted that when she initially notified her employer of the incident immediately after her injury, she did not correctly describe how the accident occurred. She reported that the injury was the result of her walking and "tripping over [a] cart." (T. 26) Petitioner participated in at least two meetings regarding the incident investigation with several managers present including Fred Swain, the plant manager; William Sayvor, the operations manager; Brian Brown, the HR manager, Jessica Tirado, the quality manager, and Chad, an engineer. (T. 75-76) It was not until after the incident that petitioner admitted that her injury was the result of her jumping off the top of a cart. (T. 28) Petitioner testified that she told the union chair how it happened, but not anyone in management. (T.29)

When petitioner initiated treatment, she provided a history to Dr. Borchardt of OrthoIllinois that her injury was the result of her walking and twisting her knee when she tripped over a cart. (T. 30) Following her injury, petitioner continued working until March 29, 2018 when work restriction were unable to be accommodated. (T. 33) No light-duty work accommodations were available after petitioner underwent surgery. (T. 34) She had not received any TTD benefits.

After viewing (RX5) petitioner identified herself and Mr. Barragan in the video and noted that she could be seen mounting the autoloader platform wearing a red sweater. (T.78) Petitioner admitted that the video showed that there was physical contact between petitioner and Mr. Barragan and that at no time did she retrieve a bridle from him. (T. 79,80) Petitioner testified that the video depicted an accurate representation of her standing on top of a cart and of how she fell on the date of injury. (T.79) Petitioner also admitted Richard Barragan pushes a button to control when the carts move. (T.80).

On June 19, 2018, the second day of trial, petitioner admitted that on the date of her injury, she climbed on top of the cart by first stepping on the orange skirting at the bottom of the cart, and then on top of the cart and onto the autoloader. She stated that she noticed that Mr. Barragan was getting ready to pick up an engine and there was not enough space so she decided to get out of his way by stepping on top of a cart, and jumping down. She testified that "the same way I got up on the autoloader is the same way I was going to get down." (T. 2-79) She admitted that she did not retrieve any bridles from the autoloader platform. When asked why she did not use the stairs along the side of the autoloader she responded "it was quicker for me to hop down." Petitioner testified that while she had never jumped off a moving cart before February 2, 2018, she had previously jumped off the top of a cart near the autoloader several times without being disciplined. (T. 2-81)

Rubin Alonzo testified that he had been employed by Android Industries for approximately six years and held the position of a Team Leader for Zone 4, which encompassed the autoloader station. (T. 2-6) Mr. Alonzo testified that RX6 was a photo which depicted an autoloader operator dropping an engine onto a rack on top of the autoloader platform. Mr. Alonzo testified that that the autoloader operator is responsible for advancing the carts down the line by pushing a button. (T. 2-16) He noted that RX6 also depicted a cart in front of the autoloader and stairs on the side of the platform which he observed employees regularly use to mount and dismount the autoloader platform. He testified that he had never observed anyone standing on top of or riding on a cart. (T. 2-12)

Mr. Alonzo testified that on February 2, 2018 he found petitioner laying on the ground near the autoloader and helped her up once he noticed she was injured. She informed him that her right knee began to hurt although she did not describe how the injury occurred.

Richard Barragan testified that he had been employed as an assembly line worker with Android Industries for a little over three years and worked as an autoloader operator. He knew petitioner and considered her a friend. (T. 84) He described his duties as pressing a button to lift an engine off of a cart, turning the engine and hitting the button again to release the engine on a rack. He testified that "it's just like one quick, two or three second" process. He then presses a button to advance the carts down the assembly line. He testified that he did not witness petitioner's injury, but recalled that something had happened to her on February 2, 2018. He testified that petitioner approached him to bring him bridles that she had taken off an engine, and when he turned around from placing an engine on the rack, he noticed petitioner was on the ground holding her knee. (T. 85) He claimed to be unaware of how petitioner got to the ground. He could not recall the content of their discussion before she fell and denied any physical contact between himself and petitioner. (T. 86)

On cross examination, Mr. Barragan testified that he was currently on parole and regularly reported to a parole officer stemming from a past crime. He testified that on the day of incident, February 2, 2018, he saw petitioner approach him with two bridles in her hands when she climbed up onto the autoloader platform and placed them in a bucket. He testified that he was not facing petitioner when she got down off the autoloader platform and was not aware of how she got down. When asked whether she used the stairs on the side of the autoloader, he responded "I wasn't looking. I had to turn around with the engine to do what I had to do." (T. 91)

After reviewing RX5, Mr. Barragan testified that the video depicted the autoloader station and he identified himself and petitioner in the video. He testified that he did not see anything in petitioner's hands when she climbed on top of the autoloader. (T. 94 and 96) He admitted that at no point in the video did he turn his back on petitioner. When asked whether he saw petitioner jump off of a cart, he responded "I guess." He admitted that petitioner did not bring any bridles to him, and that he was responsible for pushing the button which advanced the carts. (T. 97)

On re-cross Mr. Barragan admitted he was in very close proximity to Ms. Santos when he pushed the button to advance the cart, but did not recall if he warned her. (T. 98)

On cross examination, petitioner admitted that on the day of her injury, she never picked up a bridle from Mr. Barragan. Also, she admitted that her injury was the result of falling off the top of a cart and hitting the floor. She admitted there were metal fixtures on top of the cart. (T49, 50) She testified that the First Report of Incident was completed in her own handwriting and signed on February 2, 2018. (RX1) On the incident report, she indicated the cause of injury as tripping over a cart. She also listed Richard Barragan as a witness to the incident. She had an opportunity to explain the cause of her injury to her supervisor Danny Gutierez before he completed Incident Report. With regard to Exhibit #9, Petitioner also placed an "X" on the spot where she fell. (T. 53)

Petitioner testified that she indicated on the UNUM Short-Term Disability Form her injury was the result of her falling from the top of a cart. (RX2) (T. 54)

Petitioner testified that since her injury she had spoken to Richard Barragan several times, including the morning of trial. The following is the text message exchange between petitioner and Richard Barragan from the morning of trial.

Ms. Santos - "They are trying to say we were horseplaying and that is how I got hurt."

Mr. Barragan - "I never said we horseplayed and you didn't either so as long as we keep it like that, you should be okay."

Ms. Santos - "I wonder what Rubin is going to say. He didn't see me get hurt."

Mr. Barragan - "He said he only know (sic) of when he came to pick you up from the ground."

Mr. Barragan - "Dude, they might not even call us depending on what you said."

Ms. Santos - "Lol, really."

Mr. Barragan - "Yup." (T. 72)

Henrietta Washington testified that she had been employed by Android Industries for 11 years; 8 of which she had been a Union representative. Ms. Washington testified that she had previously worked as an Assembler and was familiar with the tasks of the "tear down" station. She testified that while performing the tasks of tear down, it was sometimes necessary for an Assembler to stand on top of the metal cart that the engines rest on to take things off the top of the engine if they are too short to reach above. (T. 101) She stated that the employees would stand "maybe a foot" off the ground, and then "just step down off of it." (T. 102)

Ms. Washington identified on a photo of the cart the part of the cart she had earlier testified to seeing people jump or hop off. The Arbitrator stated she "is pointing to a part of the cart that has an orange oval around it which is not on the top of the cart ..." (T.110)

On cross examination, Ms. Washington clarified that she had never observed an employee standing on top of a cart, and that she had been referring to the orange skirting that covered the wheels and that was about 1 foot of the ground. She identified the orange skirting area in RX6. (T. 106) She was asked once more whether she has ever seen anyone standing on or jumping off the *top* of a cart and she answered "no." (T. 111)

Brian Brown testified that he had been employed with Android Industries for eight years as the Human Resource Manager. (T. 2-58) His responsibilities include everything from staffing the plant to payroll, safety, and workers' compensation matters. In regards to workers' compensation program, Mr. Brown testified that when an injury or illness is reported in the plant, as soon as he is notified about it he tries to make sure that the accident is fully investigated and he is responsible for following the case through closure. Mr. Brown also testified he took the photos contained in RX6-10, including the measurements observed in RX8.

Mr. Brown was notified on February 2, 2018 that petitioner was injured in a work-accident. He testified that RX1 was the First Report of Injury which was to be partially filled out by the injured employee. The remainder of the form was to be completed by the Shift Leader while speaking with the injured employee to learn exactly what happened and to get more details regarding the incident. (T. 2-60). He testified that RX1 was completed by

Danny Gutierrez, petitioner's team leader, who signed page two of the document.

Mr. Brown testified that following petitioner's injury the investigation included going out to the production floor where petitioner alleged the injury to have taken place to try to recreate how the incident occurred and learn how to avoid a repeated injury. During the course of the investigation Mr. Brown noticed a few "red flags" with how petitioner described the accident such as the location she initially stated she was in was not consistent with her description of getting her foot caught between two carts. Despite having three conversations with petitioner following the injury, she did not explain to Mr. Brown that she was injured after standing on top of a cart. (T. 2-66)

Petitioner's Exhibit 1 contained the records of OrthoIllinois. Mr. Brown testified that he completed the personnel meeting notes (RX3), also known as a disciplinary notice. He met with with petitioner along with the Union rep chair, Damarcas Griffin. He read the document to petitioner and all three parties involved in the meeting signed the document. Petitioner was disciplined as a result of the February 2, 2018 incident for a violation of Rule 3, Category 3—engaging in "horseplay". (RX3) Mr. Brown testified that information regarding the policy against horseplay is contained on the back of the contract of the collective bargaining agreement.

SUMMARY OF MEDICAL TREATMENT & PETITIONER'S OTHER EXHIBITS

Petitioner presented to Dr. Borchardt of OrthoIllinois on February 2, 2018 complaining of a right knee injury sustained earlier that morning. X-rays were negative for any acute fractures and petitioner was diagnosed with a possible knee sprain. Dr. Borchardt provided petitioner with a hinged knee brace and suggested a follow up. An MRI of petitioner's right knee was taken March 27, 2018 at OrthoIllinois and showed a complete ACL tear. Dr. Borchardt referred petitioner to Dr. Whitehurst for surgery. Dr. Whitehurst performed arthroscopic surgery to repair petitioner's ACL tear on May 17, 2018. At the time of hearing, petitioner was four or five weeks into physical therapy post-surgery. She stated that she had a follow up scheduled with Dr. Whitehurst in July but was unsure of the exact date. Petitioner's Exhibit 1.

Petitioner's Exhibit No. 2 consisted of a denial letter from UNUM Life Insurance Company of America denying petitioner's claim for group disability benefits.

Petitioner's Exhibit No. 3 was a March 14, 2018 letter from Phemy Lim at Gallagher Bassett Services, Inc. denying disability benefits for the alleged accident of February 2, 2018.

SUMMARY OF RESPONDENT'S EXHIBITS

Respondent's Exhibit No. 1 consisted of the five page First Report of Incident dated February 2, 2018. Petitioner acknowledged filling out in her own handwriting page one of the report and signing that report on February 2, 2018, the date of accident. In describing what led up to the incident, petitioner wrote: "I was talking to Richard. Noticed the carts about to move, so as I was walking away the cart caught my leg and I went down landing on my knee." At the time of the incident, petitioner wrote that she was "talking to Richard then getting out of way of cart." With regard to how the incident could have been prevented, she wrote: "Should have never been standing in the middle of two carts." The remainder of the form constitutes the shift manager's investigation generally restating what petitioner indicated on page one of the report.

Respondent's Exhibit No. 2 is the UNUM short term disability claim form prepared by petitioner and submitted to UNUM and dated April 4, 2018. That form signed by the petitioner in part indicates the injury occurred from getting down from the auto loader. Petitioner specified: "I was getting down off the auto loader, the cart took off, I lost my balance, I jumped off and landed on my knee."

Respondent's Exhibit No. 3 consisted of the March 1, 2018 personnel meeting notes, indicating that petitioner was disciplined for engaging in horseplay. Respondent's Exhibit No. 4 was the February 2, 2018 consultation note prepared by Dr. Borchardt from Rockford Orthopedic Riverside. The history of incident contained within the medical record is: "Patient states that she twisted the knee when she tripped over a cart." Under the treatment section, it was also indicated: "The patient states while walking, she twisted her right knee when she tripped over a cart."

Respondent's Exhibit No. 5 consisted of a video of the incident comprising of approximately one and a half minutes of video from 8:44:01 to 8:45:25 on February 2, 2018. Both Jasmine Santos and Richard Barragan agreed the video portrays the incident in question. The video appears to be one second interval photos of the auto loader platform. Witness Richard Barragan is seen on the auto loader platform leaning against a rail. There is no audio with the video, but it appears he may have been talking with a coworker on the plant floor. The auto loader platform is approximately two feet or more off the floor of the plant. At 8:44:35, petitioner approaches and steps up onto the platform. She is wearing a red sweatshirt and dark or black pants. From the testimony at trial with regard to the location of the steps up to the platform, it is apparent that Ms. Santos did not use the steps to get up on the platform. After a short discussion with Mr. Barragan, claimant steps off the platform onto a cart. At approximately 8:44:57/58, the petitioner is observed falling off the cart. At no time did Mr. Barragan turn his back on the petitioner, and it appears that he saw the entire event. At 8:44:10/11, Mr. Barragan gets down off the platform, walking in the direction claimant fell, presumably to assist her or check on her. The video ends at 8:44:25.

Respondent's Exhibits 6 through 10 are photographs of the auto loader station, cart top, measured height of the cart top, open carts, and area petitioner originally identified as location of the fall. All photos were taken by witness Brian Brown.

CONCLUSIONS OF LAW

On the disputed issue C, whether an accident occurred that arose out of and in the course of petitioner's employment by respondent, the Arbitrator finds as follows:

It is axiomatic that the petitioner bears the burden of proving all elements of the claim. Among those are whether the injury arose out of and in the course of petitioner's employment by respondent. In this case, petitioner stepped onto a cart that is intended to hold an engine block and contains tooling on the top of the cart upon which she stood, petitioner knew that those carts moved along the assembly line and petitioner fell when she lost her balance attempting to jump off the moving cart. Petitioner stepped onto the cart from the auto loader platform and based on the credible testimony, it is apparent petitioner had no business purpose in being on the auto loader platform or the top of the cart at the time of injury. This was an inherently dangerous risk and had nothing to do with her assigned duties of tear down on the date of injury. Evidence established that she never worked on the auto loader platform during the course of her employment by respondent. Petitioner assumed a personal and inherently dangerous risk unrelated to her employment duties.

In the Supreme Court case of Orsini v. Industrial Commission, 117 Ill.2d 38, 509 N.E.2d 1005 (1987), benefits were denied when an auto mechanic suffered an injury while working on his own personal automobile during the regular hours of his employment and with the knowledge of the employer. While adjusting a carburetor, the car suddenly lurched forward injuring the claimant's legs. The Court noted that an injury arising out of one's employment may be defined as one which has its origin in some risk so connected with, or incidental to, the employment as to create a causal connection between the employment and the injury. The risk must be peculiar to the work or a risk to which the employee is exposed to a greater degree than the general public by

reason of employment. An injury is not compensable if it results from a personal risk to the employee rather than a risk incidental to employment. Even acquiescence to the task being performed by the employee is insufficient to bring that task within the arising out of context. The Supreme Court specifically noted as follows: "Employer acquiescence alone cannot convert personal risk into an employment risk. [citation deleted]. A similar result was upheld in Hatfill v. Industrial Commission, 202 Ill.App.3d 547, 560 N.E.2d 369 (1990) when an employee jumped over an accumulation of water at the base of an incline on his way to his car in the respondent's parking lot and suffered injury. In affirming the Commission's denial of benefits, the Court noted that the Commission could have inferred the claimant's injuries resulted from a personal risk assumed by the claimant. Claimant was engaged in an activity which only benefitted himself and not his employer. This line of reasoning was further confirmed in Dodson v. Industrial Commission, 308 Ill.App.3d 572, 720 N.E.2d 275 (1999) when a waitress and cocktail server leaving work walked across a slippery, sloping grassy path, slipped and caused injury to her ankle. The Court noted an injury arises out of employment where its origin stems from a risk connected with or incidental to employment or is caused by some risk to which the employee is exposed to a greater degree than the general public by virtue of the employment. (citing Orsini, supra.) The Court further noted that under either approach, an injury does not arise out of the employment where an employee voluntarily exposes himself or herself to an unnecessary personal danger solely for his own convenience. (citing Orsini, supra.) It was further noted by the Court that the fact that some people may choose to leave the workplace in an unsafe manner did not make such voluntary act compensable, nor was respondent required to police exits routes to prevent all unsafe voluntary acts.

In the instant case, witness Fred Swain provided testimony that petitioner had no business purpose on the auto loader platform. Both Mr. Swain and Richard Barragan verified that Mr. Barragan was the only operator on the auto loader platform that day. Mr. Barragan did not need anything on the platform to do his job. Mr. Barragan testified that petitioner brought some bridles to him, while petitioner testified that she went on the auto loader platform to get bridles. She also admitted that she could have gotten the bridle from other stations not far away from her tear down station. Petitioner's conduct was an unexpected and unnecessary deviation from her assigned duties of tear down. Furthermore, the video evidence offered by respondent (RX 5) clearly shows no work-related activity performed by the petitioner on the auto loader platform when she apparently went up on that platform to chat with Mr. Barragan. Specifically, the petitioner neither brought bridles to Mr. Barragan nor did the petitioner retrieve any bridles from the auto loader platform. The Arbitrator notes that the petitioner had a safer way to enter and exit the auto loader platform in the form of the stairs, but the petitioner chose not to use the stairs.

Witness Ruben Alonzo, who worked as a team leader in Zone 4, the area in which this incident occurred, testified that he had never seen an employee stand or ride on top of a cart. Henrietta Washington, called in petitioner's case in chief, contradicted petitioner's testimony about stepping or riding on top of the cart. Ms. Washington testified that in her many years of employment for Android Industries, she had never seen anyone on top of the cart.

Both witnesses, Fred Swain and Richard Barragan, testified that no tear down of a bad engine was performed on the auto loader platform. Petitioner was not assigned to work on the auto loader platform. Furthermore, the auto loader platform can be accessed by steps, which petitioner chose not to use in getting up onto the auto loader platform or getting off the auto loader platform. Witness Fred Swain testified that all tear down activity that would have been performed by petitioner takes place at floor level and not the raised level of the auto loader platform.

The Arbitrator specifically finds that neither Jasmine Santos nor Richard Barragan were credible witnesses, for a variety of reasons. Petitioner admitted at the start of her testimony that she did not correctly describe to the employer how she actually fell on the date of injury. Petitioner in her own handwriting filled out a First Report of Injury indicating that she tripped over a cart. Petitioner acknowledged that she participated in an investigation of the incident and never told the team of investigators how the accident actually happened.

According to witness Brian Brown, this deception was repeated in three different conversations after the alleged injury. Petitioner finally admitted to the Union representative how she claims the incident happened, but never told anyone in a supervisory capacity, in management or in HR, this version of how the incident happened. The progress notes of Dr. Robin Borchardt dated February 2, 2018 contain an inaccurate history of alleged injury, confirming that petitioner held to this deception even when she saw a treating physician. It was not until she filled out a UNUM short term disability claim form on April 4, 2018 that she changed her story and acknowledged her new version of how the incident actually happened.

Petitioner's sworn testimony regarding her second version of how the incident happened is contradicted in key parts by the video offered by respondent. This video depicts the approximate one and a half crucial minutes showing petitioner stepping up onto the auto loader platform, conversing with Mr. Richard Barragan, getting onto the top of the cart, and then falling off the top of the cart onto the shop floor. The video contradicts petitioner's initial history given to Danny Gutierrez as recorded in the First Report of Injury, RX 1 and signed by the petitioner. The video contradicts the petitioner's sworn testimony that she went to pick up a bridle when she climbed on to the auto loader platform. Petitioner also testified there was no physical contact between herself and Richard Barragan, although that is contradicted by the video when Mr. Barragan makes physical contact with the petitioner. Petitioner stated that Mr. Barragan was getting ready to pick up an engine to put on the auto loader platform but none is observed in the video. The video demonstrates that petitioner carefully stood on top of the cart and did not just use it to jump down to the shop floor.

The video contradicts Mr. Richard Barragan sworn testimony on several key points. Mr. Barragan testified the petitioner approached him to bring bridles up to his station; however, the video shows nothing in petitioner's hands, which Barragan later acknowledged after reviewing the video. Mr. Barragan testified he did not witness the fall, having turned his back to place an engine on the auto loader. Nothing of that sort is depicted on the video and it is clear that he was facing the petitioner at all times. Mr. Barragan also denied any physical contact, yet the video reveals physical contact.

In addition, the Arbitrator notes that petitioner and Barragan communicated via text messages before trial on the morning of trial in an apparent effort to coordinate their testimony. Ms. Santos texted to Mr. Barragan, "They are trying to say we were horse playing and that is how I got hurt." Mr. Barragan texted back, "I never said we horse played and you didn't either so long as we keep it like that, we should be okay." The Arbitrator also noted that while Mr. Barragan was present at trial pursuant to a subpoena served upon him by respondent, he was initially called to testify in petitioner's case in chief. The Arbitrator finds that neither Jasmine Santos nor Richard Barragan were credible witnesses at trial and therefore the Arbitrator views all testimony presented by them to be extremely suspicious.

Finally, although respondent disciplined petitioner for horseplay in a written Personnel Meeting Note dated March 1, 2018, the Arbitrator concludes this incident went far beyond horseplay into the realm of personal risk and that petitioner is not an innocent victim of horseplay by another employee. All witnesses understood that carts move around the assembly line as a routine part of the assembly process. Petitioner testified she knew that Richard Barragan controlled the movement of the carts at his station, the auto loader platform. Mr. Barragan assisted Ms. Santos onto the top of the cart as clearly depicted in the video, and by her own testimony, petitioner knew that cart would ultimately move. She may not have anticipated falling from that cart when it moved, but she clearly would have known there was risk inherent in standing on the top of the cart at the time of the incident. This may be the reason petitioner failed to accurately report the manner in which the incident occurred.

The Arbitrator notes petitioner's attorney claim that petitioner is the innocent victim of horseplay committed by Mr. Barragan. In response to this argument, the Arbitrator notes that the petitioner went to the auto loader platform of her own volition and not for any purpose to further the interests of the respondent. The

petitioner chose to enter and exit the auto loader platform by climbing onto and subsequently jumping off a cart designed to carry engines through the facility as opposed to utilizing the stairs right next to the auto loader platform. The Arbitrator also finds that under these circumstances the petitioner was clearly not an innocent victim of horseplay but rather a willing participant in it.

Based on all the above, the Arbitrator finds that the petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment on February 2, 2018. The Arbitrator further finds that the petitioner's injuries arose out of a personal and inherently dangerous risk that had absolutely nothing to do with petitioner's assigned duties and that petitioner was not engaged in any activities to benefit the respondent's interests at the time of her injury. Accordingly, all benefits are denied.

On the disputed issue F, whether petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds this issue moot based on the finding of no accident.

On the disputed issue J, whether respondent has paid for reasonable and necessary medical services, the Arbitrator finds this issue moot based on the finding of no accident.

On the disputed issue K, whether the petitioner is entitled to prospective medical care, the Arbitrator finds this issue moot based on the find of no accident.

On the disputed issue M, whether petitioner is entitled to TTD benefits, the Arbitrator finds this issue moot based on the finding of no 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Eduardo Bustos,
Petitioner,

vs. No. 14 WC 31505

Ed Miniat, Inc.,
Respondent.

20IWCC0164

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 Partial Disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner, a 33-year-old meat packer, testified that on July 8, 2014, he was performing his duties which, in addition to meat packing, included assembling machines. In the course of assembling a machine on that day, Petitioner unpacked and lifted a 15 lb. roller. Upon doing so, he felt immediate pain in his right wrist.

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Petitioner informed his supervisor, Florentino, that he was experiencing pain and a burning sensation in his hand; he was sent to Ingalls Occupational Health. There, after being examined and x-rayed, Petitioner learned that his wrist had been fractured. He was also informed his x-rays revealed a pre-existing scaphoid bone fracture and non-union with avascular necrosis. Prior to that time, Petitioner's wrist had been asymptomatic and he had not been aware of those pre-existing conditions. He had never had problems with his right wrist prior to July 8, 2014, nor seen a doctor for right wrist problems.

Petitioner came under the care of Dr. Mark Gonzalez, who on August 21, 2014, performed surgery: a scaphoid non-union excision and a 4-corner fusion. Thereafter, Petitioner performed occupational therapy, but had difficulty attaining his prior level of right hand function.

Respondent's Section 12 expert, Bryan Neal, examined Petitioner on February 17, 2015, and opined that Petitioner's pre-existing condition had been "significantly worsened" by his July 8, 2014 work injury, and that consequently, his current condition was causally related. Dr. Neal opined that Petitioner's treatment, including his surgery, had been reasonable, necessary and causally related to his accident. He further opined that because Petitioner's August 2014 surgery was unsuccessful, Petitioner would need further treatment and another possible surgery. In follow-up reports dated May 21, 2015 and September 8, 2015, Dr. Neal opined that a bony fusion had not occurred in Petitioner's wrist, and that he would require a 20-lb. work restriction.

At arbitration, Petitioner testified that he is working at a job in which his permanent restrictions are being accommodated. He continues to experience pain, but at this time he has chosen to live with the pain, rather than undergo the surgery which had been recommended.

The Commission affirms the Arbitrator's finding that Petitioner proved an accident arising out of and in the course of his employment on July 8, 2014. Records from Ingalls Occupational Health dated July 8, 2014 document Petitioner's history of moving a cylindrical meat cutting machine part when he felt wrist pain, and corroborate Petitioner's testimony. Respondent offered no witness testimony to contradict Petitioner's described work duties or his mechanism of injury. Although the Ingalls records contain a note which reported that two weeks before his work accident Petitioner had complained of some right wrist soreness, that alone does not disprove that Petitioner suffered an injury on July 8, 2014.

Dr. Neal opined that Petitioner's accident significantly worsened his pre-existing right wrist scaphoid nonunion with avascular necrosis. He further opined that Petitioner's work accident of July 8, 2014 caused a, "permanent worsening of his pre-existing condition." The Commission finds this evidence, from Respondent's own expert, sufficient to establish a causal connection between Petitioner's July 8, 2014 lifting incident and his current condition of ill-being.

20IWCC0164

While the Commission affirms the Arbitrator's award of medical expenses related to Petitioner's right wrist and hand, it finds that some of the bills offered into evidence were not for treatment of Petitioner's right wrist and hand. On July 30, 2014, Petitioner saw Dr. Banas for complaints of abdominal pain and a rash on his face. The Commission finds those conditions unrelated, and reverses the Arbitrator's award of $67.44 for that office visit. The Commission further finds Petitioner did not prove that all of the prescription expenses he submitted were for treatment to his wrist and hand. There was no evidence presented which proved a causal connection for these medications: clonidine (a hypertension drug); pantoprazole (prescribed for gastroesophageal reflux disease), and gabapentin and Paxil (anti-depressants). The Commission reverses the award of medical expenses for these specific medications. The Commission affirms the award of payment of all other prescription expenses submitted into evidence.

Respondent has argued that some of the medical bills in Petitioner's Exhibits #8 and #10 are duplicates of each other. The Commission has reviewed the bills in each of those exhibits, and disagrees; none of the bills in those two exhibits are duplicate charges.

Finally, with regard to the Arbitrator's award of 35-6/7 weeks of temporary total disability for the period July 8, 2014 through March 15, 2015, the Commission modifies that award down by one day, to 35-5/7 weeks, for the period between July 9, 2014 through March 15, 2015. Section 8(b) of the Act provides that TTD benefits shall commence on the day *after* the accident.

All other parts of the Arbitrator's decision, including the PPD award of 50% loss of use of the right hand as provided in Section 8(e)9 of the Act, are affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 15, 2018, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical expenses is modified. The award of $67.44 for Petitioner's July 30, 2014 office visit with Dr. Banas is reversed. In addition, the award of medical expenses for the following prescription medications is reversed, as they have not been proven causally related to treatment of Petitioner's right wrist and hand: clonidine, pantoprazole, gabapentin and Paxil. The award of all other prescription expenses awarded by the Arbitrator is affirmed.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary total disability benefits is modified, and that Respondent pay Petitioner the sum of $422.40 per week for 35-5/7 weeks, commencing July 9, 2014 through March 15, 2015, as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $380.16 per week for a period of 102.5 weeks, as provided in §8(e)9 of the Act, for the reason that the injury caused the 50% percent loss of use of the right hand.

20IWCC0164

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

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

Bond for 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 9 - 2020

o-01/23/20
mp/mcp
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Marc Parker

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUSTOS, EDUARDO
Employee/Petitioner

Case# **14WC031505**

ED MINIAT INC
Employer/Respondent

20IWCC0164

On 5/15/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2553 LAW OFFICE OF McHARGUE & JONES
BRENTON M SCHMITZ
123 W MADISON ST SUITE 1800
CHICAGO, IL 60602

0075 POWER & CRONIN LTD
ELENA CINCIONE
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

Eduardo Bustos,
Employee/Petitioner

v.

Ed Miniat, Inc.,
Employer/Respondent

Case # **14** WC **31505**

Consolidated cases:

20 IWCC0164

An *Application for Adjustment 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 M. Harris**, Arbitrator of the Commission, in the city of **Chicago**, on **April 20, 2018.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 8, 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 **$n/a**; the average weekly wage was **$633.60**.

On the date of accident, Petitioner was **33** years of age, ***married*** with 4 dependent children.

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$15,146.00** 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:

Accident: Petitioner has proven he sustained accidental injuries arising out of and in the course of his employment for Respondent on July 8, 2014.

Causal Connection: Petitioner has proven a causal connection exists between his current condition of ill-being and the accidental injuries sustained on July 8, 2014.

Temporary Total Disability:

Respondent shall pay Petitioner temporary total disability benefits of $422.40/week for 35-6/7 weeks, commencing July 8, 2014 through March 15, 2015, as provided in Section 8(b) of the Act

Medical Benefits:

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of Ingalls Occ. Health, $470.00, Union Medical Center, $202.32, University of Illinois Hospital, $37,205.21, Illinois Orthopedic Network, $9,158.56, Injured Workers' Pharmacy, $998.74, Midwest Specialty Pharmacy, $50.61, Metro Health Solutions, $10,040.04, University of Illinois Orthopedics, $3,665.00, Dr. George Kuritza, $1,250.00, as provided in Sections 8(a) and 8.2 of the Act.

Permanent Partial Disability:

Respondent shall pay Petitioner permanent partial disability benefits of $380.16/week for a period of 102.5 weeks, because the injuries sustained caused the **50%** loss of use of the right hand, as provided in Section 8(e)9 of the Act.

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

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

Robert M. Harris

Signature of Arbitrator

May 14, 2018
Date

MAY 15 2018

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE WORKERS' COMPENSATION COMMISSION
IN THE STATE OF ILLINOIS

EDUARDO BUSTOS,)
Petitioner,)
) Case: 14 WC 31505
vs.)
)
ED MINIAT, Inc.,)
Respondent.) 20IWCC0164

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that on July 8, 2014, he was employed Respondent Ed Miniat, Inc. Petitioner has been employed there as of April 2018 for seven years. Respondent is a meat packing company. In July 2014, Petitioner was employed as a laborer, working on a line, packing meat. Petitioner is right-hand dominant.

On July 8, 2014, Petitioner testified he arrived at work at approximately 5:15am. As part of starting work, Petitioner had to assemble a machine with rollers. The rollers weigh between 12 and 15 pounds each. As Petitioner was lifting-picking up a roller with both hands, he felt an immediate onset of pulling and burning in his right wrist. Petitioner stopped and notified his supervisor of the incident and was sent to another area to do other work sealing boxes. Petitioner began doing this, but shortly thereafter, advised his supervisor that the pain in his wrist was too great and he could not continue. Petitioner was sent to Ingalls Occupational Health. PX1.

Petitioner was examined at Ingalls by Dr. Daniel Bakston at approximately 9:47 am. PX1. Dr. Bakston's history noted a sharp severe right wrist pain that began while "moving a cylidrical (sic) meat cutting machine part with both hands." PX1. X-rays indicated a remote right wrist scaphoid fracture with possible avascular necrosis. Petitioner was placed in a thumb spica cast, given naproxen, and advised to follow up with his primary care physician. Light duty restrictions were imposed.

On instructions from Dr. Bakston, Petitioner sought care later that afternoon at Union Medical Center. PX2. Dr. Stanislaw Banas referred Petitioner to the orthopedic surgery department at the University of Illinois at Chicago Medical Center. PX2. Petitioner was initially seen on July 16, 2014 at the University by Dr. Mark Gonzalez. PX3 at 33. Dr. Gonzalez noted a consistent history of one week of right wrist pain since lifting a 25# object. Id. Dr. Gonzalez noted an old right scaphoid fracture on x-ray. Id. Dr. Gonzalez recommended a CT of the right wrist, and returned Petitioner to work with 10# lifting restrictions. Id. at 39. On August 13, 2014, Dr. Gonzalez reviewed the CT scan, which indicated nonunion of the scaphoid at the wrist with osteonecrosis and fragmentation of the proximal pole. Id. at 32. Dr. Gonzalez recommended surgery, namely a right wrist scaphoid excision and four-corner fusion. Id. This procedure was completed on August 21, 2014. Id. at 21-23.

Petitioner followed up with Dr. Gonzalez multiple times in September and October 2014. PX3. On September 18, 2014, Petitioner sought a second opinion with Dr. Irvin Wiesman at the Illinois Orthopedic Network. PX4 at 97. Dr. Wiesman took another consistent history and noted the surgery "appears to have been well done." Id. Dr. Wiesman recommended occupational therapy to help with fingertip swelling and finger motion. Id. Dr. Wiesman suggested that Petitioner remain in his cast for another three weeks. Id. On November 3, 2014, Dr. Wiesman placed Petitioner in a splint, and recommended continued occupational therapy. Id. at 94. On December 10, 2014, Dr. Wiesman discontinued the splint and recommended formal physical therapy. Id. at 91. As of February 17, 2015, Petitioner was at 1/10 pain with good range of motion, and Dr. Wiesman recommended a Functional Capacity Exam followed by discharge from care. Id. at 85.

On February 12, 2015, Petitioner was seen for the first time for an examination by Dr. M. Bryan Neal at Respondent's request pursuant to Section 12 of the Act. RX2. Dr. Neal reviewed records dating back to 2011. RX2. Dr. Neal opined that prior to his accident, Petitioner had a pre-existing scaphoid wrist fracture sometime in the "distant past" and "most likely a number of years ago" and "remote." RX 2, pp. 10, 11. While Petitioner could not recall a prior wrist injury and so testified at trial, Dr. Neal stated that:

> "[T]his is not too uncommon with this specific injury and most likely was a number of years ago. Frequently, someone has a wrist sprain which they attribute to a sprain, do not seek treatment, and the scaphoid nonunion can be asymptomatic for a prolonged period of time." Id.

Dr. Neal opined causal connection: "It is my opinion the work event of July 8, 2014, significantly

worsened his preexisting (and apparently asymptomatic) right wrist scaphoid nonunion with avascular necrosis. I do find that since there was a permanent worsening of his pre-existing condition that work activities/events of July 8, 2014, aggravated his right wrist condition." RX2, p. 11. Dr. Neal repeated his causation opinion, stating, "...I therefore find that work activity of July 8, 2014, significantly worsened (aggravated) his preexisting asymptomatic right wrist condition." RX2, p. 12. Petitioner's pre-existing condition was permanently worsened by the work accident of July 8, 2014, thus necessitating the "appropriate treatment" of the surgical intervention (scaphoid excision and four-corner fusion). RX2, p. 12. Dr. Neal opined treatment to date had been reasonable and necessary, and that Petitioner would possibly need a CT scan of the wrist to confirm a solid fusion. RX2. Dr. Neal further commented that after the surgery that was performed, "One inevitably loses range of motion with this surgery." RX2, p.10.

Following the Section 12 examination on February 12, 2015, Petitioner again met with Dr. Wiesman. PX 4 at 70. The FCE had not been completed yet. Id. Petitioner told Dr. Wiesman that his work would not accept light duty and Petitioner was willing to attempt to return to work without restrictions. Id. Dr. Wiesman assented and advised Petitioner he could return and be given permanent work restrictions if he could not tolerate working full duty. Id. Petitioner returned to work, and has been working since this date through the date of trial, but testified he has continued to have pain and difficulty at work. Id. at 63. Dr. Wiesman issued light duty restrictions, which were accommodated, and an FCE was completed on May 28, 2015. Id. at 45. Petitioner's FCE was deemed to be valid and it placed him at the light physical demand level. Id.

On May 18, 2015, Dr. Neal, Respondent's Section 12 examiner, again examined Petitioner at Respondent's request. RX3. Petitioner advised Dr. Neal regarding his current status and his symptoms. The physical examination indicated, "residual right wrist pain and stiffness, greater than expected, status post right wrist scaphoid excision and four-corner arthrodesis; right ulnar neuropathy (cubital tunnel syndrome) with examinee assigned April 2015 onset." (Dr. Neal did not find that the cubital tunnel was causally related to the work accident). Dr. Neal reviewed additional records an MRI from April 6, 2015 and was not able to "...judge definitively about the quality of the potential arthrodesis site from these studies." RX 3, p. 6. Dr. Neal took digital radiographs during this office visit but was unable to "...appreciate definitive fusion at the other arthrodesis sites." RX3, p. 6.

Accordingly, Dr. Neal again recommended "first treatment" of a CT scan to confirm a solid

fusion, followed by a possible radiocarpal joint injection and possible further surgery. RX3, p. 7. Finally, Dr. Neal opined that work restrictions at this point are reasonable and to continue with a 20-pound lifting limit with his right hand. RX3, p. 8.

A FCE was performed on May 28, 2015. PX4, pp. 45-60. This GCE was considered valid. The FCE results indicated Petitioner demonstrated only light physical demand level capabilities, falling far short of the requirements of his heavy physical demand level job.

Based on Dr. Neal's second report, Dr. Wiesman ordered a CT scan of the wrist. PX4 at 33. On August 4, 2015, Dr. Wiesman reviewed the CT and indicated that he felt there was a fusion, though corticated pieces of the scaphoid remained within the wrist. Id. at 25. Dr. Wiesman opined that Petitioner did not need further surgery or a wrist fusion now, though he further opined this may be required in the future. Id.

Respondent's examiner Dr. Neal issued an addendum report dated September 8, 2015 after he reviewed the CT images. RX4. Dr. Neal disagreed with Dr. Wiesman; Dr. Neal opined he was unable to conclude that the four-corner fusion was successfully fused. RX4, pp.1-3. Dr. Neal opined regarding the CT report that "One cannot interpret the CT scan report that definitive bony fusion has occurred." Dr. Neal reviewed the actual CT wrist imaging studies. RX3, p. 2. Based on his review of these studies, Dr. Neal opined, "In summary, I do not observe or conclude definitive 4 corner arthrodesis (fusion) has actually occurred even though there was an attempt to fuse these four bones." RX3, p. 2.

Dr. Neal then opined regarding his diagnosis, which he revised after reviewing the CT studies: "Probable right wrist failed arthrodesis status post attempted 4 corner arthrodesis and scaphoid excision." RX3, p. 3. Dr. Neal opined that if and when a definitive conclusion has been reached regarding whether a complete fusion has occurred, the possibility is then raised that a repeat fusion procedure or an additional reconstructive procedure is indicated, as may be necessary, "a very difficult decision for which it principally depends upon the severity of Petitioner's symptoms. RX3, p. 4.

Dr. Neal lastly opined that Petitioner may continue working within his same previous restrictions. If Petitioner declines future procedures, then he is at MMI. RX3, p. 5. Ultimately, Petitioner declined any future surgery.

A subsequent FCE was performed on October 29, 2015. PX54, pp.11-18. This FCE was also considered valid. The FCE results indicated Petitioner was capable of performing in the medium physical demand level, meaning that his capabilities appeared to fall far below the required job demands. PX4, p.

Petitioner was discharged from Dr. Weisman's care on November 23, 2015 with permanent restrictions pursuant to that FCE (at the medium physical demand level, and Dr. Weisman understood Petitioner's job to be at the "heavy physical demand level.") PX4, p. 9. Petitioner has continued working with these permanent restrictions and is still working for Respondent as of the trial date. Dr. Wiesman again opined that future surgery may be required, indicating that Petitioner's condition "could continue to worsen", all in agreement with Dr. Neal. PX4, p. 9.

Petitioner returned to Dr. Wiesman on January 6, 2017 to discuss further surgery. PX4, p. 7. After discussion, Petitioner elected to return to work and consider the possibility of further surgery. Id.

On February 3, 2017, Petitioner saw Dr. Weisman's PA. PX3, p. 3. Petitioner had decided not to have the surgery, though Dr. Wiesman again opined that a "salvage procedure" would be needed at some point in the future. Id. at 3. These records further indicate that in addition to the restrictions from the FCE, the record indicates, "No repetitive use of the right arm extremity." Id.

Petitioner again returned to Dr. Wiesman's PA on July 25, 2017, in "pretty severe pain." PX 1, p. 1. There was a "pretty high clinical suspicion for a TFC complex injury based on his symptomatology." The "gold standard" of arthroscopic surgery was discussed surgery and Petitioner elected to proceed, though Petitioner would ultimately change his mind before undergoing surgical intervention. Id. at 1. Petitioner has not been to Dr. Wiesman's office again since July 25, 2017.

At trial, Petitioner testified he was scared of undergoing further surgery, based on his poor recovery from the initial operation with Dr. Gonzalez. Petitioner testified he is able to work within his restrictions, though he has difficulty with repetitive work at speed. At home, he has difficulty working out and playing with his children. Petitioner experiences depression on occasion.

CONCLUSIONS OF LAW

(C) DID AN ACCIDENT OCCUR ARISING OUT OF AN IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT ON JULY 8, 2014?

After carefully reviewing the entire record, including considering Petitioner's testimony and the treatment records, the Arbitrator finds and concludes that Petitioner has met his burden of proof that he sustained an accident arising out of and in the course of his employment with Respondent on July 8, 2014. The Arbitrator finds and concludes that Petitioner was a credible witness. Petitioner's testimony

was unrebutted and was corroborated by credible evidence in the trial record.

Petitioner testified that on July 8, 2014, he suffered a sudden onset of right wrist pain while lifting rollers to assemble a machine at work. This was unrebutted testimony. Respondent presented no evidence to contradict or rebut Petitioner's credible testimony that he was injured and felt pain while working for Respondent. The treating medical records, as well as numerous statements found within Respondent's own Section 12 reports with Dr. Neal's opinions, contain histories consistent with and corroborate Petitioner's testimony at trial regarding an accident sustained while working.

In order to recover under the Act, Petitioner must prove that the occurrence giving rise to the injury arose out of and in the course of his employment with Respondent. "In the course of" refers to the time, place, and circumstances of the accident. There is no dispute that at the time of injury, Petitioner was at work lifting rollers to assemble a machine for his employer. Thus, the injury occurred in the course of employment.

In order to prove "arising out of" Petitioner must show that the origin of his injury is in a risk connected with or incidental to the employment. In this case, the employee was exposed to the risk of lifting rollers, which is a risk distinctly associated with the employment.

The "arising out of" component of accident also encompasses analysis of preexisting conditions. 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,* 6 Ill.2d 296, 128 N.E.2d 718, 720 (1955). The record as a whole sufficiently demonstrates Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent on July 8, 2014.

The record also indicates that Petitioner had a pre-existing - but asymptomatic - condition of ill-being in his right wrist prior to the accident date. The radiological studies and CT scans make clear that at some undetermined past time, Petitioner suffered a right wrist scaphoid fracture that never fully fused. However, the record is clear that Petitioner was able to work full duty with this condition for years without any issue. Respondent's expert examiner Dr. Neal acknowledged this. While Petitioner testified he had no recollection of a prior right wrist injury, Dr. Neal stated (in Petitioner's favor) that this was not uncommon with this type of injury. Dr. Neal had the specific opportunity to review years of Petitioner's primary care records and he found no complaints of right wrist problems.

The employer takes the employee as he or she comes. If a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Rock Road*

Construction Co. v. Industrial Commission, 37 Ill.2d 123, 227 N.E.2d 65, 67 – 68 (1967); *Illinois Valley Irrigation, Inc. v. Industrial Commission,* 66 Ill.2d 234, 362 N.E.2d 339, 5 Ill.Dec. 868 (1977).

It is well-established that an accident need not be the sole or primary cause—as long as employment is a cause—of a claimant's condition. Sisbro, Inc. v. Industrial Comm'n, 207 Ill. 2d 193, 205 (2003). Furthermore, an employer takes its employees as it finds them. St. Elizabeth's Hospital v. Illinois Workers' Compensation Comm'n, 371 Ill. App. 3d 882, 888 (2007). A claimant with a preexisting condition may recover where employment aggravates or accelerates that condition. Caterpillar Tractor Co. v. Industrial Comm'n, 92 Ill. 2d 30, 36 (1982). Where an accident accelerates the need for surgery, a claimant may recover under the Act. Caterpillar Tractor Co., 92 Ill. 2d at 36.

In this case, Respondent's Section 12 examiner, Dr. Neal, clearly opined that the incident of July 8, 2014 "significantly worsened his preexisting (and apparently asymptomatic) right wrist scaphoid nonunion with avascular necrosis." That opinion alone is sufficient for Petitioner to show that his pre-existing condition was "worsened" as a direct result of the accidental injury sustained and Respondent is therefore liable for the subsequent causally related and compensable consequences of Petitioner's condition of ill-being.

Therefore, the Arbitrator finds and concludes Petitioner sustained an aggravation of his pre-existing condition of ill-being in an accident arising out of and in the course of his employment with Respondent on July 8, 2014.

(F) IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

After carefully reviewing the entire record, including considering the Petitioner's testimony and the treatment records, the Arbitrator finds and concludes that Petitioner has met his burden of proof regarding the disputed issue of causation. The Arbitrator adopts his findings and conclusions as indicated in the Section on "Accident" noted above. The Arbitrator specifically relies on and adopts the opinions of the treating physicians, as well as especially the opinions of Respondent's Section 12 examiner, Dr. Neal, who opined causation.

As noted above, if a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Rock Road Construction Co. v. Industrial Commission,* 37 Ill.2d 123, 227 N.E.2d 65, 67 – 68 (1967); *Illinois Valley Irrigation, Inc. v. Industrial Commission,* 66 Ill.2d 234, 362 N.E.2d 339, 5 Ill.Dec. 868 (1977). Dr. Neal opined that Petitioner's pre-existing condition was "significantly worsened" by the work event of July 8, 2014. RX2. Dr. Neal

opined that based on Petitioner's statements as well as years of prior medical records, Petitioner was asymptomatic prior to the work accident, and was significantly symptomatic after the accident, necessitating surgical intervention. Dr. Neal's opinions alone are sufficient for Petitioner to show that his pre-existing condition was "worsened" as a direct result of the accidental injury sustained and Respondent is therefore liable for the subsequent causally related and compensable consequences of Petitioner's condition of ill-being.

Therefore, the Arbitrator finds and concludes that Petitioner's compensable injuries, namely a right wrist scaphoid fracture with avascular necrosis, were aggravated and worsened by the work accident of July 8, 2014, and therefore, Petitioner's compensable injuries are 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?

Having found for Petitioner regarding the disputed issues of accident and causal connection, the Arbitrator further finds for Petitioner on the issue of medical care. Respondent's Section 12 examiner Dr. Neal issued three reports, on February 17, 2015, May 21, 2015, and September 8, 2015. In the first report, Dr. Neal opined that treatment to date had been reasonable and necessary. Dr. Neal did not discuss the issue of past medical in his second report or third report, but in those reports, he recommended future medical care, which medical care was undertaken, namely diagnostic scans and joint injection. Dr. Neal also recommended future care in the form of a possible revision surgery, which was not undertaken by Petitioner's choice.

The Arbitrator further relies on the opinions of the treating physicians (who ordered treatment, performed the fusion surgery and clearly felt it reasonable and necessary) as well as the opinions of Dr. Neal, and awards all unpaid medical bills submitted by Petitioner at trial. as **found in Petitioner's Exhibits 1 through 11.** Bills shall be paid at the lesser of Illinois Workers' Compensation Fee Schedule Section 8.2 of the Act or any applicable negotiated rate pursuant to the Act.

(K) WHAT TEMPORARY BENEFITS ARE IN DISPUTE (TTD)?

The parties stipulated that, if accident and causal connection were found, Petitioner would be entitled to TTD benefits at a weekly rate of $422.40 from July 8, 2014 through March 15, 2015, a period of **35-6/7 weeks.** The Arbitrator finds that the evidence in record corroborates the stipulation of the parties. Therefore, Having found for Petitioner on the issues of accident and causal connection, the Arbitrator awards temporary total disability for the period of July 8, 2014 through March 15, 2015, a

period of **35-6/7 weeks.** Further, based upon the parties' further stipulation in the Request for Hearing form admitted into evidence as **Arb. Ex. No. 1,** the Arbitrator finds that Respondent has already paid its full TTD liability as awarded herein and shall receive credit for that full amount.

(L) WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Sec. 8.1b of the Act controls the issue of the determination of permanent partial disability.

Section 81b states as follows:

For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:

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

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.
(Source: P.A. 97-18, eff. 6-28-11.)

Petitioner underwent a right wrist four-corner fusion on August 21, 2014. Petitioner underwent significant physical therapy. Dr. Neal opined that Petitioner should continue working with a 20-pound lifting limit with his right hand/wrist. RX3, p. 8; RX 4,p. 5. Treating physician Dr. Wiesman discharged Petitioner from care pursuant to the second Functional Capacity Exam and he placed lifting restrictions of 60 pounds overall, with 26 pounds overhead and 32 pounds to chest, and no repetitive use of the right upper extremity. Petitioner has been working within these restrictions since March 2015. At trial, Petitioner testified that he has difficulty with repetitive work at speed. At home, Petitioner has difficulty working out and playing with his kids. Petitioner experiences depression on occasion.

The Arbitrator assigned weight to the requisite factors in §8.1(b) as follows:

(i) An AMA rating was not submitted into evidence. Therefore, the Arbitrator assigns no weight to this factor.

(ii) Petitioner is a laborer working in a meat packing business. This is considered a **heavy** position. Petitioner's injuries (and restrictions) will negatively affect his ability to maintain continuing future employment working in this type of hard work. The arbitrator assigns moderate weight to this factor.

(iii) At the time of the injury the Petitioner was 33 years old, and therefore the Petitioner has a relatively long work-life expectancy. The Arbitrator assigns moderate weight to this factor.

(iv) The Petitioner has not alleged, nor is there any evidence to indicate, any decrease in future earning capacity as a result of this injury. There was no testimony or evidence that he is not or will not be eligible for promotions or wage increases that he otherwise would have been eligible for absent this injury. Petitioner confirmed that he currently is working with the same employer earning the same wages as prior to the injury. The arbitrator assigns minimal weight to this factor.

(v) Petitioner has residual symptoms and restrictions due to his injury and failed surgery. Petitioner was discharged from care with permanent restrictions, both from his treating physician Dr. Weisman and from Respondent's Section 12 examining expert Dr. Neal. The valid May 28, 2015 FCE indicates demonstrated only light physical demand level capabilities, falling far short of the requirements of his heavy physical demand level job. A subsequent FCE was performed on October 29, 2015. PX54, pp.11-18. This FCE was also considered valid. The FCE results indicated Petitioner was capable of performing in the medium physical demand level, meaning that his capabilities appeared to fall far below the required job demands. PX4, p. 11. Future surgery is still a potential reality. The medical records clearly corroborate evidence of permanent disability and significant restrictions and limitations. The Arbitrator assigns great (and most significant) weight to this factor.

In consideration of all the above and all the evidence in the record, the Arbitrator finds and concludes that Petitioner sustained the permanent partial loss of use/permanent partial disability of the right hand to the extent of **50%** thereof pursuant to Section 8(e) of the Act and orders Respondent to

pay Petitioner 102.5 weeks of disability at a weekly benefit rate of $380.16.

Robert M. Harris

Robert M. Harris, Arbitrator

May 15, 2018

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 Credit	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MIRANDA CHAUDHRY,

Petitioner,

vs.

NO: 17 WC 31643
17 WC 31839 (cons)

AMAZON,

Respondent.

20IWCC0165

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, prospective medical, temporary disability, penalties and fees, credit, and Petitioner's allegations of fraud/malfeasance, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator awarded Respondent a $2,545.71 credit under Section 8(j) for short term disability benefits. The Commission finds this was error.

Section 8(j) provides, "...amounts so paid to the employee from any such group plan...shall be credited to or against any compensation payment for temporary total incapacity for work or any medical, surgical or hospital benefits made or to be made under this Act." *820 ILCS 305/8(j)1*. Here, Petitioner's claim was denied and consequently no Section 8(a) or Section 8(b) benefits awarded; hence, there exists no "compensation payment for temporary total incapacity for work or any medical, surgical or hospital benefits made or to be made under this Act" against which the short term disability benefits can be credited. As such, the Commission vacates the award of Section 8(j) credit.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 4, 2018, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's claim for benefits is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of §8(j) credit is hereby vacated.

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission.

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

DATED:
MAR 10 2020
LEC/mck

O: 1/15/2020

43

L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

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

CHAUDRY, MIRANDA D
Employee/Petitioner

Case# **17WC031643**
17WC031839

AMAZON
Employer/Respondent

20IWCC0165

On 12/4/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.49% 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:

0000 MIRANDA D CHAUDRY
PO BOX 124
DYER, IN 46311

0560 WIEDNER & McAULIFFE LTD
TIMOTHY S McNALLY
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

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

Miranda D. Chaudhry
Employee/Petitioner

v.

Amazon
Employer/Respondent

Case # **17** WC **31643**

Consolidated cases: **17** WC **31839**

20IWCC0165

An *Application for Adjustment 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 **Ottawa**, on **August 20, 2018** and proofs were closed on **October 22, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of 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 28, 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 as explained *infra*.

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 $29,514.20; the average weekly wage was $560.00.

On the date of accident, Petitioner was 55 years of age, *married* with no dependent children.

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

Respondent shall be given a credit of $0 for TTD, $0 for TPD[1], $0 for maintenance, and $2,545.71 for other benefits (i.e., variable compensation/short term disability), for a total credit of $2,545.71. *See* AX1.

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

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner failed to prove that she sustained a compensable accident at work as claimed. By extension, all other issues are rendered moot and all requested compensation and benefits are denied. Petitioner's claim for penalties and attorney's fees is specifically denied. Respondent is awarded a credit in the amount of $2,545.71 for short-term disability benefits paid to and received by Petitioner.

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

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

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

Signature of Arbitrator

November 20, 2018
Date

DEC 4 - 2018

[1] The parties stipulated that there is no overpayment or underpayment at issue regarding Petitioner's temporary partial disability period. *See* Arbitration Hearing Transcript.

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

Miranda D. Chaudhry
Employee/Petitioner

v.

Amazon
Employer/Respondent

Case # **17** WC **31643**

Consolidated cases: **17** WC **31839**

FINDINGS OF FACT

The issues in dispute in this case include whether Petitioner sustained a compensable accident, whether there is a causal connection between such an accident and her current condition of ill-being, whether Respondent is liable for certain unpaid medical bills, whether Petitioner is entitled to temporary total disability benefits from October 28, 2016 through October 17, 2018, whether Respondent is entitled to a credit, and whether Petitioner is entitled to prospective medical treatment. Arbitrator's Exhibit[2] ("AX") 1. The parties have stipulated to all other issues.

Background

Miranda D. Chaudhry (Petitioner) testified that she was employed by Amazon (Respondent) as a Problem Solver. Tr. at 20. Petitioner explained that her job was to handle and document mis-shipped packages as well as to track down inventory or locate vendors for the universal workers. Tr. at 21.

On September 20, 2016, Petitioner requested a leave of absence from November 2, 2016 through November 16, 2016. On October 19, 2016, Respondent approved the request.

October 28, 2016

Petitioner testified that she was injured on October 28, 2016 while working at a building referred to as the "MDW2" at 401 Laraway Road in Joliet, Illinois. Tr. at 20. Petitioner described the injury at work as follows:

> A: I was exposed to some chemicals that I was checking in a box. My job description as a problem solver is to document mis-shipped packages or track down inventory or locate vendors for the universal workers to check them in.
>
> This package was sent to our facility. It came in through the docks. The operator cannot scan the box package without a freight number. So when it came to my desk, it is my job to first look at the sizes of all the boxes and try to get as much information as I can off of it, try to find its location.
>
> When you can't find its location, then you have to open up the box, inventory it, take pictures and fill out paperwork for it, so that it can go to the next department, ICQA where they do more research. This box would not open. It had a canister that had a biohazard sign on the outside. It was about maybe 12 inches tall, 4 inches wide.

[2] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. The arbitration hearing transcript of August 20, 2018 is referenced with corresponding pages as "Tr. at _."

When I took it out of the box, I just was registering the box. I reached in the box to cut and put everything on the table.

THE ARBITRATOR: Let the record reflect the Petitioner is gesturing that she reached towards something with her right arm to her right.

BY THE ARBITRATOR:
Q. Go ahead, ma'am.
A. I put it on the table and that's where I take pictures of it. When I reached into the box, it had a powdery like substance like and it looked like it had some leaking or damage or whatever was in the canister, probably it leaked in the box and it was damaged.

I took all the canisters out and put it on the table. I have to take pictures of it. I have to put down where it came from, whose the vendor, the PPO number, all those things that I find in a purchase order. I put it also in the computer and I put it under a number. It generates a number. I do have that number here today [Box No. 0098796799].

Tr. at 21-22, 25.

Petitioner testified that the box then went to the ICQA department for more research. Tr. at 25. After about minutes, Petitioner testified that "[her] arm started blistering up, and then [she] started itching and then [her] skin started being irritated and it started swelling right then and there." Petitioner explained that she had symptoms in both hands. She testified that she had "to clean up the package, and the stuff that was in the bag was like damaged like liquid and a little crystal powder in there."

Respondent's Medical Department (Amcare)

Petitioner testified that she then went to Amcare, Respondent's in-house medical department "and showed them what was going on with my arms, that it was swelling." Tr. at 25-26. She testified that she was itching and "trying to explain to them I had been exposed to some chemicals out there while I was checking in some boxes. They told me to go and get the box. As I went to go get out of the box, they had to say well you can't come in here unless you are with your supervisor. My supervisor at that time was Ryan Brenner. Ryan Brenner was radioed to come to Amcare which is the on-site medical care where employees go to for care. I went back to my station. That's when I obtained that number." Tr. at 26. Petitioner testified that she signed her name at the Amcare desk and someone looked at her arms and hands, and said take some cortisone packages and apply that to the affected area, but otherwise at that time they did not do anything for her. She explained that it was then about lunch time and she was feeling kind of tired as well as irritation and swelling on her arms and hands from the elbows down. Tr. at 26-27.

Additional Testimony

Petitioner went on to describe the substance to which she was exposed as well as an onset of symptoms and subsequent events as follows:

A. Yes. That's the part where you go in the box and everything you lay on the table. What happened was while I had the canister out, another co-worker came and probably knocked my water over which could have made the powdery substance active and I didn't think nothing of it.

I had just cleaned off the table. That's when I started blistering up and swelling up. At that time about 12:30 after lunch I wasn't feeling well. I just went home. I didn't equate that I was sick or tired. I felt like I was tired and exhausted.

I went home that day early. On my way home I was driving but I was hallucinating. I thought somebody had hit my car. I called the police. I followed the individual. Then I went on back home. I went home and laid down. I am not thinking about the reaction because it's just a skin rash and just some swelling and some blistering.

I put the cortisone on. Everything goes good. I am preparing to go to for a trip already, a missionary trip. I had already gotten from Amazon two weeks off. So I come back into work on Saturday which is the next day the 29th.

I am standing there trying to do my work but I am moving slow and slower. Ryan comes up and asks me how are you doing, Ryan Brenner, my supervisor. He said would you like to go home. I said, yes, please. I am just so exhausted. I am feeling exhausted.

Come Monday he asked me how is your arm. I said, it's swelling up worse. So I pulled up my sleeves and I showed him. I had been observed by
someone in the plant to see if I am doing my work right, but I haven't went to the doctor yet because my symptoms haven't gotten worse. My symptoms got worse
about maybe the fifth day. That's when I started breaking down.

People could see but I couldn't see it. I wasn't quite myself. I am on my vacation in Nairobi, Kenya and I am having all kinds of confusion with my mind. I don't know what's happening to me. Everybody wants to say put me in the doctor. I am rejecting. I thought the people was trying to rob me, doing all kinds of things. I am really hallucinating, having real trouble.

I come home early because I am real sick. I end my trip after four days, five days and I get another plane ticket to come back home. I get back home. I'm looking ill. I am still not understanding what's happening to me.

Everybody is saying I am trying to say I am glad to be back home because I didn't know what happened. I didn't want to be over there when I got sick. I am home first. The first time I called the doctor's office my husband called for me. That's on the 11th [of November 2016].

Tr. at 27-30.

On cross-examination, Petitioner denied that when she first presented to the doctors she attributed all her issues to drinking water and eating local food in Kenya. Tr. at 51. She also denied failing to report any workplace exposure when she first saw her doctor upon returning from Kenya. Tr. at 52. Petitioner explained that when she went to the doctor, she was feeling "ill, off[]" and she did not know what was happening to her. Petitioner further denied returning from Kenya with a headache and other symptoms.

On cross-examination, Petitioner testified that Dr. Suganthi Vijayaraj became her doctor on December 20, 2016 and denied that Dr. Vijayaraj's records failed to mention any alleged exposure. Tr. at 53. She explained that Dr. Vijayaraj's records document "a person that is confused, not making sense, hallucinating, having infections and they don't know what the cause of it is and they still didn't know what the cause was."

On cross-examination, Petitioner testified that she worked for Respondent in some capacity even after she returned from Kenya. Tr. at 55-56. However, Petitioner explained that she worked one day here and missed a couple of days there and she was unable to be at "full force."

Medical Treatment

Petitioner submitted various medical records, medical bills, correspondence, and other documents in a group exhibit. Respondent submitted 13 exhibits including records from: (1) Franciscan Alliance testing; (2) Franciscan's Alliance Olympia Field; (3) Dr. Young Ro; (4) Dr. Vijayaraj Suganthi; (5) Dr. Daniel Smith; (6) Riverside Medical Center; (7) Franciscan Health – Chicago Heights/Olympia Field; (8) Advocate; (9) Dr.

Gulati; (10) Future Diagnostics Group; (11) March 31, 2017 correspondence from OSHA; (12) records regarding Petitioner's dates worked; and (13) OSHA response to Petitioner's allegations.

The medical records reflect that Petitioner presented at Franciscan Express Care on November 14, 2016. The following history is noted:

> Miranda Chaudhry is a 55 y.o. who presents with a complaint of abdominal cramping and diarrhea for the last 2 days, no fever, +chills, diarrhea is watery, 5-6 episodes yesterday and 3 episodes today, very minimal oral intake, decreased appetite. +Recent travel to Africa (Kenya), she stayed in a rural area and ate the native food. She is also taking the Mefloquine once a week, so far she has taken 4 doses and her last dose was 2 days ago. No increased urinary frequency, no dysuria, she first noted blood in urine at today's visit. +nausea, +metalic [sic] taste , off and on back pain, +fatigue, weakness, no dizziness, but she feels "off. " She has been told in the past to have elevated blood pressure.

Petitioner was diagnosed with abdominal cramps, diarrhea of presume infectious origin, dehydration, and hematuria.

On December 20, 2016, Petitioner presented to Franciscan Express Care with shortness of breath, blurred vision, and slurred speech over the past two days.

Petitioner presented to Franciscan Health Dyer on December 21, 2016. The examining physician, Grace Duarte, D.O., noted the following:

> Patient is a 55-year-old female who presents with speech difficulties, feeling off balance, confusion, and memory loss for the past 3 days. Patient states that her symptoms come and go. Patient feels like she knows what she wants to say but can't get the words out at times. She denies lightheadedness, chest pain, shortness of breath. Patient states that she got back from Kenya at the beginning of November and since then, has had multiple problems. Patient states she has been having pounding headaches all over her head since then. No fever. Patient was also diagnosed with a UTI which she was told may have been a parasite. Patient states she took medication for 2 weeks for that. Patient still has a residual pain in her lower abdomen. No nausea/vomiting since diarrhea.

Dr. Duarte noted intermittent episodes of expressive aphasia during the physical examination and history. Petitioner underwent a CT of the head/brain. The interpreting radiologist noted that it was compared to a CT of the brain taken on July 11, 2009. The results were normal, but if symptoms persisted, the radiologist recommended considering an MRI. Petitioner then stated that she wanted to leave. Petitioner reported that she had an appointment with Dr. Vijayaraj at 9:00 a.m. and she needed to make care arrangements for her grandchild. Dr. Duarte discussed the risks with Petitioner and noted that, if she stayed, she could see the neurologist for a consult and undergo the recommended MRI. Against medical advice, Petitioner declined indicating that she would have this performed as an outpatient. Dr. Duarte diagnosed Petitioner with expressive aphasia.

However, Petitioner agreed to admission at the hospital on December 22, 2016 where she was examined by Vladimir Selounski, M.D. Dr. Selounski noted that Petitioner underwent a workup for TIA and CVA. She underwent an MRI of the brain, carotid ultrasound for any stenosis, and TTE for any thrombi, which were all normal. Petitioner reported continued difficulty with speech and word finding. A physical therapy evaluation was ordered for stroke-like symptoms, but Petitioner declined the treatment.

Petitioner was discharged from the hospital on December 23, 2016 with a final diagnosis of headaches and expressive aphasia. Upon discharge, possible CVA was also noted. Petitioner was instructed to follow up with Suganthi Vijayaraj, M.D., her primary care physician, and Thomas Zabiega, M.D., a neurologist.

On December 28, 2016, Petitioner followed up with Dr. Vijayaraj. She complained of headaches for three weeks that were worsening with additional confusion, vision changes, and slurred speech. Petitioner was admitted to the hospital after the last office visit, and obtained a workup including an MRI, Doppler labs, and an echocardiogram. The neurological review showed speech difficulty and headaches, but was negative for dizziness, tremors, seizures, syncope, weakness and numbness. Petitioner's psychiatric behavioral workup was positive for confusion and decreased concentration. Dr. Vijayaraj's impression was daily headache, difficulty concentrating, microcytosis and stress. Dr. Vijayaraj recommended a neurologist visit.

On January 11, 2017, Petitioner followed up with Dr. Vijayaraj for headaches, memory problems, and confusion. She reported being off work at this time because of her headaches and noted forgetfulness, but she was able to function at home and engage in normal housework. She continued to deny depression or anxiety problems, but reported stress at work. Dr. Vijayaraj diagnosed Petitioner with daily headache, confusion, memory problem. Dr. Vijayaraj noted that it was unclear if Petitioner had some kind of dementia or psychiatric problem. Dr. Vijayaraj placed Petitioner off work note until the end of the month.

On January 18, 2017, Petitioner presented at Riverside Medical Center and saw Bruce Dodt, M.D. Dr. Dodt noted the following in pertinent part:

> HPI This 55-year-old right-handed female who was in Kenya in Africa from November 3 through November 11, 2016. After she came back she developed diarrhea and cramping and was somewhat disoriented. She was seen by her doctor and was felt to have a parasitic infection. The patient does not know what the infection was. The diarrhea has improved. On December 18, 2016 the patient developed a headache which is a sharp pain in the back [of] the head was dizzy felt confused and had some slurred speech for short period [of] time. ... Since that time she has continued to have the headaches daily. She denies any further confusion or speech difficulties. She denies any difficulty with her walking. She does have intermittent skin rash since November 2016. She denies any past history of migraines, CVAs, or seizures. ... Since she had a parasitic infection from Africa I am going to refer her to infectious disease for further evaluation of that.I am going to try the patient on Neurontin for the headache.

Dr. Dodt diagnosed Petitioner with new daily persistent headache, parasite infection, arthritis, and numbness and tingling of the right side of the face.

On January 30, 2017, Petitioner returned to Dr. Vijayaraj for a follow up for headaches. The primary diagnosis at this time was paranoid behavior. Petitioner reported that she saw the neurologist, but did not follow up with him. She also reported that she did not want to take the prescribed medication because it was for seizures. Per the records, Dr. Vijayaraj spoke with Petitioner's neurologist, Dr. Bruce. Dr. Bruce stated that he gave Petitioner an order for labs. Dr. Bruce also gave her an order to see an infectious disease specialist because of his concerns about her travel to an African country that November. Dr. Bruce further indicated that Petitioner exhibited paranoia and called his office accusing them of stealing her records.

On January 31, 2017, Petitioner called Dr. Vijayaraj's office. Per the records, she inquired regarding the reason for a referral for behavioral health. It was explained to Petitioner that the referral was a recommendation from her neurologist and, if she did not comply, Dr. Vijayaraj would no longer fill out FMLA forms as stated in her last office visit. Petitioner stated "send me back to work, I am not going." On February 2, 2017. Petitioner

called Dr. Vijayaraj's office again. Morgan, Dr. Vijayaraj's assistant, noted telling Petitioner that she needed to see a psychiatrist before she would be released from work. Petitioner stated she was busy and hung up.

On February 13, 2017, Petitioner followed with Dr. Vijayaraj complaining of right side headaches and intermittent, but continued, pain. Petitioner also reported confusion and memory problems. Dr. Vijayaraj previously evaluated Petitioner and explained to both her and her husband that she needed to see a psychiatrist and also follow up with a neurologist. Dr. Vijayaraj reiterated to Petitioner that, if there were continued compliance problems, she would have to find a new medical provider.

On February 16, 2017, Petitioner presented to discuss her FMLA and follow up regarding her visit with the internal medicine doctor. Petitioner's MRI cardiac workup was negative. Dr. Vijayaraj noted that Petitioner exhibited signs of paranoid behavior, and Petitioner's claim that Vanessa, from Dr. Vijayaraj's office, was trying to forge her records.

On February 17, 2017, Dr. Vijayaraj requested that a letter be sent to Petitioner with notice of her non-compliance. The letter stated, "[d]ue to non-compliance it is recommended that patient Miranda follow up with I.D. specialist Dr. Smith on February 20, 2017. Also, patient needs to follow up with a neurologist and psychiatrist for consult and clearance along with the proper documents that are in need of completion to determine clearance for returning to work. If patient is unable to follow these recommendations Dr. Vijayaraj will no longer be able to provide patient with FMLA documentation due to non-compliance. After appointments with the specialists, patient should follow up with Dr. Vijayaraj on March 2, 2017 and discuss work clearance with the specialist."

Ultimately, Dr. Vijayaraj completed several "attending physician statements of work capacity and impairment" forms in support of Petitioner's request for medical leave from work in January and early February of 2017. Dr. Vijayaraj diagnosed Petitioner with paranoid behavior and daily headaches that prevented her from working. In these forms, Dr. Vijayaraj indicated that Petitioner's condition was unrelated to her employment. Petitioner applied for short term disability benefits under the Family and Medical Leave Act (FMLA) with Respondent, which were approved for the period from December 21, 2016 through January 10, 2017 and January 11, 2017 through February 20, 2017.

Petitioner also underwent infectious disease treatment with Daniel J. Smith, M.D. beginning on February 13, 2017. At that time, Dr. Smith noted that Petitioner "returned from Kenya with headache, diarrhea." He ordered comprehensive lab testing noting "chronic diarrhea since Kenya[.]"

OSHA Complaint

Petitioner filed a complaint with OSHA on or about March 20, 2017 regarding exposure to hazardous chemicals and biohazard spills. Petitioner submitted several documents into evidence directed to or received from Kathy Webb, OSHA Area Director. On March 31, 2017, Ms. Webb ultimately responded that after receiving a response from Respondent and conducting an investigation into the allegations, she felt that the case could be closed.

Continued Medical Treatment

On May 11, 2017, Petitioner was evaluated by a neurologist, Young-Il Ro, M.D. Dr. Ro noted the following history in pertinent part:

> This 56-year-old right-handed woman is complaining of headache. Patient states that the headache began in October 2016 after exposure to "nerve gas" at work. It is a right sided headache with bioccipital headache, throbbing and sometimes associated with nausea, vomiting, photophobia, and phonophobia. She has a headache everyday andshe [sic] cannot sleep at night. She also has had intermittent difficulty with getting the words out. She had the loss of balance and mental confusion. MRI brain with and without contrast was negative on 12/22/16. Doppler carotid study was negative. Lyme's disease test, B.12, folate, hemoglobin A1c, TSH, and ANA were negative.
> She saw a neurologist who gave her Neurontin but that did not help. Elavil did not help. ....

Dr. Ro diagnosed Petitioner with a headache disorder, probably migraine, and scheduled a follow up visit in one month.

On May 17, 2017, Petitioner returned to Franciscan Health with continued complaints of headaches, speech issues, loss of balance and confusion since being exposed to "nerve gas at work." On May 17, 2017, Petitioner underwent a CT angiogram of the head and neck, which was unremarkable.

Petitioner continued to see Dr. Dodt through 2018 during which time he made differential diagnoses attempting to address her symptoms including headache and diarrhea. In the interim, Petitioner also underwent emergency room care on occasion. Specifically, on December 4, 2017, Petitioner was evaluated at the emergency room at Franciscan Health in Olympia Fields by Justin Lo, D.O. He noted, in pertinent part, the following prior medical history:

> ... of dysarthria 2/2 to chemical exposure a year ago and high cholesterol who presents with increased slurring. History provided by patient and husband at bedside. Per patient, she has had slurred speech since about a year ago after chemical exposure however over the past week, she has been experiencing increased slurring of the speech and left sided facial paresthesias. She also complains that she has recently been having lower extremity swelling and tingling down her lo[we]r extremities. ....

Dr. Lo diagnosed Petitioner with dysarthria and she was admitted to the hospital for further care and evaluation for TIA, migraine, and to rule out CVA.

Neeti Sharma, M.D. evaluated Petitioner at approximately 11:00 p.m. Dr. Sharma noted Petitioner's report that "[s]he had exposure to an unknown chemical in 10/2016 at work and has since been having intermittent blurred vision, slurred speech, and memory trouble. She has followed with neurologist Dr. Young Ro, last visit in 06/2017. She is unable to tell me what the official diagnosis of her symptoms is. Per chart review, he is treating her for migraine without aura with Topomax 25mg bid."

In the discharge summary, Joon Suh, D.O. noted Petitioner's report that she experienced short episodes of loss of consciousness, including while driving. "Of note, she states she was exposed to a chemical irritant while handling a package at work (Amazon) last year, which is when her symptoms began." Petitioner was discharged from the hospital on December 5, 2017.

On December 22, 2017, Petitioner returned to Dr. Ro. He noted that she had a recent hospital stay and negative testing including a Doppler carotid study, CT of the brain and MRI of the brain. Dr. Ro diagnosed Petitioner with headache disorder and blackout spells.

On January 16, 2018, Petitioner presented to Surendra Gulati, M.D. who noted her complaint of mini-strokes. Dr. Gulati noted the following history in pertinent part:

> Worked at Amazon from October 20, 2015 to March 24, 2017: Universal problem receiver and receiver. Checking in a package that she had to open, biohazard cannister that contained a powder. Says powder got on her hands and arms. States in less than 15 minutes bilateral forearm blistered and turned red. Reported to company doctor and given cortisone cream and returned back to work til February 21,2017. Date of incident October 28,2016. [sic]
>
> TIA"s: " a lot" Beginning December 2016
> - slurred speech
> -memory loss
> -incoordination
> -Right face gets numb
> -Both eyes cannot focus
>
> History of migraine since December 2016
> ....

Dr. Gulati performed a neurological examination, which was normal. She noted that Petitioner had multiple symptoms that developed over time since the incident at work and "[w]e have no knowledge of what the chemical was, how it affected her, we have no emergency room records from that incident, patient's belief is that she has symptoms as a result of the chemical." Dr. Gulati determined that Petitioner's history of episodes was not consistent with epilepsy, TIAs or multiple sclerosis and "[s]he demonstrated dysarthria in the office from time to time with nonorganic features." Dr. Gulati further stated that "[i]n this patient who has many symptoms, normal neurological examination, symptom pattern does not speak for a definite organic neurologic disorder." Dr. Gulati referred Petitioner for an MRI of the brain and cervical spine, and advised her to seek consultation at the University of Chicago.

Petitioner also underwent medical treatment at Advocate Medical Group in 2018. Petitioner presented on March 16, 2018, complaining of blackouts and significant memory difficulties. She reported that the issues were present since 2016, but denied injury. Petitioner reported having a headache "all the time ever since a work-related chemical exposure in 2016...." As of March 19, 2018, she reported a work chemical exposure in 2016 that caused migraines and blackouts. Petitioner went on to state that she had "lots of testing done and says she has been misdiagnosed." Petitioner's December of 2017 hospitalization was noted as well as her report that she was diagnosed with a TIA during that admission. Petitioner continued to complain of what she classified as blackouts, and her January 17, 2018 neurological workup was noted as normal. Petitioner returned to Advocate on April 4, 2018 requesting x-rays of her head and chest. Throughout the Advocate records, Petitioner received various diagnoses including anemia, abdominal cramping, gastroesophageal reflux disorder, chronic diarrhea, loss of consciousness, and hypertension.

Petitioner underwent further evaluation and treatment at Future Diagnostic Group. As ordered by Dr. Gulati, Petitioner underwent a brain MRI on April 23, 2018. The tests showed no acute intercranial abnormality with unchanged mild chronic ischemic degenerative changes when compared to the prior study of December 5, 2017.

Ryan Brenner

Respondent called Ryan Brenner (Mr. Brenner) as a witness. Mr. Brenner testified that he is the Operations Manager at MDW2 Amazon and has been so employed for 2½ years. Tr. at 58. In this position, he oversees associates who unpackage freight, repackage it and send it to other fulfillment centers. The MDW2 warehouse holds the goods that Amazon customers might order to their homes. Tr. at 62. Mr. Brenner testified that consumers cannot order biohazardous materials on Amazon.com and it does not deliver nerve gas. Tr. at 62-63.

Mr. Brenner testified that he knows Petitioner through the course of his employment and was aware that she claims to have been exposed to an unknown substance on October 28, 2016. Tr. at 59. However, he did not recall Petitioner reporting that she had been exposed to an unknown substance on that date or at any time. Mr. Brenner explained that Respondent has policies and procedures that he must follow if such an incident is reported to him. Tr. at 59-60. He would immediately walk the associate to Amcare and take pictures of the associate's work station to document what they might have come into contact with. Tr. at 60.

Mr. Brenner testified that Amcare is where an on-site medical team assists and treats any workplace illness or injuries. Tr. at 60. Amcare generates a physical and an electronic record for an associate's visit. When an associate walks into Amcare, the associate needs to scan their badge into a recorder that will change their time card to show that they went to and left Amcare at specific times. Mr. Brenner testified that he reviewed Respondent's records, and there are no physical or electronic records that Petitioner visited Amcare on October 28, 2016. Tr. at 60-61. Mr. Brenner also testified that he has no pictures of any alleged hazard presented to Petitioner.

Mr. Brenner also testified that Petitioner requested vacation time around this time. Tr. at 61. He recalled that Petitioner applied for a personal leave to go on a missionary trip to Africa that was during Respondent's peak period, which is October, November, and December during the holiday periods when Respondent does not allow personal leave. Petitioner returned to work after that trip.

On cross-examination, Mr. Brenner testified that Petitioner's job duties were of a universal associate in which she received packages and was a problem solver. Tr. at 64. The duties of a problem solver are to fix anything that cannot be received such as adding an item to a shipment, addressing a bar code that does not work, etc. Mr. Brenner acknowledged that it is possible for another vendor to send mis-shipped boxes to the freight in Respondent's receiving. Tr. at 64-65. When there are mis-shipped items, Mr. Brenner testified that the contents in the box could be from Amazon or from someone else. Tr. at 65.

On cross-examination, Mr. Brenner testified that the policy to scan one's badge has been in effect since he has been employed by Amazon. Tr. at 65. He testified that he had no records reflecting that Petitioner had been injured at Amazon. Tr. at 65-66. Mr. Brenner further testified that the area manager, injured employee, and/or medical staff at Amcare scan their badges, and the person who is getting medical treatment is required to scan their badge. Tr. at 66-68. Mr. Brenner did not know if there was a written policy to this effect. Tr. at 68. However, he testified that everybody that got hurt on the job had to scan a badge to get their time coded. Tr. at 68-69.

On cross-examination, Mr. Brenner testified that he did not know how many times Petitioner was injured at work or presented to Amcare. Tr. at 69. He testified that he did not know because he has a lot of associates that report to him, over 300 on any given day during the time that Petitioner was employed by Respondent. Tr. at 69-70.

Don Westfield

Petitioner called her husband, Don Westfield (Mr. Westfield), as a witness. Mr. Westfield testified that he was employed by Respondent during a period that overlapped with Petitioner's employment. Tr. at 72-73. He explained that he worked in the same building as Petitioner, specifically in the universal department. Tr. at 73. Mr. Westfield did not know how many times he had been to Amcare. He testified that he had to scan a badge to get into Amcare most, but not all, of the time. Tr. at 73-74.

Additional Information

Petitioner testified that she is requesting to undergo a brain study that has been recommended for her by Dr. Gulio so that she can find out the extent of her injury. Tr. at 40-41. She also requests monthly B12 injections for her memory loss, follow up with her speech therapist, MRI studies ordered by neurologists (Dr. Dodt, Dr. Ro Young, and Dr. Gulio), and an IME evaluation at UIC.

Regarding her current condition of ill-being, Petitioner testified that she recovered most of her memory back where she can remember family, friends and things like that, but she still has a speech problem. She testified that she also has good concentration now compared to before, but when she was at work she found it difficult when she came back to try to get back and remember past words, things like that. Petitioner explained that she still struggles with that today. Tr. at 43. Petitioner testified that she wishes to undergo the recommended medical treatment.

Petitioner testified that Respondent is not entitled the claimed credit of $2,545.71, which was paid through its short-term disability carrier, because they gave that credit to her as income. Tr. at 37. She further testified that she was not represented by an attorney at the time of the hearing.

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 (C), whether an accident arose out of and occurred in the course of Petitioner's employment, the Arbitrator finds the following:

Based on the totality of the record, which consists of Petitioner's testimony, the testimony of two additional witnesses, and thousands of pages of documentary evidence submitted by the parties, the Arbitrator finds that Petitioner has failed to establish that she sustained a compensable injury at work on October 28, 2016 as claimed.

An employee's injury is compensable under the Act only if it arises out of and in the course of the employment. 820 ILCS 305/2 (LEXIS 2003). The "in the course of employment" element refers to "[i]njuries 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...." *Metropolitan Water Reclamation District of Greater Chicago v. IWCC*, 407 Ill. App. 3d 1010, 1013-14 (1st Dist. 2011). The "'arising out of' component refers to the origin or cause of the claimant's injury and requires that the risk be connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Metropolitan Water Reclamation District*, 407 Ill. App. 3d at 1013-14 (*citing Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (1989)). A claimant must prove both elements were present (i.e., that an injury arose out of and occurred in the course of his employment) to establish that the injury is compensable. *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006).

As an initial matter, there is no evidence corroborating Petitioner's testimony that she was exposed to a hazardous substance at work on October 28, 2016. Petitioner testified that she had to catalog a package containing a hazardous substance that caused her to immediately blister on the arms and hands. She testified that she also took photographs of the package and its contents and later cleaned up her desk. Petitioner testified that she went to Respondent's onsite medical department, who redirected her to her supervisor Mr. Brenner, and later returned receiving cortisone treatment. She then returned to her desk, but felt tired and exhausted, and left work early. Petitioner explained that she did not equate the occurrence to being sick, but she then hallucinated while driving home believing that someone hit her car and she called the police. No evidence was submitted to corroborate this sequence of events after the alleged exposure to a hazardous substance at work.

In contrast, Mr. Brenner testified that mandatory company policy requires him to immediately walk an associate that has reported an injury to Amcare. He would then take pictures of the associate's work station to document the hazardous condition to which they might have been exposed. Mr. Brenner did not recall Petitioner's alleged report of injury due to contact with an unknown hazardous substance on October 28, 2016 or thereafter. He had no pictures of any alleged hazard presented to Petitioner. Mr. Brenner also testified that Respondent had no physical or electronic records reflecting that Petitioner visited the onsite medical department or received treatment there on October 28, 2016. He did, however, recall Petitioner's application for a personal leave to go on a missionary trip to Africa during Respondent's busy holiday season during which Respondent does not allow personal leave.

Notwithstanding the foregoing lack of evidence corroborating Petitioner's claim that she was exposed to a

hazardous substance at work and Mr. Brenner's testimony to the contrary, there are voluminous medical records regarding Petitioner's condition after the alleged accident. These records contradict Petitioner's claim that any of her symptoms or medical treatment stemmed from exposure to a hazardous substance at work as opposed to a non-occupational disease.

Petitioner first sought treatment approximately two weeks after her alleged injury on November 14, 2016 after returning from her missionary trip to Kenya. Petitioner reported an onset of gastrointestinal and other symptoms, but she made no mention of any exposure to a hazardous substance at work prior to her trip. Petitioner next sought treatment one month later with her primary care physician, Dr. Vijayaraj, on December 20, 2016. She then returned for emergency treatment at Franciscan Health in Dyer on December 21, 2016 and she was admitted to the hospital for several days. Petitioner did not report any workplace exposure to any chemical or unknown hazardous substance to Dr. Vijayaraj, in the emergency room, or during her hospitalization.

Petitioner continued to follow up with Dr. Vijayaraj as of December 28, 2016 through the spring of 2017. Dr. Vijayaraj's records do not contain a history from Petitioner relating any workplace exposure to any chemical or hazardous substance. To the contrary, Dr. Vijayaraj's records contain several physician's statements, in support of Petitioner's claim for FMLA leave at work, specifically stating that Petitioner's condition was not work-related.

Petitioner's continued treatment, including emergency medical care and hospitalizations over the next five months, are devoid of any reference to a hazardous workplace exposure to a chemical, nerve gas, biohazardous material, powder or unknown irritant. To the contrary, Petitioner's histories for many months after her accident relate an onset of symptoms only after her travel in November, if not directly to food ingested during her trip.

The first documented report of any exposure to a hazardous substance at work occurred in March of 2017 when Petitioner filed a complaint with OSHA. The OSHA Area Director, Ms. Webb, investigated Petitioner's complaint and, finding no evidence of any OSHA violation, closed the case. It was only after this complaint was closed that Petitioner sought medical treatment purportedly relating to a hazardous condition at work in October of 2016. The first documented report of any exposure to a hazardous substance at work to a physician occurred on May 11, 2017. Petitioner sought treatment with Dr. Ro told him that she was exposed to "nerve gas" at work in October of 2016. After an examination and testing, Dr. Ro did not relate Petitioner's diagnoses to any workplace exposure to a hazardous substance.

Petitioner also saw numerous other physicians. She related her symptoms to a chemical exposure at work to Dr. Dodt and he also noted Petitioner's international travel from November 3 through November 11, 2016 after which she developed intermittent skin rash and disorientation among other symptoms. Petitioner's primary care physician, Dr. Vijayaraj, noted that Petitioner was seen by Dr. Bruce who referred Petitioner for an infectious disease evaluation given her travel that November. Neither Dr. Dodt, Dr. Vijayaraj nor Dr. Bruce related any of Petitioner's diagnoses with any workplace exposure to a hazardous substance. Petitioner was also hospitalized in December of 2017 and evaluated by numerous doctors, none of whom related any of her diagnoses to any workplace exposure to a hazardous substance. Petitioner sought further treatment with Dr. Gulati. Instead of relating any diagnosis to a workplace exposure to a hazardous substance she noted, to the contrary, that Petitioner "demonstrated dysarthria in the office from time to time with nonorganic features." Dr. Gulati stated that "[i]n this patient who has many symptoms, normal neurological examination, symptom pattern does not speak for a definite organic neurologic disorder."

Ultimately, the many physicians that evaluated Petitioner for her constellation of symptoms from November 14, 2016 through 2018 did not relate any of her diagnoses to any chemical or hazardous substance exposure even after she began to provided histories relating her symptoms to the alleged incident at work. While Petitioner asserts that, as a layperson, she was unaware of the source of her symptoms between the alleged accident and her first history relating her symptoms to "nerve gas" exposure at work, she was purportedly aware of the hazardous substance exposure that caused her to blister and hallucinate even prompting a call to the police. Petitioner's failure to provide her physicians with a history of the allegedly debilitating exposure to a hazardous substance at work for months brings the reliability of her testimony into question. The further consideration that that Petitioner's poor memory may have resulted from the injury, explaining the failure to relate the exposure to her symptoms for months, is similarly unsupported by the medical records. Petitioner's treating physicians and numerous emergency room, clinic, and hospital physicians ordered batteries of tests beginning on November 14, 2016 including neurological exams, MRIs of the brain and CT scans of the head, all of which were normal. There is simply no credible evidence that relates any of Petitioner's diagnoses or symptoms to the alleged workplace exposure to a hazardous substance, which is itself unsupported by the record.

Based on the totality of the record, the Arbitrator finds that Petitioner did not sustain a compensable accident as alleged on October 28, 2016. By extension, all other issues are rendered moot and all requested compensation and benefits are denied.

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:

Notwithstanding the finding that Petitioner failed to establish that she sustained a compensable accident at work, the Arbitrator addresses her claim that she is entitled to penalties and fees. Given the facts presented in this case, and after considering the record as a whole, the Arbitrator finds that Respondent had a reasonable dispute as to whether Petitioner's sustained a compensable injury at work, whether she gave proper notice of such an injury, whether her current condition of ill-being was causally related to a compensable accident at work, and whether they were liable for payment of any medical bills, temporary benefits, or further medical treatment. Respondent's conduct was not unreasonable, vexatious and/or in bad faith given the lack of corroborating evidence to support Petitioner's claim. Thus, Petitioner's claim for penalties and fees under Sections 19(k), 19(l) or 16 of the Act is denied.

In support of the Arbitrator's decision relating to Issue (N), whether Respondent is due any credit, the Arbitrator finds the following:

Notwithstanding the finding that Petitioner failed to establish that she sustained a compensable accident at work, the Arbitrator addresses Respondent's claim that it is entitled to a credit in the amount of $2,545.71 for payment of short term disability benefits. Petitioner disputes Respondent's claimed credit for the period of December 20, 2016 to February 20, 2017 asserting that it was obtained under fraudulent condition to obtain her patient medical records. The record reflects that Petitioner applied for short term disability benefits under the Family and Medical Leave Act (FMLA) with Respondent, which were approved for the period from December 21, 2016 through February 20, 2017. At the hearing, Petitioner admitted that she received payment of this amount of short-term disability benefits, although she also asserted that Respondent was not entitled to the amount of requested credit because it was provided to her as "income." Given the foregoing, the Arbitrator finds that Respondent has established that it paid, and Petitioner received, $2,545.71 in short-term disability benefits corresponding to a credit due to Respondent in that amount.

STATE OF ILLINOIS)
) SS.
COUNTY OF ST. CLAIR)

☐ 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

Phyllis Oliver,

Petitioner,

vs.

No. 18 WC 18322

20IWCC0166

East St. Louis School District #189,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary disability and wage calculations, 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).

The Commission modifies the Arbitrator's decision with respect to the average weekly wage. The Commission calculates Petitioner's earnings during the year preceding the injury to total $27,231.96. Dividing this figure by 52 weeks yields the average weekly wage of $523.69. In arriving at this figure, the Commission relies on RX2 which we observe contains the complete wage records for the 52 weeks prior to the accident.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 27, 2019, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $349.13 per week for a period of 46 2/7 weeks, from May 16, 2018 through April 4, 2019, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay related medical bills in evidence pursuant to §§8(a) and 8.2 of the Act.

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

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

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

No bond is required for 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 12 2020
o-02/11/2020
SM/sk
44

Stephen Mathis

L. Elizabeth Coppoletti

Douglas McCarthy

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

OLIVER, PHYLLIS
Employee/Petitioner

Case# **18WC018322**

EAST ST LOUIS SCHOOL DISTRICT #189
Employer/Respondent

20IWCC0166

On 6/27/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0810 BECKER HOENER & YSURSA PC
RODNEY W THOMPSON
5111 W MAIN ST
BELLEVILLE, IL 62226

20IWCC0166

STATE OF ILLINOIS)
)SS.
COUNTY OF St. Clair)

- [ ] 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)

Phyllis Oliver
Employee/Petitioner

v.

East St. Louis School District #189
Employer/Respondent

Case # 18 WC 018322

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 **Mt. Vernon, IL**, on **04/04/2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of 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. [x] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] 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

STATE OF ILLINOIS)
)
COUNTY OF ST. CLAIR)

20IWCC0166

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION, continuation
Phyllis Oliver v. East St. Louis School District #189
Case Number: 18 WC 018322

FINDINGS OF FACT

THE PETITIONER – PHYLLIS OLIVER

The Petitioner, Phyllis Oliver, worked for the Respondent as a security guard at East St. Louis Senior High School. (Tr. 8:11-15). She was 61 years old at the time of the injury. (Arbitrator's Exhibit 1,2). Her job duties included breaking up fights between students and generally trying to keep a safe environment for the children enrolled at school there. (Tr. 8:19-20). She has worked there for 14 years. (Tr. 8:13). She was paid a salary of $1,129.67 every two weeks. (PX 12).

INJURY AND TREATMENT

On 5/03/18, Ms. Oliver was attempting to break up a fight between students when she fell to the ground, impacting her right knee, elbow and shoulder. (Petitioner's Exhibit 1, 2, Transcript 9). She went to the emergency room at Gateway Regional Medical Center the next day where she complained of pain into her right knee, right shoulder and right elbow. (PX 3). X-rays of each injured body part indicated no fracture, but x-rays of the knee demonstrated arthritis. (PX 3). She was given a prescription for Tramadol, an ACE wrap and told to avoid activities that cause pain, ice the affected areas and follow-up with her primary care physician. (PX 3).

On 5/09/18, Ms. Oliver presented to St. Elizabeth's Hospital with complaints of pain in the right knee, shoulder and elbow. She reported that she had attempted to return to work but was unable to do so due to pain. (PX 4). X-rays of the right elbow indicated a possible avulsion fracture. (PX 4). X-rays of the knee indicated a minor joint effusion, a possible osteochondroma, and tricompartmental degenerative changes. (PX 4). She was prescribed Flexeril and asked to follow-up with her primary care physician. (PX 4).

On 5/16/18, MS. Oliver saw her primary care provider, Delora Brooks, complaining of pain in the right knee, right shoulder and right elbow since the injury on 5/03/18. (PX 6). Ms. Brooks gave her a knee brace, prescribed hydrocodone, recommended that she follow-up with an orthopedic surgeon and recommended that she stay off work. (PX 6).

On 6/19/18 Petitioner saw Dr. Charles Lehmann, orthopedic surgeon, at Memorial Hospital in Belleville, Illinois. (PX 7). He noted a history of the injury at work on 5/03/18. (PX 7). On exam, he found a slight effusion in the knee, found her to be tender to palpation throughout the knee, but especially over the tibial insertion of the MCL. (PX 7). He also noted a significant

RESPONDENT'S § 12 OPINIONS 20IWCC0166

Following the injection on 6/29/18, Ms. Oliver saw Dr. Lyndon Gross on 7/26/18 at the request to the insurance carrier for the purposes of a §12 evaluation. (RX 1). She gave a history of no pain in the knee prior to the fall and severe pain after the fall. (RX 1). She rated her pain at that time at 6/10 in pain. (RX 1). In his first report, Dr. Gross believed that her subjective complaints were consistent with her objective findings. (RX 1). Dr. Gross recommended in his report that Ms. Oliver had not yet reached MMI and recommended further non-operative treatment to "return her to her baseline", which he anticipated would happen within 6-12 weeks after non-operative treatment is instituted. (RX 1). He further recommended NSAIDs and physical therapy "to try to improve her knee and return her to her baseline." (RX 1). He diagnosed her with right knee osteoarthritis but indicated that the work injury of 5/03/18 did not cause the condition. (RX 1). He believed that while arthroscopy is an option, the best treatment for her was a total knee arthroplasty. (RX 1). In his first report, Dr. Gross recommended restrictions that were related to the injury. (RX 1).

In an addendum dated 10/01/18, Dr. Gross indicated that his review of the MRI did not change his opinions and believed that it did not indicate any acute findings. (RX 1). He believed that Petitioner had reached MMI and her "exacerbation" had resolved. (RX 1). He had not seen the Petitioner since his initial §12 exam on 7/26/18. (RX 1).

At deposition, Dr. Gross stated that he is a sports medicine surgeon. (RX 1, 5:19). He estimated that roughly 40% of his practice is devoted to knee injuries. (RX 1, 6:18-19). He estimated that 70-80% of the "IMEs" he provides are at the request of insurance carriers or defense. (RX 1, 7:7-10). He charges $1500 for a standard report and record review. (RX 1, 7:13-14). For a deposition, he charges $2000 and an additional $500 for every hour thereafter. (RX 1, 33:1-6). He further testified that he charges $350-$500 for an addendum. (RX 1, 33:21). Dr. Gross's CV demonstrated little in the way of publications, the most recent from 2011 discussing fractures to the clavicle. (RX 1, 27:1-3).

Dr. Gross testified that he agreed that the MRI report demonstrated meniscal tears, edema and effusion. (RX 1, 11:22-12:8). While he believed that the meniscal tears were degenerative in nature, he also stated that the edema occurred when "the bone absorbed that force because there's no cartilage." (RX 1, 13:12-14). He indicated that the joint effusion did suggest an acute injury. (RX 1, 14:3-9). Dr. Gross indicated that an effusion can "exacerbate" the underlying arthritis and "can cause you to have symptoms", however he indicated that is "usually" a temporary finding. (RX 1,14:16-24). He stated that he believed the trauma at work on 5/03/18 resulted in an "exacerbation" of her underlying condition. (RX 1, 16:14-15). Dr. Gross stated that permanent aggravations with regard to an underlying condition such as Ms. Oliver's are more consistent with "diffuse edema in the bone,...subchondral fracture of the bone, or...a large piece of cartilage knocked off." (RX 1, 23: 19-21). He admitted that a total knee arthroplasty would be reasonable to address her symptoms. (RX 1, 25:5-8). However, he did not believe that treatment would be related to the 5/03/18 as he expected that injury to only lead to a temporary exacerbation. (RX 1, 25:5-8).

PETITIONER'S TESTIMONY 20IWCC0166

The Arbitrator finds the Petitioner's testimony to be credible and straightforward. Prior to this injury, she had no complaints of pain in the knee, no recommendations for treatment, no evaluations for right knee pain and no recommendations to restrict her work for problems with the right knee. (Tr. 28:6-15, 13:13-14:18). Between the injury and the surgery, she had been in constant pain, had been kept off work, and had been offered treatment by every doctor she saw. (Tr. 15:4-14). She testified that the physical therapy and injection did not resolve her pain. (Tr. 17:11-14). Since the surgery, her pain has improved. (Tr. 16:14-16).

CONCLUSIONS OF LAW

With regard to issue **"F" – "Is Petitioner's current condition of ill-being causally related to the injury?"**

The Arbitrator concludes Petitioner's current condition of ill-being is causally related to the 5/03/18 date of injury. In support of this conclusion the Arbitrator relies on the credible testimony of the Petitioner that she had no prior complaints and had consistent complaints afterwards. The Arbitrator further relies on the opinions of Dr. Lehmann, specifically his opinions that the work injury caused the symptoms that persisted until the surgery. The Respondent suggests that Dr. Gross's opinions should be given more weight, but Dr. Gross admitted that he would have to defer to Dr. Lehmann regarding how she was doing at any given time, and Dr. Lehmann opined that her complaints were always related to the injury at work. Dr. Gross stated in his report that once she returned to "baseline" that she would be at MMI, but there is no evidence that she did return to her baseline

The Arbitrator considers the Petitioner's demeanor and finds her testimony credible. The Petitioner testified believably in a straight forward manner that she had never had difficulties before the incident and had persistent difficulties thereafter. She remained symptomatic from the date of the accident through the date of surgery. The only inference of abatement was a minor decrease in pain, that didn't materially indicate a change in her overall condition. It is clear her symptoms did not abate. The Arbitrator finds the Petitioner's condition never returned to baseline.

The following case law establishes that the absence of symptoms prior to an event and the persistent presence after creates a chain of events sufficient to determine the event caused the symptoms and the need to treat them.

In Steak N Shake v. IWCC, 2016 IL App (3d) 150500WC, the Appellate Court considered the case of a restaurant manager who was injured by simply wiping down tables on a busy day. She had pre-existing arthritis of her thumb. The sole doctor's opinion claimed that the activity caused *"manifestation of symptoms"* but that her current symptoms were not related to her movement. Despite Dr. Wysocki's ultimate opinion regarding causation the Arbitrator, Commission, Circuit and Appellate Court all found for the Petitioner based on

thereafter. The Petitioner's doctor said the injury was the straw that broke the camel's back causing the underlying arthritic conditions to be symptomatic.

See also Peabody Coal v. Industrial Comm'n, 571 N.E.2d 1182, 213 Ill.App.3d 64 (Ill. App. 5 dist. 1991) wherein the Court noted that *"casual connection between work duties and condition of ill-being may be established by chain of events including workers' compensation claimant's ability to perform job duties before date of accident and inability to perform said duties following that day"*.

With regard to the issue of **"J" – "Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary services?"**

Based on the finding in Issue F and the testimony from Drs. Lehmann and Gross, the Arbitrator finds that the medical services provided were reasonable, but that the charges have not been paid. The Arbitrator awards all charges listed in Petitioner's exhibit 10.

With regard to issue **"G" – "What were Petitioner's earnings?"**

The Arbitrator finds that the Petitioner earned an Average Weekly Wage of $567.14. This is based on the unrebutted testimony of the Petitioner and Petitioner's exhibit 12.

With regard to issue **"L" – "What temporary benefits are in dispute?"**

The Arbitrator finds that the Petitioner has been kept off work by her treating physician, Dr. Lehmann through the date of the hearing, and that she should be paid TTD through the same, and until she reaches MMI or is able to return to work in some capacity. The Arbitrator awards Petitioner TTD benefits from 5/16/18 through the date of this decision at the TTD rate of $378.09. Through the date of the hearing on 4/04/18, this comes to a period of 46 and 2/7 weeks. Respondent to be given a credit for $10,161.81 in paid TTD.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JESSICA GREEN,

Petitioner,

vs. NO: 18 WC 006901

STATE OF ILLINOIS, DEPARTMENT OF REHABILITATION SERVICES,

Respondent.

20IWCC0167

DECISION AND OPINION ON REVIEW

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

The Arbitrator ordered that Respondent shall pay to Petitioner permanent partial disability benefits at a weekly rate of $253 for 5 weeks, as the injury caused a 1% loss of the use of the person as a whole. However, Petitioner testified at the hearing that she is no longer seeking treatment for the smoke inhalation at issue. Petitioner also testified she did not have lingering symptoms or issues associated with the smoke inhalation. She stated that she was no longer taking medication related to the smoke inhalation. She further stated that she was provided an inhaler by Rockford Memorial Hospital and used it for some time but was not using it at the time of the arbitration. Petitioner testified that she remained afraid of fire but Petitioner's counsel objected to any consideration of psychological issues in this matter. Accordingly, the Commission concludes the weight of the evidence does not support an award of permanent partial disability benefits and reverses the Decision of the Arbitrator on this issue.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner's condition of smoke inhalation was causally related to the accidental injury at work on February 14, 2018.

20IWCC0167

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay Petitioner's medical expenses in the amount of $1,143.74 pursuant to the fee schedule and §§8(a) and 8.2 of the Act, and to reimburse the State of Illinois Department of Family and Healthcare Services for benefits paid under Medicaid in the amount of $263.04.

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

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

DATED: MAR 12 2020
d: 1/23/20
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Deborah L. Simpson

Dissent

I respectfully dissent from the decision of the majority. I would have affirmed the well-reasoned decision of the Arbitrator in its entirety. In this case, Petitioner suffered significant smoke inhalation, had difficulty breathing, and developed a cough following the work-related accident on February 14, 2018. She was treated with an inhaler for weeks thereafter, from February 19 through October 15, 2018. During her treatment, Petitioner learned that she was pregnant and had been so at the time of the accident. She discontinued treatment because of her pregnancy. While Petitioner testified at the hearing in this matter, which was held well over a year after the accident, that she had no lingering symptoms from the smoke inhalation, that testimony, in my opinion, does not prevent an award of permanency. The Arbitrator awarded permanent partial disability benefits representing a 1% loss of use of the person as a whole. Under the circumstances of this case, I believe the award was appropriate.

Therefore, I respectfully dissent from the decision of the majority.

Marc Parker

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GREEN, JESSICA
Employee/Petitioner

Case# **18WC006901**

STATE OF IL - DEPT OF REHAB SERVICES
Employer/Respondent

20IWCC0167

On 5/24/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.34% 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:

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

6285 ASSISTANT ATTORNEY GENERAL
DANIEL KALLIO
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

MAY 24 2019

Brendan O'Rourke, Assistant 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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jessica Green
Employee/Petitioner

v.

State of IL Dept. of Rehab Services
Employer/Respondent

Case # **18** WC **6901**

Consolidated cases: _____

20IWCC0167

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Doherty**, Arbitrator of the Commission, in the city of **Rockford**, on **5/10/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **2/14/18**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**14,490.84**; the average weekly wage was $**278.67**.

On the date of accident, Petitioner was **25** years of age, ***single*** with **1** dependent children.

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

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

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

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

ORDER

Arbitrator orders respondent to pay to petitioner medical benefits of $1,143.74 pursuant to the IL Work Comp Fee Schedule and to reimburse IL Department of Healthcare and Family Services for payments made pursuant to Petitioner's Exhibit 8.

Arbitrator orders respondent to pay to petitioner permanent partial disability benefits at a weekly rate of $253 for 5 weeks as the injury caused 1% loss of use man 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.

Carolyn M. O'Neill

Signature of Arbitrator

5/23/19
Date

MAY 24 2019

FINDINGS OF FACT

Petitioner worked as a care giver for respondent for 6 months. On February 14, 2018, she was caring for a patient in her home assisting with cooking, cleaning, bathing and other self care of the patient. The patient required the use of oxygen 24 hours a day. On February 14, 2018, the patient removed her oxygen hose from her nose and placed it in her lap. She then lit a cigarette and started to fall asleep. The cigarette fell to the floor and the oxygen tube caught fire. Petitioner was in the kitchen at the time and heard the patient yell. When she got to the patient, Petitioner saw that a blanket covering the patient was on fire. Petitioner grabbed the blanket and removed it and attempted to put out the flames. Petitioner then got the non-ambulatory patient up out of the chair lifting her under the arms and carrying her from the house. Petitioner testified the room quickly filled with smoke. When she reached the kitchen, she stopped to call 911. She then brought the patient out of the home to a waiting ambulance. Petitioner attempted to return to the home for her belongings but was unable to enter as the smoke had completely filled the home. Petitioner testified that she inhaled thick black smoke. Accident is not in dispute. ARB EX 1.

Petitioner was checked over by EMTs at the scene but declined transportation to the hospital by the Byron Fire Department. PX 3. RX 2. She testified that she immediately had coughing and trouble breathing but went home. Later that night she was coughing continuously so she went to the emergency room at Mercy/Rockford Memorial on 2/15/18. PX 4. She was treated for smoke inhalation while in the ER. PX 4. She testified she was discharged with medication and an inhaler and told to followup with her family doctor. Two weeks later she was still suffering coughing fits and chest pain so she returned to the emergency room but at Swedish American Hospital on 2/27/18. PX 5. The records indicate that she complained of a sore throat but denied cough or chest congestion. PX 5. She was diagnosed with a virus and released. PX 5. The 2/27/18 records further indicate that Petitioner was involved in a house fire on 2/14/18 and that she requested a referral to a psychiatrist due to her trauma and continued nightmares. PX 5.

Petitioner testified that symptoms persisted for a few weeks and she was then seen at OSF St. Anthony hospital on 3/6/18. Petitioner presented with a congested cough. Chest x-rays taken on that date were normal. PX 6. Petitioner was diagnosed with a viral syndrome and was told she was pregnant. She was told to followup with an OGBYN doctor and a primary care doctor. PX 6. She testified she then sought treatment with Dr. Rizzo and her OBGYN for her pregnancy and to monitor her breathing. PX 7. Petitioner testified that her doctor recommended that she seek evaluation with a psychiatrist or psychologist as she was fearful of fires and was having nightmares. Petitioner testified that she was not able to see a psychiatrist. She did not seek any further treatment for her coughing after her last visit to OSF on 3/6/18.

At the time of trial, petitioner testified that she no longer is seeking treatment for the smoke inhalation. She testified that she was no longer taking medication nor using the inhaler. She had not sought psychiatric treatment but still felt fearful of fires and was unable to go to bonfires or have fires at home with her family because of that fear.

The only disputed issues at trial were causal connection, payment of medical bills and the nature and extent of the injury. ARB EX 1.

CONCLUSIONS OF LAW

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

Arbitrator finds that petitioner's condition of ill being was causally related to the accidental injury at work on February 14, 2018.

The evidence supports a finding that petitioner was injured at work on February 14, 2018 when a patient she was caring for started a fire in her home. Petitioner had to put the fire out on the patient's leg and couch and assist the patient out of the home. Petitioner's undisputed and credible testimony was that the home filled quickly with black smoke and that as a result of extensive damage to the home the patient had to relocate permanently to a nursing home. Petitioner credibly testified that she inhaled smoke from the fire. Petitioner was evaluated by the EMTs on the scene. PX 3. Despite petitioner declining transportation by ambulance to the hospital, she did seek treatment on her own later that same day. PX 4. The records of Rockford Memorial Hospital show that Petitioner presented on the date of the accident for treatment due to smoke inhalation. Based on a chain of events theory with treatment the same day and a history of the work injury consistent with petitioner's testimony, the Arbitrator finds that petitioner's condition of ill being, smoke inhalation, was causally related to the fire in the patient's home where she was working on February 14, 2018.

Arbitrator finds that respondent is responsible for payment of medical benefits pursuant to Section 8(a).

The respondent did not dispute the reasonableness of the medical treatment and bills submitted at trial in Petitioner's exhibit 8. Respondent only disputed liability for the bills based on causal connection. The bills all correspond to treatment for smoke inhalation. Therefore, the arbitrator orders the respondent to pay to petitioner medical benefits of $1,143.74 pursuant to the IL fee schedule and Sections 8 and 8.2 of the Act. Further, Arbitrator orders respondent to reimburse the State of IL Department of Family and Healthcare Services for benefits paid under Medicaid of $263.04.

Arbitrator finds that petition suffered permanent partial disability as a result of the injury.

Petitioner suffered smoke inhalation from the fire that took place at work on February 14, 2018. She sought and received treatment for her complaints of chest pain, coughing, and difficulty breathing for approximately one month as evidenced by her treatment records and testimony. Pursuant to Section 8.1b:

> *In determining the level of permanent partial disability, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability.*

No impairment rating was offered by either party into evidence. Therefore, no weight was given to that factor. On the date of accident, Petitioner was employed as a home care giver/personal assistant. This occupation involves physical care of a patient. However, Petitioner testified that she never returned to work as a personal care giver. Rather, she testified that she currently works at a Lowe's distribution center and that she does not have a breathing problem which interferes with her work ability. No testimony regarding economic impairment was provided. The Arbitrator further notes that Petitioner was 25 years old at the time of the injury and that she has an extended work force life. Some weight is given to this factor.

The final factor is evidence of impairment in the records. Petitioner consistently sought treatment for cough, congestion and breathing difficulty through 3/6/18. She was treated conservatively for her complaints. Petitioner testified that she stopped seeking treatment for cough and congestion due to her discovered pregnancy. Petitioner credibly testified that she was not having any ongoing symptoms at the time of trial. The Arbitrator places the greater weight on this factor. Given full consideration of the five factors, the Arbitrator finds that petitioner's permanent partial disability is 1% loss of use man as a whole pursuant to Section 8(d)(2) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARTIN G. WEIR,

Petitioner,

vs. NO: 04 WC 008139

CITY OF CHICAGO,

Respondent.

20IWCC0168

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary disability, permanent disability, and maintenance, 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. Maintenance

The Commission initially addresses the maintenance awarded to Petitioner. Under section 8(a) of the Act (820 ILCS 305/8(a) (West 2018)), an employer "shall *** pay for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto." "Since maintenance is awarded incidental to vocational rehabilitation, an employer is obligated to pay maintenance only 'while a claimant is engaged in a prescribed vocational-rehabilitation program.'" *Euclid Beverage v. Illinois Workers' Compensation Comm'n*, 2019 IL App (2d) 180090WC, ¶ 29 (quoting *W.B. Olson, Inc. v. Illinois Workers' Compensation Comm'n*, 2012 IL App (1st) 113129WC, ¶ 39). Vocational rehabilitation may include, but is not limited to, counseling for job searches, supervising job search programs, and vocational retraining, which includes education at an accredited learning institution. *Euclid Beverage*, 2019 IL App (2d) 180090WC, ¶ 30. An employee's self-directed job search or vocational training also may constitute a vocational rehabilitation program. *Roper Contracting v. Industrial Comm'n*, 349 Ill. App. 3d 500, 506 (2004).

In this case, the Arbitrator awarded maintenance benefits in the amount of $746.52 per week for 176 and 1/7ths weeks, from August 28, 2012 through January 16, 2016. This was the period during which Petitioner was receiving vocational rehabilitation and job search services from Coventry Workers' Comp Services (Coventry). Petitioner argues that he is entitled to an award of additional maintenance benefits for the time periods prior to and after he received services from Coventry. The Commission considers each period in turn.

A. March 1, 2006 – August 27, 2012

The first time period in dispute extends from March 1, 2006 through August 27, 2012, prior to the referral to Coventry. During this initial period, Respondent had sporadic contact with Petitioner regarding vocational rehabilitation and alternate employment.

On March 6, 2007, Robert Serafin, Respondent's Director of Workers' Compensation, wrote to Petitioner. In the letter, Mr. Serafin stated that to provide Petitioner with an opportunity for vocational rehabilitation, he had arranged an interview for Petitioner with the Department of Personnel. Mr. Serafin also wrote that based on Petitioner's qualifications, he would be placed on as many eligibility lists for positions with Respondent as appropriate. Mr. Serafin added that failure to attend the interview could jeopardize Petitioner's TTD benefits. Petitioner testified that he attended the meeting, but no job offers resulted from it.

A little over one year later, in an unsigned April 15, 2008 letter, Respondent notified Petitioner it had identified a position of Watchman with the Department of Water Management within Petitioner's physical capabilities. The letter set a date and time to process Petitioner's paperwork. The letter further stated that if Petitioner believed his restrictions would prevent him from performing the duties of the job, Petitioner must bring the relevant documentation to the appointment.

On the accompanying "willingness and ability questionnaire," Petitioner indicated he was willing and able to work in all types of weather, wear the proper clothing, check in hourly, remain alert, and work in various locations around the City of Chicago. However, Petitioner also indicated he was unable and unwilling to check all exterior facility doors, check the property perimeter, check all vehicle gates, check exterior protective lighting, check the entire perimeter of construction sites, maintain a clean and safe working area, or be assigned to various shifts including 16-hour shifts. At this point in time, the treating surgeon Dr. Nelson had opined Petitioner would "clearly need to have a work place that offers him primarily a sitting job" and could "walk on an occasional basis." Petitioner testified without rebuttal that he was not offered the Watchman position due to an issue with his ability to walk. Petitioner further testified without rebuttal that he had been unsure about the scope of the question about maintaining a clean and safe working area.

In the following month, Petitioner received two letters. In a May 1, 2008 letter, Mr. Serafin wrote that to return Petitioner to the workforce, the Committee on Finance had arranged for him to attend a career development workshop which included professional resume writing and interviewing skills. The letter again noted that if Petitioner did not attend, his benefits could be suspended or terminated. Petitioner testified that he attended the workshop.

Mr. Serafin (now identified as Director of the Committee on Finance) also wrote a May 2, 2008 letter arranging an appointment for Petitioner with the Department of Human Resources to create a profile for Petitioner on Respondent's then-new online job application system. Mr. Serafin again warned that failure to attend the interview could jeopardize Petitioner's TTD benefits. Petitioner testified he attended the interview, which did not result in any job offers.

Two years later, in a March 9, 2010 letter, Ellen Bell, Respondent's Director of Workers' Compensation, wrote that to help Petitioner pursue the job search or vocational rehabilitation necessary to establish an ongoing entitlement to workers' compensation benefits, the Committee on Finance had arranged another appointment for Petitioner with the Department of Human Resources to create a profile for Petitioner for Respondent's online job application system. Ms. Bell warned that failure to attend the interview could jeopardize Petitioner's workers' compensation benefits. She also provided a telephone number for Petitioner's "return to work coordinator." Petitioner testified he attended the interview but received no job offers.

Almost two and a half years later, on August 28, 2012, Respondent referred Petitioner to Coventry for full vocational services. The regular reports from Coventry by Courtney Goodwin indicate Petitioner received job skills training, developed his resume, provided at least 7 to 10 job leads weekly (occasionally dozens per reporting period), applied in person to prospective employers (occasionally also attended by Ms. Goodwin), reported to an interview for a Watchman position with Respondent, attended job fairs, and provided weekly logs of his job searches. Petitioner's vocational goals included but were not limited to light assembler, cashier, and customer service positions. Petitioner's vocational barriers were assessed as his age, employment gap, and lack of basic computer skills. Ms. Goodwin wrote that she encouraged Petitioner to take classes to increase his computer skills; he began taking basic computer classes by July 9, 2014. Petitioner testified that, generally, he met with Ms. Goodwin weekly and attended job fairs perhaps monthly.

Petitioner contends that the letters sent by Respondent establish that Respondent was providing its own vocational rehabilitation program from 2006 to 2012. However, a "program" inherently denotes some sort of plan. The difference between the letters and the systematic services later provided by Coventry (albeit unsuccessfully) is clear. Respondent's letters address vocational rehabilitation, but they do not establish any sort of plan for returning Petitioner to work. As Respondent observes, five letters sent over the course of approximately four years is not a vocational rehabilitation program, at least not based on the contents of the letters in this case.

Nevertheless, as noted above, section 8(a) obligates employers to pay for necessary vocational rehabilitation, including maintenance. 820 ILCS 305/8(a) (West 2018). Moreover, "section 8(a) does not place any burden upon employees to request vocational rehabilitation from their employer before maintenance may be awarded." *Roper Contracting*, 349 Ill. App. 3d at 505. Thus, the issue presented here is the extent of an employer's obligation during a period where an employee complied with each of Respondent's internal instructions but there was no "prescribed vocational-rehabilitation program" yet in place.

Petitioner cites the Commission's regulation requiring employers, when appropriate, to prepare a written assessment of the vocational rehabilitation required to return the injured worker to employment, including the necessity for a plan or program that may include vocational evaluation and retraining. 50 Ill. Adm. Code 7110.10 (eff. June 22, 2006) (amended at 30 Ill. Reg. 11743 (eff. June 22, 2006) and since recodified at 50 Ill. Adm. Code 9110.10 (eff. Nov. 9, 2016)).[1] In this case, both an assessment and program were "appropriate" under the Commission's rules, as proved by Respondent's own statements and actions. Respondent's Director of Workers' Compensation wrote to Petitioner expressly to provide him with an opportunity for vocational rehabilitation on March 6, 2007. On March 9, 2010, Respondent's Director of Workers' Compensation wrote with directions to help Petitioner pursue the job search or vocational rehabilitation necessary to establish an ongoing entitlement to workers' compensation benefits. By August 28, 2012, Respondent finally referred Petitioner to Coventry for full vocational services, raising the question of why this was not done earlier, particularly given that Petitioner's employment gap was later assessed as an employment barrier by Coventry. Furthermore, during this initial period, Respondent identified another potential job for Petitioner with Respondent.

This record leaves no doubt that Respondent believed Petitioner required vocational rehabilitation but never produced the assessments required by law, let alone a program aimed at returning Petitioner to work. The Commission's rule is not a suggestion. An employer that knowingly fails to prescribe a program of vocational rehabilitation when one is appropriate cannot rely on that failure to deny maintenance benefits to an employee who is willing to participate in vocational rehabilitation. Here, Petitioner consistently complied with Respondent's directions regarding vocational rehabilitation. The Commission is aware that there are a multitude of considerations and difficulties inherent in managing a workforce as large as that of this particular Respondent. However, the same individuals and offices were involved in Petitioner's particular post-injury assessments, so it cannot be said that Respondent was unaware that it was issuing vocational guidance over a prolonged period without performing an assessment or prescribing a program such as Coventry. Accordingly, Petitioner is entitled to maintenance benefits for the period of Respondent's knowing refusal of a vocational rehabilitation program.

B. January 12, 2016 – October 19, 2018

The Arbitrator also did not award maintenance benefits from January 12, 2016 through the hearing date of October 19, 2018. This is the period after the services from Coventry ended. Regarding this period, the Arbitrator was only partially correct.

The record indicates that a January 12, 2016 report from Coventry closed Petitioner's file after he reported obtaining employment with Respondent as a Laborer. Petitioner testified he attempted to return to the Department of Transportation on his own initiative. Petitioner also testified that he informed Coventry that he thought he was going back to work. According to Petitioner, he was fingerprinted and photographed for an identification card. However, Petitioner testified he "didn't get a job."

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[1] Moreover, Respondent knew or should have known when Petitioner reached MMI, inasmuch as the records indicate Dr. Maday's and Dr. Nelson's reports were marked for distribution to MercyWorks.

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In an August 26, 2016 letter, Margaret Wiencek of Respondent's Department of Transportation wrote to inform Petitioner that to continue receiving his disability benefits under the Act, he was required to actively pursue gainful employment using his current job skills and training. Ms. Wiencek directed him to submit weekly reports reflecting the pertinent data about each job sought, completing at least ten searches weekly to be documented using an attached "Injury on Duty Job Search Log." She also warned that failure to comply with job search requirements could jeopardize his weekly benefits or result in other disciplinary action.

Petitioner submitted Petitioner's Exhibit 3, which was comprised of the search logs which Petitioner submitted to Respondent weekly after receiving the August 26 letter. The first log, dated September 8, 2016, covers the week from September 1-7, 2016. The final log, dated October 16, 2018, covers the period from October 10-15, 2018.

Respondent submitted a labor market survey prepared by Coventry on April 3, 2018. The jobs listed therein, *e.g.*, cashier/receptionist or customer service representative for various automobile dealerships, AmeriCash loans, Horseshoe Hammond Casino, and Standard Parking, are essentially similar to the types of positions Coventry previously sought for Petitioner.

Petitioner further testified that he had submitted a reasonable accommodation request to Respondent. The request, dated September 4, 2018 and signed by Petitioner's treating surgeon, Dr. Nelson, raises Petitioner's restriction on lifting to 40 pounds. Petitioner testified that he has not heard from Respondent about any work since submitting the request. Petitioner later testified that he believed he could work for Respondent again with a reasonable accommodation but was not currently working with anyone to obtain a job with an accommodation.

The Arbitrator determined that a supposed *bona fide* job offer Petitioner received in January 2016 set the final date for maintenance benefits. Petitioner disputes that he received a *bona fide* job offer at that time. Respondent notes that Petitioner believed he would be returning to work and advised Coventry that he had secured the job.

The record includes Petitioner's unrebutted testimony that he did not get the job. The episode is consistent with several others in which Petitioner was photographed and fingerprinted as part of Respondent's application process but ultimately was not employed. Of note, Respondent provided no witness or evidence to controvert Petitioner's testimony establishing why he was not ultimately employed in the position. This is information that only Respondent controlled, and the lack of such evidence allows a negative inference to be drawn against Respondent on this point.

Nevertheless, Petitioner represented to Coventry that he had secured a job and as a result, Petitioner stopped receiving services from Coventry. Accordingly, after January 12, 2016, Petitioner was no longer engaged in a prescribed vocational rehabilitation program. There was also no evidence that Petitioner immediately engaged in a self-directed job search or vocational program.

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After receiving Respondent's August 26, 2016 letter, Petitioner regularly submitted the required search logs documenting ten weekly job searches for the period from September 1, 2016 through October 15, 2018. The logs, apparently accepted by Respondent without objection and detailing efforts similar to those Petitioner put forth while working with Coventry, establish that Petitioner was engaged in a diligent, self-directed job search during this period.

In sum, given the record as a whole, the Commission concludes that in addition to the period from August 28, 2012 through January 16, 2016, Petitioner also shall be awarded maintenance benefits for the period from March 1, 2006 through August 27, 2012, as well the period from September 1, 2016 through the hearing date of October 19, 2018.

II. Permanent Disability

The Arbitrator awarded Petitioner permanent partial disability benefits in the amount of $550.47 per week for 200 weeks, finding the injuries sustained caused 40% of the person as a whole pursuant to § 8(d)2 of the Act. Petitioner maintains that he is permanently and totally disabled and that he fits into the "odd-lot" category. Respondent argues that there is no evidence Petitioner is medically permanently and totally disabled, or that the vocational evidence or any opinion establishes that Petitioner cannot find work in a stable labor market. Indeed, Respondent asserts that Petitioner's job search resulted in a *bona fide* job offer from Respondent.

Initially, the Commission considers the timing of the permanency determination. The Illinois Supreme Court has written that "[u]ntil the claimant has completed a prescribed rehabilitation program, the issue of the extent of permanent disability cannot be determined." *Hunter Corp. v. Industrial Comm'n*, 86 Ill. 2d 489, 501 (1981). The Arbitrator here determined that vocational rehabilitation ceased on January 12, 2016 and thus could determine permanency. However, the record establishes Petitioner did not get the Laborer job in 2016, Respondent directed Petitioner to begin his own job search in August 2016, and the job search continued until the hearing date in this matter. Thus, determining permanency as of January 12, 2016 was in error. The remaining question is whether Petitioner's job search should be considered concluded now, as that question is central to Petitioner's argument for permanent total disability benefits.

An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify the payment of wages. *A.M.T.C. of Illinois v. Industrial Comm'n*, 77 Ill. 2d 482, 487 (1979). If a claimant's disability is of such a nature that he is not obviously unemployable, or there is no medical evidence to support a claim of total disability, the burden is upon the claimant to prove that he fits into an "odd lot" category; that being an individual who, although not altogether incapacitated, is so handicapped that he is not regularly employable in any well-known branch of the labor market. *Valley Mold & Iron Co. v. Industrial Comm'n.*, 84 Ill. 2d 538, 546-47 (1981).

Petitioner is not obviously unemployable and there is no medical evidence supporting a claim of total disability. Thus, the issue is whether Petitioner fits into the "odd lot" category.

A claimant seeking "odd lot" status must establish it by a preponderance of the evidence. *City of Chicago v. Illinois Workers' Compensation Comm'n*, 373 Ill. App. 3d 1080, 1091 (2007). A claimant ordinarily satisfies his burden in one of two ways: (1) by showing diligent but unsuccessful attempts to find work, or (2) by showing that, because of his age, skills, training, and work history, he will not be regularly employed in a well-known branch of the labor market. *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527, 544 (2007). Once a claimant establishes that he falls within an "odd lot" category, the burden shifts to the employer to prove that the claimant is employable in a stable labor market and that such a market exists. *Id.*

By these standards, Petitioner is eligible for permanent total disability benefits. Petitioner worked with Coventry for approximately three and one-half years and received no job interviews other than with Respondent. Petitioner's unrebutted testimony was that he ultimately did not get a job with Respondent in January 2016. Petitioner then followed Respondent's order and conducted a self-directed job search for over two years, again with no success.

In rebuttal, Respondent submitted a labor market survey from Coventry, but the positions listed are the same sorts of jobs for which Petitioner unsuccessfully applied for years. Petitioner was middle-aged with a job history consisting entirely of manual labor. Petitioner had some college education and a technical degree, but neither assisted him in finding employment during his multi-year efforts under the professional direction of Coventry. These factors all weigh in favor of finding permanent total disability.

Medical examinations by Drs. Cohen and Nelson both found Petitioner employable, but with significant, permanent work restrictions. Petitioner also testified that he believed he could work for Respondent again with a reasonable accommodation, but he was not ultimately employed by Respondent, which has an internal program established specifically to employ its injured workers. Respondent also was unsuccessful in otherwise placing Petitioner by using Coventry or during his self-directed job search.

Not all of the evidence supports a finding of permanent total disability, however. For example, the Arbitrator noted in her findings that there was no medical evidence submitted to support Petitioner's claim that he could not maintain a clean and safe work environment or was limited in the hours he could work for the Watchman position. The Arbitrator also noted that the surveillance video provided to Dr. Cohen contradicted Petitioner's claim at the time that he could walk no longer than 35 feet.

Yet, the Arbitrator generally found Petitioner credible regarding his medical history, mechanisms of injuries, course of medical treatment, and current subjective complaints. Accordingly, given the record in this case, the Commission concludes the weight of the evidence demonstrates that Petitioner is permanently and totally disabled.[2]

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[2] The Commission opts to award Petitioner benefits for permanent and total disability under section 8(f). Claimants otherwise have the option of seeking permanency awards under either permanent partial disability or wage differential. Our supreme court has expressed a preference for wage differential awards. *Lenhart v. Illinois Workers' Compensation Comm'n*, 2015 IL App (3d) 130743WC, ¶ 43. In this matter, however, Petitioner was never offered employment to establish earning capacity to differentiate from his prior earnings and calculate the wage differential. Moreover, the determination that Petitioner is permanently and totally disabled implies that he cannot obtain gainful employment, therefore his current earning potential is zero and, again, there is no basis upon which to

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In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $83,290.30, representing $746.52 per week for a period of 111 and 4/7ths weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner maintenance benefits of $746.52/week for 515 and 3/7ths weeks, commencing March 1, 2006 through January 16, 2016, and 111 and 1/7ths weeks, commencing September 1, 2016 through October 19, 2018, as provided in Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is awarded a credit of $204,973.06 for temporary total disability benefits already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is awarded a credit of $370,807.15 for maintenance benefits already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner permanent and total disability benefits of $550.47 per week for life, commencing January 23, 2018, as provided in § 8(f) of the Act, because the injury sustained caused the complete disability of the Petitioner rendering him wholly and permanently incapable of work.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing on the second July 15th after the entry of this award, the Petitioner may become eligible for the 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.

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award a wage differential.

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

DATED: MAR 12 2020
d: 1/23/20
BNF/kcb
045

Barbara N. Flores

Marc Parker

Concurrence in Part and Dissent in Part

I respectfully concur in part and dissent in part from the Decision of the majority. The Arbitrator awarded Petitioner 111&4/7 weeks of TTD, 176&1/7 weeks of maintenance, and 200 weeks of PPD, representing loss of 40% of the person-as-a-whole. The majority modified the Decision of the Arbitrator to increase the award of maintenance to 515&3/7 weeks and to increase the PPD award from 40% of the person-as-a-whole to declare Petitioner permanently and totally disabled from employment for life. I concur with the majority in increasing the maintenance award. However, I dissent from the portion of the decision of the majority increasing the PPD award from 40% of the person-as-a-whole to PTD. I would have affirmed the Arbitrator's PPD award.

The Arbitrator found, and the majority conceded, that there was insufficient medical evidence to find Petitioner medically PTD. No doctor has opined that Petitioner was PTD. Rather, the majority declared Petitioner PTD based on the odd-lot theory of permanent and total disability. Petitioner did conduct a job search for several years. Respondent identified a job as security guard. However, Petitioner did not even apply or try to perform the job duties. Instead, he decided on his own that he could not do it even though it was within his restrictions. He placed restrictions on himself that no doctor imposed.

The record reveals that Petitioner advised the third-party administrator that he was offered a job, which resulted in vocational rehabilitation being terminated on January 11, 2016. However, the record also indicates that Petitioner never began the job, though there is no evidence in the record why Petitioner did not work the job, or whether he informed the third party administrator either that the job offer was withdrawn or that he declined the offer. Nor is there any evidence that Petitioner advised the administrator that his lifting limit was raised so that the jobs for which he could apply could be revised to include more job categories. Therefore, Petitioner has not established an unsuccessful job search.

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In addition, regarding his suitability for employment generally, on April 3, 2018, Respondent commissioned a labor market survey finding various job categories within his weight restrictions at the time, which was 25 pounds. Those categories included customer service clerk/representative, receptionist, cashier, and greeter/information clerk. Thereafter, on September 4, 2018, Dr. Nelson increased Petitioner's weight restrictions from 25 pounds lifting to 40 pounds lifting. It seems obvious to me, that if there were various job categories suitable for Petitioner with a 25-pound limit, there would be more job categories suitable for Petitioner with a 40-pound limit. Because Petitioner was actually offered a job by Respondent and Respondent has identified various job categories for which Petitioner was qualified, Petitioner has not sustained his burden of proving he was PTD. Finally, I agree with the reasoning and analysis of the Arbitrator by which she awarded Petitioner 200 weeks of PPD representing loss of 40% of the person-as-a-whole.

For the reasons stated above, I concur with the majority in increasing the maintenance award. However, I dissent from the portion of the decision of the majority increasing the PPD award from 40% of the person-as-a-whole to PTD. I would have affirmed the Arbitrator's PPD award. Therefore, I respectfully dissent.

DLS/dw
O-1/23/20

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WEIR, MARTIN G
Employee/Petitioner

Case# **04WC008139**

02WC058348

CITY OF CHICAGO
Employer/Respondent

20IWCC0168

On 3/29/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLEN HASKINS NICHOLSON ET AL
PATRICK B NICHOLSON
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0766 HENNESSY & ROACH PC
AUKSE R GRIGALIUNAS
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

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STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Martin G. Weir
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **04** WC **08139**

Consolidated cases: **02 WC 58348**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Tiffany Kay**, Arbitrator of the Commission, in the city of **Chicago**, on **10/19/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **9/25/2003**, Respondent ***was*** operating under and subject 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 **$58,228.56**; the average weekly wage was **$1,119.78**.

On the date of accident, Petitioner was **48** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$204,973.06** in TTD, **$0** for TPD, **$370,807.15** for maintenance, and **$0** for other benefits, for a total credit of **$575,780.21**.

Order

Respondent shall pay temporary total disability benefits in the amount of $746.52 per week for 111 4/7 weeks from November 13, 2003 through October 3, 2004 and December 1, 2004 through February 28, 2006;

Respondent shall pay maintenance benefits in the amount of $746.52 per week for 176 1/7 weeks from August 28, 2012 through January 12, 2016;

Respondent shall pay permanent partial disability benefits in the amount of $550.47 per week for 200 weeks, because the injuries sustained caused 40% loss of use of a man as a whole pursuant to Section 8(d)(2) of the Illinois Workers' Compensation Act for a change in occupation.

See attached Findings of Fact and Conclusions of Law for detailed findings.

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

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

03/28/19
Date

ICArbDec p. 2

MAR 29 2019

PROCEDURAL HISTORY

This case has been consolidated with the following case: 02WC58348.

The matter of case # 04WC8139 was heard before Arbitrator Tiffany Kay (hereinafter "Arbitrator Kay") on October 19, 2018 in Chicago, Illinois. The submitted records have been examined and the decision rendered by Arbitrator Kay. The parties stipulated that the City of Chicago (hereinafter "Respondent") and Martin G. Weir (hereinafter "Petitioner") were operating under the Workers' Compensation Act (hereinafter "Act") on September 25, 2003, that there was a relationship of employer and employee between the Respondent and Petitioner, the Petitioner did sustain an accident that arose out of and in the course of her employment with Respondent, that his current condition of ill-being is connected to his injury and that timely notice was given. In addition, the parties stipulated that the medical services provided to Petitioner were necessary and reasonable and that Respondent has paid all medical bills. The stipulated average weekly wage in accordance to the Act was $1,119.78, the Petitioner was 48 years old at the time of the accident, married with 1 dependent child. (Arb.X1)

The issues in dispute were whether Petitioner was entitled to temporary total disability for the periods of 11/13/2003 to 10/03/2004, 12/01/2004 to 3/31/2009 to 04/06/2013 to 04/19/2003, representing 274 4/7th weeks and for maintenance for the period of 04/01/2009 to 04/05/2013; 04/20/2013 to 10/19/2018 representing 496 5/7th. In addition, the nature and extent of the injury is in dispute. (Arb. X1)

SUMMARY OF FACTS AND EVIDENCE

The Petitioner testified that he was still employed by Respondent as a cement mixer at the time of his accident on September 25, 2003. (T.8) He had been working there since 1994. His job duties included digging holes for forms, unloading trucks, preparing sites for concrete. He stated that he used jackhammers, shovels, rakes and bars to dig out rocks. (T.8-9) His team mostly repaired streets, curbs, gutters, and sidewalks. (T.9) He also carried wood forms which are 2X10 and weigh approximately 20 pounds each. (T.10)

On September 25, 2003, the date of the accident, Petitioner testified that he was running the cement chute. (T.16) There was a big mound of dirt and stone and he fell because the chute was so heavy. (T.16) Petitioner testified that he fell on a mound of dirt and stone. (T.16) When he fell he fell on his right knee and he felt something twist in his knee. (T.17) Petitioner testified that his left knee was hurt also. (T.17)

On September 25, 2003, Petitioner went to MercyWorks for treatment. (P.X6) X-rays were performed of both knees, and the petitioner was diagnosed with a bilateral knee strain at that time and was released to return to work full duty. The petitioner returned to MercyWorks on October 15, 2003 and they recommended an MRI of the bilateral knees.

On October 16, 2003 an MRI was performed of the petitioner's bilateral knees. (PX 12) The MRI revealed stress fracture in proximal tibia, extensive tear of medial meniscus with some displacement of fragments, joint fluid volume which may represent meniscal tear or arthrosis identifiable as degenerative change in medial femoral tibia compartment. (PX. 11).

On October 29, 2003, Petitioner saw Dr. Maday who recommended surgeries to both knees. (T.18) Petitioner remained at work until November 12, 2003 (T.18) On December 1, 2003, Dr. Maday performed arthroscopic surgery on Petitioner's right knee. Petitioner underwent a course of PT at MercyWorks. The post

operative diagnosis was right knee medial meniscal tear with degenerative changes with lateral meniscal tear. (PX 12)

On February 5, 2004, Petitioner underwent a second surgery by Dr. Maday to his left knee. The operation that was performed was a left knee partial medial and lateral meniscectomy as well as a microfracture of the medial femoral condyle. (PX 12) Petitioner underwent a course of PT at MercyWorks following the surgeries.

On October 4, 2004, Petitioner returned to work through November 30, 2004 with the use of a cane. (T.21) The petitioner was not improving, so Dr. Maday referred him to Dr. Nelson. The petitioner saw Dr. Nelson on December 10, 2004 and he recommended additional left knee treatment in the form of a left total knee replacement.

On July 27, 2005, Petitioner underwent a left total knee replacement at the hands of Dr. Nelson (PX 12) The petitioner underwent a post-operative course of physical therapy, followed by work hardening. The petitioner was discharged from work hardening on February 27, 2006. The discharge notes indicated that the petitioner could lift 20 pounds occasionally. It stated that the petitioner needed to change positions frequently between sitting, standing and walking. (PX 8)

On February 28, 2006, Petitioner followed up with Dr. Nelson. Dr. Nelson stated that the petitioner was at maximum medical improvement and could return to work consistent with the work hardening discharge. (PX 12) Dr. Nelson further indicated that the petitioner should work primarily in a sitting job and can walk on an occasional basis, but climbing and kneeling and squatting should be limited. The Arbitrator notes that there was no evidence that the Petitioner began a job search at this time, nor that vocational rehabilitation was demanded or provided by the Respondent.

On October 12, 2012, Petitioner underwent a §12 exam, by Dr. Cohen, at the Illinois Bone and Joint Institute. (R. X1) Dr. Cohen reviewed Petitioner's medical records and also performed x-rays of the Petitioner that day. The x-rays showed total left knee replacement in satisfactory position. The right knee showed arthritic changes of the medial compartment. He also reviewed video surveillance that was performed on July 6th and July 9, 2012 which lasted for 54 minutes. The surveillance depicted the Petitioner walking around and performing various errands/tasks and descending stairs. There was no evidence of marked pain behavior or issues with walking. (RX 1) Dr. Cohen diagnosed Petitioner with stable left total knee replacement with good motion. (RX 1) He states no further treatment is needed for the left knee and that he was at MMI. The report stated that Petitioner was capable of working. Petitioner stated that he could not walk more than 35 feet, however, the video showed otherwise. Dr. Cohen indicated that reasonable restrictions would be to avoid squatting, kneeling, crawling or repetitive climbing, indicating he could work on level surfaces and a sedentary position. It indicated that the petitioner had a lifting restriction of 25 pounds, and he stated that the petitioner cannot return to his regular duties as a cement mixer. (RX 1)

On August 28, 2012, Respondent provided vocational rehabilitation services through Coventry for Petitioner. (PX 13) The Petitioner met with a vocational counselor once a week and was provided job search training. He went to job fairs about once a month and took computer classes at Oak Lawn library. The petitioner testified that Exhibits 1 and 2 constitute job search logs prepared by himself from August 24, 2012 through January of 2016. Petitioner's Exhibit 3 constitutes job search logs created by himself and turned in to the Respondent from August 8, 2016 through the present.

According to a letter sent by the Respondent, on April 15, 2008, it indicated that a job as a watchman had been identified for Petitioner within his physical capabilities. (P.X5) The letter stated that the Petitioner should appear on April 21, 2008 in order to begin the process of returning to work in this position. It stated that if Petitioner did not believe he was able to perform the job, he should bring relevant documentation. According to the "Willingness and Ability Questionnaire," which the Petitioner testified that he filled out, he stated that he is not willing or able to perform the job of a Watchman, going so far as to say that he could not even maintain a clean or safe working environment, or work up to a 16-hour shift. (T. 41-42, PX 5) The Arbitrator notes that there was no medical evidence submitted to support that Petitioner cannot maintain a clean and safe work environment, nor limited in any way in the number of hours he is allowed to work.

On August 13, 2013, Petitioner was offered a job for the City of Chicago as a Traffic Enforcement Technician at the Department of Transportation. (T. 26, PX 5) This was a sedentary job with no physical requirements where the Petitioner's primary tasks would be to view video from the City's speed cameras and verify speed enforcement incidents. (PX 5) Petitioner was asked to come in for finger prints and to fill out pre-employment paperwork. The petitioner testified that he complied and had his fingerprints and photos taken for security purposes. Petitioner testified that he did not receive the position. (T.27)

On September 4, 2018, Dr. Nelson completed a reasonable accommodation request which Petitioner submitted to Respondent. This request reiterated the foregoing restrictions but with lifting not greater than 40 pounds. (RX. 4).

The Arbitrator notes that the Petitioner introduced into evidence logs regarding job searches performed at the request of Coventry from August 24, 2012 through January 8, 2016 (PX. 1, PX. 2 and PX. 4) and from September 18, 2016 through September 25, 2018. (PX. 3) Petitioner submitted approximately 86 pages of handwritten job logs from August 24, 2012 to May 16, 2013 with five job searches on most pages. (PX. 1) Petitioner submitted approximately 212 pages of job logs for Coventry from February 9, 2013 to January 8, 2016 with five job searches on most pages (PX. 2) as well as 486 pages of computer job searches with Career Builder. (PX. 4) Petitioner also submitted approximately 186 pages of job searches as required by Respondent beginning September 18, 2016 of ten searches per week. (PX. 3)

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment/Summary of Testimony:

The Petitioner, Martin G. Weir, was the only witness to testify at trial. The Arbitrator finds the overall testimony of Petitioner to be truthful, credible and otherwise unrebutted regarding his past medical history, mechanisms of injuries, course of medical treatment and current subjective complaints.

With respect to issue (L), whether the Petitioner is entitled to TTD for the period of 11/13/2003 to 10/03/2004, 12/01/2004 to 3/31/2009 to 04/06/2013 to 04/19/2003, representing 274 4/7th weeks and for maintenance for the period of 04/01/2009 to 04/05/2013; 04/20/2013 to 10/19/2018 representing 496 5/7th weeks the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. The Arbitrator awards temporary total disability benefits in the amount of $746.52 per week for 111 4/7 weeks from November 13, 2003 through October 3, 2004 and December 1, 2004 through February 28, 2006. In support of this finding, the Arbitrator relies on the following facts:

First, the petitioner was not taken off work completely by any physician until November 13, 2003 and the petitioner testified that he did return to work full duty immediately following the injury date of September 25, 2003 for a few weeks. Second, the petitioner testified that he returned to work for the respondent for a short period of time while using a cane from October 4, 2004 through November 30, 2004. Finally, Dr. Nelson placed the petitioner at maximum medical improvement following his work hardening discharge on February 28, 2006.

Therefore, relying on the facts provided in the medical records and corroborated by the petitioner's testimony, the Arbitrator finds that the petitioner is entitled to TTD from November 13, 2003 through October 3, 2004 and December 1, 2004 through February 28, 2006.

Respondent claims that it has paid $204,973.06 in TTD benefits, the amount is not disputed by the petitioner, and shall receive a credit for same.

The Arbitrator awards maintenance benefits in the amount of $746.52 per week for 176 1/7 weeks from August 28, 2012 through January 12, 2016. In support of this finding, the Arbitrator relies on the following legal precedent and facts of the case:

For a claimant to be entitled to maintenance benefits he must prove, by a preponderance of the evidence, his injury impaired his earning capacity, AND that he is either enrolled in a vocational rehabilitation program or engaged in a diligent, self-directed job search. Roper Contracting v. Industrial Commission, 349 Ill. App. 3d 500 (2004); see also Nascote Indus. v. Indus. Comm'n, 353 Ill. App. 3d 1067, 1075 (2004); Connell v. Industrial Comm'n, 170 Ill.App.3d 49, 55 (1988). Petitioner failed to prove the second of these elements from March 1, 2006 through August 27, 2012 and following January 12, 2016.

Upon review of the complete record, there does not appear to be evidence of either a self-directed job search or formal vocational rehabilitation (nor a demand for same) for quite some time following the petitioner's MMI date of February 28, 2006. While there were a few letters forwarded to the petitioner by the City of Chicago requesting the petitioner appear at job fairs and to come in for an interview regarding the watchman position, as well as offering the position for "Traffic Enforcement Technician," (PX 5) there is no indication that the petitioner was engaged in a diligent, self-directed job search or enrolled in a vocational rehabilitation program from the period of March 1, 2006 through August 27, 2012.

The record is also devoid of evidence that vocational rehabilitation was demanded by the petitioner, or that any requests for hearing were filed by the petitioner demanding this Commission to order vocational rehabilitation benefits, if the respondent was not offering same. Eventually, it does appear as though vocational rehabilitation was provided by the respondent through Coventry, however this did not begin until August 28 of 2012. (PX 13) There was no explanation provided by either party for the delay in providing these services. There is no evidence submitted by the petitioner indicating that vocational rehabilitation was demanded, that it was refused by the respondent, or that any motions were filed before this Commission requesting that vocational rehabilitation with a counselor of his choice be ordered by the Commission. It is unknown, based on the evidence submitted in the record, why vocational rehabilitation was not initiated. The petitioner did not testify as to any problems regarding obtaining vocational rehabilitation between 2006 and 2012, nor did he testify that he demanded vocational rehabilitation between 2006 and 2012.

Second, there is no evidence that the petitioner was engaged in a self-directed job search between his MMI date of February 28, 2006 and August 28, 2012. All job search logs provided in Petitioner's exhibit 1 and 2 outline the petitioner's job search beginning in 2012, but there are no job logs which predate the petitioner's

vocational rehabilitation with Coventry. The petitioner also did not testify as to ever performing a self-directed job search, only that he underwent job placement services through Coventry beginning in 2012.

Therefore, because the petitioner was not engaged in a vocational rehabilitation program, nor was he performing a self-directed job search between February 28, 2006 and August 27, 2012, maintenance benefits would not be appropriate for that period of time.

Finally, the arbitrator relies on the bona fide job offer made by the City of Chicago for the Department of Transportation position as a laborer in January of 2016 as a proper termination date for maintenance benefits. The best evidence as to the petitioner's job offer is the vocational rehabilitation records from Coventry indicating on January 12, 2016, that the petitioner was to start his position next week, and he was already fingerprinted and taken photos for identification. (PX 5) Vocational rehabilitation was terminated on this day. The petitioner testified consistently with the Coventry report. There is no indication as to why the petitioner did not start this job. It appears as though the petitioner was about to begin working, however there is no evidence as to why the petitioner did not begin work at this position. There is no evidence that the job offer was withdrawn in any way. There is simply no evidence in the record as to why the petitioner did not actually begin working at this position. As such, the Arbitrator must conclude that this was a bona fide job offer made by the respondent to the petitioner in order to begin working on or about January 12, 2016. There is no evidence to support otherwise.

Therefore, based on the facts presented on the record, maintenance benefits are awarded in the amount of $746.52 per week for 176 1/7 weeks from August 28, 2012 through January 12, 2016.

The respondent has made payments in the amount of $370,807.15 and shall receive a credit for same.

With respect to issue of the Nature and Extent of the injury, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. For injuries that occur before September 1, 2011, the Commission evaluates the physical impairment and the effect of the disability on the injured employee's life. Factors that may be considered include the individual's age, skill, occupation, training, inability to engage in certain kinds of activities, pain, stiffness or limitation of motion.

With regard to the Petitioner's age, he was 48 years of age at the time of his work-related injury on September 25, 2003. Petitioner testified that when he walks two to four blocks he has to stop and rest a bit due to the pain and throbbing in his knees. (T.36) Petitioner ices his knees at night, has issues driving long distances and as a limited amount of weight he can lift due to the pressure it places on his knees. (T.37) The Petitioner's permanent partial disability with regard to his knees will be something he has to live and work with for an extended period of time. A time frame much longer than that of an older individual in his occupation. Therefore, the Arbitrator gives some weight to this factor.

With regard to the Petitioner's skill, occupation, and training, the Arbitrator notes that the Petitioner testified that he wants to return to work in his position with reasonable accommodations related to his knee. Petitioner testified that he has made a reasonable accommodation request to the City of Chicago pursuant to the Americans with Disabilities Act. (PX 14) Petitioner testified that he was hoping to return to work in a "lighter job". (T.43) In a medical questionnaire signed by the petitioner's treating physician, Dr. Nelson, on September 4, 2018, it indicates that the Petitioner's restrictions have been relaxed, and that the petitioner can lift up to 40 pounds, however the petitioner is to avoid climbing, kneeling, squatting and no extended standing or walking. The

petitioner testified that he is ready, willing and able to work at this time. (PX 14) The Arbitrator notes that the Petitioner testified that has not been assigned anyone from the City to work with to fulfill this request/accommodation. (T.43) Therefore, the Arbitrator gives some weight to this factor.

With regard to the Petitioner's inability to engage in certain kinds of activities, pain, stiffness or limitation of motion the Petitioner testified that today he notices that he can walk better now than he used to and could go 2-4 blocks before he needs to stop and rest. He stated it is hard to bend his left knee and very difficult to bend down or kneel. He stated that he takes stairs one at a time up and down. He stated that he can drive for up to an hour before he needs to get out and stretch. He can lift 20 pounds. At this point, he is no longer treating for his knees and no longer uses a cane. Therefore, the Arbitrator 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 40% man as a whole pursuant to Section 8(d)(2) of the Act.

Signature of Arbitrator

3/29/18
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gregory Sefton,
Petitioner,

vs. No. 13 WC 08516

20IWCC0169

Joiner Sheet Metal & Roofing.,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that, the Decision of the Arbitrator filed December 5, 2018, is hereby affirmed and adopted.

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.

20IWCC0169

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $17,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 12 2020

Marc Parker

mp/wj
01/23/20
68

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SEFTON, GREGORY
Employee/Petitioner

Case# **13WC008516**

11WC007247

JOINER SHEET METAL & ROOFING
Employer/Respondent

20IWCC0169

On 12/5/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.49% 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:

4075 FISHER KERKHOVER COFFEY ET AL
JASON E COFFEY
1300 1/2 SWANWICK ST SUITE 203
CHESTER, IL 62233

1337 KNELL LAW LLC
LLIR IMERI
504 FAYETTE ST
PEORIA, IL 61603

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

20 IWCC0169

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

GREGORY SEFTON
Employee/Petitioner

v.

JOINER SHEET METAL AND ROOFING
Employer/Respondent

Case # **13** WC **08516**

Consolidated cases: **11 WC 07247**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **July 9, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 9, 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, but the Petitioner reached maximum medical improvement as of September 29, 2014.

In the year preceding the injury, Petitioner earned **$57,624.32**; the average weekly wage was **$1,108.16**.

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 **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$12,384.47** for other benefits, for a total credit of **$12,384.47**.

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

ORDER

The Arbitrator finds that the Petitioner sustained a causally related injury to his upper to mid spine involving a sprain/strain, as well as to the left soft tissue area around the left shoulder blade. However, the Arbitrator finds that the Petitioner reached maximum medical improvement with regard to this injury as of September 29, 2014.

Respondent shall pay Petitioner temporary total disability benefits of **$738.77 per week** for **6/7 weeks**, commencing **July 13, 2012 through July 18, 2012**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services incurred through and including the 35th visit to chiropractor Dr. Miller, as provided in Sections 8(a) and 8.2 of the Act. This includes treatment incurred at Fairfield Hospital, Clay Medical (NP Siemer) and Advanced Healthcare/Flora Chiropractic (Dr. Miller).

Respondent is entitled to credit for any of the awarded medical benefits that have been paid prior to hearing, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$664.90 per week** for **25 weeks**, because the injuries sustained caused the loss of use of **5% of the person as a whole**, as provided in Section 8(d)2 of the Act.

The Petitioner has failed to prove that he is entitled to prospective medical treatment.

The Petitioner has proven that he did not choose physicians in excess of the two doctor rule.

The Petitioner has failed to prove that he is entitled to travel / mileage expenses.

Respondent shall pay Petitioner compensation that has accrued from **September 29, 2014** through **August 10, 2017**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

November 27, 2018
Date

DEC 5 - 2018

STATEMENT OF FACTS

The Petitioner testified that while working for Respondent Solid Platforms on 10/13/10, he was moving a heavy load with a hand jack to an outside elevator. While trying to move the jack loose from being stuck in a crack on the floor he testified he injured his spine, mainly the mid to lower back. His first treatment was with occupational medicine on 10/29/10, testifying the Respondent initially didn't want to send him for treatment. He reported moving a 5,000 to 6,000 pound load with the hand jack, and that he had 8 out of 10 level back pain with aching and a "pins & needles" feeling. Examination indicated tenderness from the lower thoracic spine centrally down to the mid-lumbar spine. Neurologic exam was essentially normal, but Petitioner had reduced range of motion. X-rays showed no acute findings but reflected mild multilevel thoracic spondylosis. Petitioner was diagnosed with thoracic and lumbosacral strains, was prescribed Hydrocodone, ibuprofen and a muscle relaxer (Metaxalone), and was given light duty restrictions. The doctor indicated the problem was related to the noted work activities. (Px1).

At an 11/5/10 follow-up, Petitioner reported improvement in his stabbing lower thoracic/upper lumbar pain but ongoing pain and soreness. He had no leg symptoms. He was working light duty and indicated he wanted to return to his regular job if possible. A safety officer was noted to be present with the Petitioner. He was released back to full duty on 11/5/10, with "caution" for reaching below the waist and heavy lifting. Petitioner returned on 11/15/10, again with a company representative, and noted ongoing symptoms in his left spine. He again advised he wanted to return to full duty, and he was again advised he could do so. (Px1).

Despite indicating he was carrying a clipboard and checking people in and out at work, as opposed to regular duty, on 11/30/10 the Petitioner reported he was considerably worse, particularly with prolonged standing, and that he was out of medication. Pain was noted from the left pelvis to the lower rib paraspinals. His work activities were again restricted, medication prescriptions were renewed, and an MRI and physical therapy were

prescribed. (Px1). The Petitioner testified he was contacted by the occupational medicine facility and advised that a follow up visit in December was not being authorized by Respondent. Petitioner next sought treatment at Clay Medical Center, his primary care provider, where he saw nurse practitioner (NP) Siemer on 12/1/10 and 12/6/10. Petitioner indicated was his first voluntary choice of physician. The report from 12/6/10 references chest pain and notes increased stress due to a work injury and loss of job. (Px2 & 3).

A 12/7/10 consultation report from the Effingham Clinic notes Petitioner injured his back at home on 10/13/10 with some chronic difficulties since and his use of medications. 12/13/10 and 12/22/10 reports from St. Anthony Hospital indicate the Petitioner reported a history of chest pain and shortness of breath going back to approximately November 30th, for which the Petitioner was worked up. No back complaints were noted. (Px3).

Petitioner testified he then saw NP Siemer in December 2010, and she prescribed MRI testing which was performed on 1/19/11. The thoracic MRI showed: 1) Mild degenerative disc disease in the mid and lower thoracic spine with small Schmorl's node at multiple levels, most significant at T11/12; 2) Diffuse disc bulge at T11/12 causing mild spinal canal stenosis but no evidence of cord compression and mild right T11/12 foraminal stenosis, with no definite evidence of impingement of the nerve root; 3) Mild foraminal stenosis at T1/2 bilaterally; 4) Small disc bulges at T1/2, T2/3, and T8/9 causing indentation of the thecal sac, but no spinal canal stenosis or foraminal stenosis; and 5) Mild degenerative disc changes and degenerative changes at the costovertebral joints at multiple levels in the mid and lower thoracic spine. The lumbar MRI impression was: 1) Disc space narrowing with dehydration of intervertebral discs at L3/4 and L4/5; 2) a Schmorl's node with indentation at the superior endplate of L4/5 with adjacent inflammatory changes; 3) a small Schmorl's node at the superior endplate of L3; 4) Diffuse disc bulge and facet arthropathy at multiple locations, but no spinal canal stenosis; 5) Focally prominent right foraminal disc bulge at L2/3 causing moderate right foramina stenosis with displacement and possible mild impingement of right L2 nerve root; and 6) moderate hypertrophic facet arthropathy at L5/S1 causing moderate bilateral L5/S1 foraminal stenosis, with bony spurs from the facet joint abutting the exiting L5 nerve roots bilaterally. (Px3; Rx17; Rx19). Following the MRI, Petitioner was referred to orthopedic surgeon Dr. Gabriel.

Petitioner initially saw Dr. Gabriel on 2/9/11, where he reported a consistent history of the accident. He noted that medication "helped some" but was "masking" the injury. Following examination and review of the MRIs, Dr. Gabriel diagnosed a thoracolumbar sprain/strain; bulging T11/12 disc protrusion with a disc-spur complex causing spinal stenosis, disc protrusions at T2/3, C8/9 and T1/2 [*Arbitrator's Note*: this appears to be a clerical error, as there is no C8/9, and that this should be T8/9, per the testimony of Dr. Gabriel]; Schmorl's nodes at L4 and L5 with degenerative disc disease, narrowing at L3/4 and L4/5, and multilevel lumbar degenerative disc disease/bulging disc/facet arthropathy. Dr. Gabriel believed that T11/12 appeared to be the most symptomatic level due to a combination of a disc protrusion and spinal stenosis. He prescribed a lumbosacral corset and lumbothoracic physical therapy as well as a T11/12 epidural and restricted Petitioner's work duties. On 3/14/11, Petitioner reported the injection and therapy had not been approved. Norco and Skelaxin were prescribed. (Px4; Rx12).

Petitioner saw pain specialist Dr. Ghalambor for consultation on referral from Dr. Gabriel on 3/31/11. He reported pain in the mid low thoracic lumbar area without radiation to the legs. Lumbar epidural was not performed by Dr. Ghalambor at L1/2 until 4/29/11 because the Petitioner had to stop taking aspirin for at least 7 days. (Px3; Rx13; Rx14). On 4/29/11, Dr. Ghalambor's impressions were: 1) thoracolumbar sprain/strain, 2) bulging disc protrusion with disc-osteophyte complex causing spinal stenosis T11/12 worst level, 3) disc protrusions at T2/3, C8/9 and T1/2, 4) neuroforaminal stenosis at right L2/3 with foraminal disc and bilateral L4/5 and L5/S1 neuroforaminal stenosis, 5) right kidney lesion, 6) Schmorl's nodes at superior L4 and L5 with degenerative disc disease, narrowing L3/4, L4/5 and multilevel degenerative disc disease and facet arthropathy

lumbosacral spine as well as bulging discs. Petitioner reported some tingling in the left leg "only one time." He was neurologically stable and intact in the lower extremities. Dr. Ghalambor noted Petitioner was waiting for therapy authorization and he wanted to see how that went before determining if further epidural injections were indicated. (Rx15).

Petitioner returned to Dr. Gabriel on 5/4/11 and reported the epidural did not help. He continued to complain of thoracic and low back pain. Dr. Gabriel's diagnosis remained the same and he recommended continuing his medications and undergoing physical therapy. Dr. Gabriel noted that Petitioner was having moderate/severe spasm at the thoracic/lumbar area. Petitioner was advised to follow up in 6-8 weeks. (Px4).

Dr. Gabriel testified via deposition on 5/13/11. He noted multiple thoracic disc protrusions (T1/2, T2/3, T8/9 and T11/12) but believed the main cause of Petitioner's symptoms of central and left thoracolumbar pain was T8/9 and T11/12, noting there were no radicular complaints and that these protrusions were most likely caused by the work accident. The other two thoracic discs did not appear to correlate with the symptoms. Facet arthropathy at T11/12 was likely chronic and preexisting, but Dr. Gabriel testified the combination of this with the disc protrusion resulted in a double crush syndrome with stenosis from both the anterior and posterior aspects. Petitioner did not appear to have any myelopathy symptoms. Conservative treatment was recommended. While Petitioner had no benefit from the epidural or corset, Dr. Gabriel noted Petitioner still hadn't undergone physical therapy, and he opined that therapy and facet blocks would be worth trying given Petitioner's pain appeared localized to the paraspinous area. Dr. Gabriel testified here was no surgical indication based on the history and exam findings. He continued Petitioner on work restrictions on 2/9/11. He opined Petitioner had not reached maximum medical improvement and his condition remained causally related. (Px4).

On cross examination, Dr. Gabriel acknowledged he had not reviewed any of Petitioner's prior medical records. He believed Petitioner had been working when he first saw him, given that he issued work restrictions, but didn't know if this would have been full or light duty. Therapy still had not been approved, and Dr. Gabriel was hopeful this would help him back to work: "I mean, he's remained quite stable." If that didn't resolve the symptoms, Gabriel would determine if facet blocks and/or epidurals should be performed. (Px4).

Petitioner testified he didn't have any further treatment until 2012 because the Respondent wasn't authorizing it. He testified to difficulty obtaining treatment from both Respondents throughout the pendency of his claims.

A hearing was held on 8/4/11 pursuant to Sections 8(a) and 19(b) of the Act with regard to the 11 WC 07247 claim. The only issues in dispute involved whether there was Illinois jurisdiction and whether penalties and fees were applicable. The Arbitrator at that time found Illinois jurisdiction and denied penalties and fees. As a result, the Petitioner was awarded TTD benefits from 11/22/10 through the 8/4/11 hearing date and all outstanding medical expenses. Prescribed treatment of Dr. Gabriel and Dr. Ghalambor was also awarded. The decision of the Arbitrator was affirmed and adopted by the Commission in its entirety on review on 5/7/12. (see Jointx1).

On 12/2/11, Dr. Gabriel completed a medical statement for Petitioner's union Defined Contribution Pension Trust Fund. This noted diagnoses of lumbosacral degenerative disc disease, spondylosis/osteoarthritis in the lumbar facets, thoracic disc herniation and spinal stenosis. Symptoms included low back pain and numbness and tingling to the legs. He noted that Petitioner had last been seen on 6/20/11, however the Arbitrator did not locate any report of Dr. Gabriel in the record from this date. Therapy had been prescribed. Dr. Gabriel indicated the Petitioner was unable to work at any gainful employment, and that he was awaiting authorization for surgery. (Rx16). The Arbitrator notes that no surgical recommendation was noted in the records of Dr. Gabriel, so it is unclear what surgery he was recommending. Additionally, Dr. Gabriel was indicating the Petitioner was unable to work despite not having examined him in at least 6 months.

Petitioner began working for Respondent Joiner starting the week prior to 7/9/12. The job involved replacing panels of a metal roof. On 7/9/12, Petitioner testified he was work on the metal roof with foreman Scott Engelmann. The testified that the roof had a low pitch, but it was slick from prior rain. Engelmann at one point asked him to bring some screw to another part of the roof. As Petitioner walked to deliver the screws, he testified that his feet flew out from underneath him and he fell onto his drill on the upper back and shoulder area, as well as onto a roof seam with his spine and the base of his neck. He testified that Engelmann was present when this happened, but he wanted to finish the job, so he initially didn't want to take the Petitioner for treatment. After his shift ended, Petitioner testified he drove himself to the Fairfield ER. An accident report from Joiner Sheet Metal was included in the Fairfield records which notes Petitioner reported a neck and back injury due to a metal roof being wet from rain, and that he required medical attention. (Px7).

Respondent Joiner presented two witnesses at hearing, Scott Engelmann and John Joiner. Mr. Engelmann agreed that he and Petitioner were replacing 20' metal roof panels in July 2012. He testified that he had gone back to the truck, about 60 yards away, and when he returned the Petitioner reported having slipped on the roof. He denied witnessing the accident and testified he did not hear the Petitioner's fall. He testified he asked Petitioner if he wanted to get treatment, but that Petitioner declined and finished the shift without problem. He denied begging the Petitioner to stay and continue to work. He indicated Petitioner said he'd see how he felt in the morning and if he was hurt he would go and see a chiropractor.

The 7/9/12 records from Fairfield reflect Petitioner reported slipping and landing on his back on the roof. He complained of pain to the right neck and low back. He was unsure if he had any tingling in his extremities. A pain drawing indicated he localized his pain to the right neck and left mid back. X-rays showed mild C5/6 degenerative disc disease, with normal findings at the thoracic level. The diagnoses were cervical and thoracic strains, medication was prescribed, and Petitioner was held off work through 7/11/12. (Px7; Rx4; Rx5; Rx6). The Arbitrator notes that the Respondent submitted a note from Fairfield which indicates that the Petitioner advised the facility not to provide medical records to workers' compensation. He was advised that this could result in a denial of a workers' compensation claim, and Petitioner stated: "Whatever they need they can get from me." (Rx4).

Petitioner followed up with NP Siemer on 7/11/12 at Clay Medical Center. He reported falling at work and landing on his back and neck. He also noted chest and sinus pain. Petitioner reported he was able to turn his head but wasn't ready to return to work. He was held off work due to continued neck and back pain through 7/18/12 and the ER medications were renewed. (Px8). Petitioner testified he didn't think Siemer understood how injured he was and, after being off work initially for about a week after the fall, he worked on an apartment job for Clifford Howell Construction for about 6 weeks.

Mr. Engelmann testified he was aware that Joiner offered Petitioner a light duty job in the shop within a couple of weeks after the incident, where there was always work to do. He wasn't sure why Petitioner declined this but noted Joiner's shop was 1.5 to 2 hours away from Petitioner's location. On cross-exam, Mr. Engelmann testified that he never met Petitioner before they started working on 7/2/12. He testified that they did not work Saturdays or Sundays, but that they otherwise worked through the accident date. On cross from Respondent Solid Platforms, Mr. Engelmann testified that Petitioner was hired out of the union hall, and when that occurs workers are just sent without any indication if they have work restrictions or not. Petitioner never told him that he had any work restrictions.

John Joiner testified that he owns Respondent Joiner, a roofing company. He was aware Petitioner reported an accident and agreed he didn't challenge it. He paid Petitioner regular wages for a 40-hour week for a period of

time after the accident as documented in his records. He testified that, to his recall, he did offer Petitioner a job a few weeks after the injury, but that Petitioner turned it down because it was not "in the extreme vicinity of his living." Petitioner also said he was working locally for someone else, a framing company. Mr. Joiner did not recall Petitioner contacting him after that at any point seeking his job back. Mr. Joiner testified that Petitioner had not indicate prior to the accident that he was unable to do any part of his job and had no back complaints to his knowledge. He "supposed" Joiner did pay Petitioner's medical expenses through 2/4/13.

Petitioner next sought treatment on 9/25/12 with chiropractor Dr. Miller at Flora Chiropractic. The report noted Petitioner reported his employment with C. Howell Construction. The records also state that Petitioner indicated "he had not experienced prior symptoms similar to his current complaints and was symptom free at the time of the aforementioned accident/onset of 7/9/12." Petitioner denied having made this statement in his testimony. The assessment at the time was of a sprain/strain to the upper thoracic spine associated with myofascitis. Recommended treatment included chiropractic adjustments, ultrasound therapy, deep muscle therapy, and electrical muscle stimulation. The Petitioner underwent approximately 107 sessions at Flora Chiropractic through 10/14/14. His complaints generally remained the same, with 7 to 8/10 level pain, and he testified that the treatments he received always remained the same. He testified that he would only feel temporary relief with each treatment over two years. After initially indicating Petitioner could return to work on two separate occasions, Petitioner was taken completely off work by Dr. Miller for an indefinite period of time on 1/22/13. (Px9).

On 9/26/12, Petitioner appeared at Fairfield Hospital for pre-operative testing regarding a right sided hernia repair. Petitioner reported chronic mid to lower back pain. He refused to tell the facility why he was taking a medication called Acyclover, but that he "takes lots of herbs." Petitioner also noted prior surgeries for left biceps tendon repair, left trigger finger release and carpal tunnel and ulnar releases of the right hand. (Rx8). The surgical repair of right umbilical and inguinal hernias was performed by Dr. Molt on 9/28/12. He was noted to have a several month history of hernia, but no cause of onset was specified. Activity restrictions were instituted for three weeks. (Rx9; Rx10).

At an 11/20/12 follow up with NP Siemer, Petitioner reported ongoing mid back pain, and that while he had tried to return to work within his abilities, his pain had recently increased. He reported some relief with chiropractic treatment. He also reported having pain originating from the low back after a fall about a year before this visit. He reported exercising three to four times per week for a total of 5 to 10 hours. He was prescribed a Medrol dosepak and Flexeril. It was noted he was given a work note, but this was not located by the Arbitrator in the evidentiary record. (Px8).

From 7/12 to 12/12, Petitioner testified he originally was off work for a week after the accident, after which he returned to work for about 6 weeks with a non-union employer. Respondent Joiner paid Petitioner his wages for about a week in July 2012, and then paid him off and on from 9/12 to 12/12. He testified when he spoke to Joiner by phone, he was told they didn't want to turn the claim in to workers' compensation, as the insurance company would fight the claim and that this would end up increasing Joiner's rates. Petitioner testified he never received any TTD benefits from Joiner's insurer.

On 12/21/12, Petitioner returned to Clay Medical Center for bronchitis. The report noted no complaints of back or neck pain in the Review of Systems, with normal musculoskeletal findings on exam. (Rx11).

Other than continuing chiropractic care, the next time Petitioner sought treatment for back pain was with Dr. Gabriel on 5/14/13 in Ohio, where the doctor had moved his practice. Petitioner complained of chronic thoracic

and low back muscle pain and cramps, as well as a new onset of left thigh and leg numbness since July/August 2011. He reported the 7/9/12 injury when he fell on a drill with his thoracic spine area while working on a roof. He reported some improvement with physical therapy after this incident and that he worked for approximately 6 weeks after it but had not worked since September 2012. Petitioner reported that since the 10/13/10 injury he worked on and off for about 5 months with a 30 pound weight limit that came from the Bonutti Clinic, which is where he had previously seen Dr. Gabriel. Dr. Gabriel diagnosed disc bulges at multiple levels of the thoracic spine, with T11/12 being the worst with disc/osteophyte complex. Disc bulging was also noted in the lumbar spine, with the worst bulging occurring at L3/4 and L4/5. He noted multilevel degenerative disc disease and facet arthropathy in multiple lumbar levels. He noted multilevel foraminal stenosis from L2 to S1. Updated lumbar and thoracic MRIs were ordered, and physical therapy and a muscle relaxer were prescribed. Petitioner reported his 2011 injection from Dr. Ghalambor "did not help him too much." (Px5: Rx21).

The updated MRIs were obtained on 10/17/13. The thoracic interpretation was: 1) Mild degenerative disease at the intervertebral disc, facet joints and costovertebral joints at multiple levels in the thoracic spine as described above; 2) small Schmorl's node in the lower thoracic spine, especially at the T11/12; 3) mild concentric disc bulge at T11/12 causing mild spinal canal stenosis (central thecae sac measuring nearly 9 mm), demonstrated mild interval worsening, but still no evidence of cord compression; 4) mild foramina stenosis but no impingement of the nerve root; and, 5) Mild foramina stenosis at the T1/2 bilaterally. It was also noted that there was a small midline disc bulge T8/9 causing indentation on the thecal sac, but no spinal canal stenosis or foramina stenosis. Also noted was right paramedian T2/3 disc bulge without significant stenosis. Lumbar films showed: 1) Disc space narrowing and dehydration of intervertebral disc at L3/4 and L4/5. Schmorl's node at superior endplate of L4/5 with adjacent inflammatory changes; 2) diffuse disc bulge and facet arthropathy at multiple locations, but no spinal stenosis; and 3) moderate right foraminal stenosis at L2/3 with displacement of nerve root, moderate hypertrophic facet arthropathy with disc bulge at L5/S1 causing moderate bilateral L5/S1 foramina stenosis, and facet joint and the disc bulge abuts existing L5 nerve roots bilaterally with no significant interval changes. (Px10 & 11; Rx18 & 20).

On 1/27/14, Dr. Gabriel prescribed L4 and L5 epidural injections. (Px10).

On 1/27/14 with Dr. Ghalambor, Petitioner reported prior epidural at L1/2 helped his mid-back pain, but the pain was bothering him more and more in the low back and was now in the left leg with numbness that was positional and dependent on how he was sitting of lying down. The 10/17/13 MRI findings were noted, and Dr. Ghalambor's assessment was: 1) clinical left lumbar radiculopathy, 2) lumbar degenerative disc disease with significant endplate changes and Schmorl's nodes at L4 and L5 per the MRI, 3) bilateral lumbar facet arthropathy, multilevel that was more pronounced at L5/S1, 4) lumbar spinal stenosis, right L2/3 foraminal stenosis and bilateral foraminal stenosis at L5/S1, 5) thoracic degenerative disc disease most pronounced at T11/12, 6) lumbar strain at work in late 2010. Dr. Ghalambor also noted that Petitioner "at this juncture is uninterested in seeing a spine surgeon." He recommended a left L4/5 epidural, noting Petitioner would first need to be off aspirin for 7 days. (Px10). An intake form that appears to have been completed and signed by Petitioner on this date notes "Left leg – foot numbness since July-August of 2011."

On 2/21/14, Dr. Ghalambor specifically noted Dr. Gabriel referred Petitioner for left epidurals at L4/5 and L5/S1 due to his complaints of left leg pain. Petitioner noted he had been treating with chiropractor Dr. Miller without significant improvement. He reported pain from the mid back into the low back and left leg numbness. Dr. Ghalambor noted weakness of the left lower extremity that was "grossly nonfocal. It is difficult to assess due to lack of effort and pain contributing." He performed epidural injection at left L4 and L5. He also prescribed a bilateral lower extremity EMG/NCV, which on 2/28/14 showed no evidence of radiculopathy or peripheral neuropathy. (Px10; Rx24; Rx25).

On 4/2/14, Petitioner saw Dr. Gabriel for the first time since 5/14/13. He complained of chronic ongoing thoracic, lumbar and sacral symptoms as well as numbness in his left leg to the foot and an occasional "vibration" feeling in the right leg. Petitioner provided the doctor a two page note regarding his symptoms. This included a knot in his upper back where he fell on the drill, occasional chiropractic treatment, muscle relaxers. He noted the chiropractor consistently found the T5/6 level out of place, occasionally T6/7 as well, and that his rib was out of place where he fell on the drill. He noted difficulty sleeping due to back and neck pain he was having since the fall. Dr. Gabriel diagnosed multiple thoracic and lumbar disc bulges, worst at T11/12 with spur disc complex and spinal stenosis. Multilevel degenerative disc disease was worst at T10/11, L3/4 and L4/5. October 2013 lumbar MRI was noted to show right (moderate) and left (mild) L2/3 neuroforaminal stenosis, mild stenosis at L3/4 and L5/S1 and lateral recess stenosis at L4/5. Bilateral lower extremity radiculopathy was also indicated. Dr. Gabriel did not believe Petitioner was a surgical candidate, and he referred Petitioner to Dr. Ghalambor for an epidural at T11/12 and facet blocks at L3 to L5, with possible radiofrequency ablation at L4 to S1. Prior to any type of surgery, he recommended discogram to be performed from L2 to S1. (Px5; Rx23).

On 9/29/14, Petitioner was examined by orthopedic surgeon Dr. Mirkin at the Respondent's request. Petitioner reported that he suffered severe thoracic and lumbar injuries on 7/9/12 when he fell on a roof on top of a drill. He reported working intermittently since with ongoing thoracic and lumbar pain radiating into the left leg. Petitioner also reported the 10/13/10 incident with severe thoracic and lumbar pain. He reported remaining on a 30-pound weight restriction until the 7/9/12 accident. Petitioner also informed Dr. Mirkin that he had been working intermittently since the injury but was not working at the time of the examination. After reviewing Petitioner's prior medical records, including the prior MRI's, Dr. Mirkin's assessment was that Petitioner had degenerative spine disease. Dr. Mirkin indicated the MRIs revealed mild disc pathology in both the thoracic and lumber spine which were present on the MRI testing both before and after the 7/9/12 injury. After examining Petitioner, Dr. Mirkin opined the Petitioner was at maximum medical improvement (MMI) and did not feel that Petitioner had any signs of pathology or injury related to the7/9/12 injury. Dr. Mirkin noted that this finding was supported by Petitioner's admission that he had worked after the 7/9/12, accident without any restrictions. He testified that he based the conclusion of working with no restrictions on the type pf job Petitioner worked, despite Petitioner stating that he worked within his restrictions. As such, Dr. Mirkin did not believe Petitioner needed any further treatment or restrictions that would be related to the 7/9/12 accident. (Rx26).

The Arbitrator did not see any further treatment in the evidentiary record prior to a 1/26/15 lumbar MRI. This was noted to have stable findings when compared to 10/17/13 films. Noted was degenerative disease with disc bulges from L2 to L5, Schmorl's nodes at L4 and L5 and multilevel facet arthropathy without significant central canal or neuroforaminal stenosis. (Px10).

The Petitioner presented to Dr. Teal at Carle Hospital for a neurosurgical consultation on 3/5/15. Petitioner testified this was on referral from Dr. Ghalambor. Petitioner's complaints at the time were of neck and back pain with hand and foot numbness. Petitioner reported developing neck, back, and left leg pain immediately after the 7/9/12 accident, later developing numbness in both arms. Petitioner also told Dr. Teal that he returned to work shortly after the 7/9/12 accident near the end of July with a different company that was building apartments and performing siding work. Petitioner told Dr. Teal that he stopped working altogether from 9/6/12 until 6/13/14. Petitioner rated his neck pain at 6-8/10 and his lumbar and thoracic pain at an 8 to 10/10. Dr. Teal read the MRIs, opining that they essentially showed degenerative disc disease. Dr. Teal's assessment was of cervical, thoracic, and lumbar strains with chronic pain and no surgical disease. The recommendation was for physical therapy and consideration for possible cervical, thoracic, and lumbar injections along with an EMG to assess the arm and leg numbness. (Rx12).

Petitioner saw Dr. Ogan on 2/27/17 for evaluation of chronic low back pain with intermittent radiation into the legs and for consideration of lumbar and cervical injections on referral from Dr. Teal. He also noted persistent cervical, thoracic and lumbar pain. It appears that epidural injection was performed bilaterally at L5/S1, and Petitioner was to follow up 2 to 3 weeks after the procedure. (Px14).

Petitioner returned to Dr. Teal on 3/16/17 for consultation following the injections. The Arbitrator notes the doctor indicated 3/14/17 injections, but the only record of injection located in the record is Dr. Ogan's on 2/27/17, so it's unclear if he received a second round of injections. Petitioner reported persistent left anterolateral thigh numbness radiating into the top of the foot with episodic shooting pain. He also noted numbness in the medial fingers in a C8 pattern since falling at work. Petitioner reported he last worked in December 2016 performing construction work as a union carpenter on bridges and fencing. Petitioner stated that he developed lumbar area pain following the initial work accident, and after he initially sought treatment in October 2010 he worked lighter duties until being laid off on 11/22/10, after which he said he remained off work until 12/7/11. He didn't have therapy because there was a dispute over who was going to pay for it, and he reported that lumbar injections in Spring 2011 did not help him. He returned to construction work on 12/7/11 doing metal framing despite his back pain and continued to work intermittently until April 2012. He returned to work in June 2012 doing IDOT maintenance but stopped after two weeks because he was asked to lift over 30 pounds. In July 2012 he returned to work loosening roofing screws to help replace roof panels, and then had his fall on 7/9/12, landing flat on his back and hitting a hand drill on his thoracic spine "and his neck and lumbar area seam [sic] on the roof." Petitioner indicated after he sought treatment he was off work for a week. He had neck, back and left leg pain at that time with numbness in his legs, and reported he later noted episodic numbness in his bilateral hands and wrists and his left thigh, as well as popping in his neck since the fall. He was treated with medication and chiropractic care and said he was off work from 9/6/12 to 6/13/14. Lumbar injections in 2013 provided no relief. He currently complained of left sided neck (6 to 8/10) and central thoracic and lumbar pain (6 to 10/10) "like an ice pick/pressure pain in his lumbar area." Following examination and review of cervical and lumbar MRIs which appear to be from 2017, Dr. Teal recommended a thoracic MRI, continued therapy and consideration of facet blocks with Dr. Ogan. Petitioner was to follow up in 6 weeks. (Px13).

The deposition of Dr. Ghalambor was taken on 9/29/15. When he first saw Petitioner on 3/31/11, his pain was confined to the mid and low thoracic and lumbar region and did not radiate to the lower extremities. Medication, ice and heat had provided only moderate relief. Petitioner was "more frustrated than being in pain." Based on symptoms and the MRI findings, Dr. Ghalambor believed that Petitioner's pain was mainly coming from the T11/12 level and agreed with Gabriel's recommendation for epidural and physical therapy. The epidural was performed at L1/2, not T11/12, because there was more space to insert the needle, but this still should have reached the T11/12 level. Dr. Ghalambor was not involved with Petitioner's work status. He testified that it was not possible to answer whether Petitioner's condition was related to the work accident. He opined that lumbar degenerative disease is a normal finding and that everyone has it at some point in life and can be symptomatic or asymptomatic. He testified: "Whether or not these radiological findings were present before the injury or they happened after the injury, it's impossible to tell." However, Petitioner indicated his symptoms started with the accident, and therefore is a result of that accident. An asymptomatic condition can become symptomatic due to trauma. He acknowledged that the Commission previously determined the condition was causally related to the accident. (Px6).

Petitioner only followed up with Dr. Gabriel after the 4/29/11 epidural, so Ghalambor didn't see Petitioner again until 1/27/14, which was after the 7/9/12 accident, on referral from Dr. Gabriel for possible left-sided epidural. Petitioner reported his left leg symptoms started after the latter accident. Petitioner reported the prior injection was somewhat helpful, but Dr. Ghalambor noted other medical records indicated Petitioner reported it hadn't

helped at all. Petitioner reported left sided lumbar radiculopathy with numbness and possible weakness but did not report any mid-back pain. He also indicated he was not interested in surgery. On exam, Petitioner had new findings of positive straight leg raise on the left and decreased left sensation in the L4 dermatome. Dr. Ghalambor agreed with the recommendation for L4/5 and L5/S1 epidural injections and also recommended EMG testing. On 2/21/14, Petitioner complained of mid to low back pain, pointing to the upper to mid lumbar spine, and the epidural was performed. (Px6).

Dr. Ghalambor opined the findings on MRI between 2011 and 2013 showed a worsening of lumbar anatomical findings. Dr. Ghalambor again testified that there was no way he could attribute Petitioner's symptoms to a work accident, as there can be symptom onset without trauma, but again noted a trauma could have worsened the degenerative condition. Petitioner didn't report a worsening of his mid to low back pain, and EMG testing was normal. To Dr. Ghalambor's knowledge, Petitioner indicated the lumbar epidural didn't help and he returned to Dr. Gabriel. Dr. Ghalambor had no opinion on whether Petitioner was a surgical candidate, but noted both Dr. Gabriel, when he referred Petitioner in 2011 and 2014, and Dr. Teal determined Petitioner was not a surgical candidate. Dr. Ghalambor testified he had no opinion on Petitioner's work status but questioned whether Petitioner could work perform all of the full duties of a carpenter, though he agreed this was based on Petitioner's subjective complaints. He had no opinion regarding MMI other than that Petitioner hadn't reached MMI when he last saw him. (Px6).

On cross examination (Solid Platforms), Dr. Ghalambor acknowledged that while Petitioner initially complained of mid and low back pain in 2011, it was mainly mid-back, and he did not complain of pain radiating into his leg. While Petitioner told Dr. Teal the 2011 epidural didn't help, on 1/27/14 he told Dr. Ghalambor it helped his mid-back pain, but his low back pain was worsening and radiated into the left leg. He didn't complain of mid-back pain to Dr. Ghalambor on 1/27/14 but did to his assistant on 2/21/14. To him, this showed the Petitioner's pain was changing depending on what day it is. (Px6).

On further cross (Joiner), Dr. Ghalambor testified that Petitioner never reported being pain free at any point after the 2010 accident. Petitioner was not very specific as to how much relief he had with the 2011 epidural. If he was not asymptomatic before a work accident, the accident could be "contributing to the worsening of symptoms or not the cause of the pain at all." Most spinal strains/sprains completely resolve with conservative treatment. Dr. Ghalambor agreed his 1/27/14 report states nothing about the July 2012 accident, but testified Petitioner did mention it on 2/21/14. Petitioner didn't say how quickly after the July 2012 accident he developed leg pain. He had no left leg complaints in 2011. Dr. Ghalambor didn't review any of Petitioner's other treating records other than Dr. Teal's 3/5/15 note. He agreed if the initial July 2012 ER report and initial 2012 chiropractor's note did not reflect low back complaints or diagnosis, this would differ from Petitioner's complaints to him of low back and left leg. He agreed that the greater the delay between a trauma and the onset of symptoms, the less likely the trauma is the cause of the symptoms. (Px6).

While Dr. Ghalambor opined the 2013 lumbar study showed a worsening versus the 2011 films, he agreed radiologist Dr. Patel noted no significant interval change between the studies. He could not recall if he reviewed the films themselves or only the reports. He agreed any worsening of degeneration could occur in the absence of trauma, and it's impossible to say if such worsening would be due to natural aging or a trauma. He also agreed neither set of films showed any "red flag" findings, such as a large disc herniation or severe spinal stenosis. Dr. Ghalambor testified that a spinal strain could be bad enough to impact the discs and joints, but that the majority of such strains get better over time, not worse. While there is a category of patients where a strain can become chronic, he testified this depends on the type of injury, noting that this is more likely with a high impact injury like a car accident than a slip and fall, which would be unlikely to result in such chronic symptoms. While Petitioner's lower extremity EMG was normal, indicating no nerve injury, Dr. Ghalambor testified this would

not necessarily rule out a milder degree of sciatica, though in a case like Petitioner's with normal EMG, the "majority of them are reversible" in terms of sciatica. (Px6).

Chiropractor Dr. Miller testified via deposition on 4/30/15. He testified he first saw Petitioner on 9/25/12, but that "he's known me from my previous employment in Flora (IL)." He reported slipping and falling on a roof at work and landing with his backside down onto the drill and hit the roof. He complained of pain between his shoulders that radiated to the top of his shoulders, mostly on the left where he indicated he landed on the drill with his left shoulder blade area. He reported low back problems from a previous injury. Exam noted limited cervical and thoracic range of motion. Following exam, Dr. Miller diagnosed an upper thoracic sprain/strain with associated myofascitis, creating altered biomechanics, and he believed this was related to the reported 7/9/12 accident. Chiropractic manipulation and treatment was instituted. (Px9).

Dr. Miller treated Petitioner between 9/25/12 and 10/14/14. He testified that, typically, treatment for a case like Petitioner's involves 25 to 35 visits, starting initially at three times per week. Treatment was directed at the upper thoracic spine, and while Petitioner would complain of the low back from time to time, he advised Miller to leave that alone since it was involved in another workers' compensation case. Dr. Miller therefore didn't always document when Petitioner complained of the low back. Dr. Miller initially took Petitioner off work when another doctor's off work prescription expired. He released Petitioner to full duty as of 1/8/13, then changed this to 1/22/13, but on that date then took him off work until further notice, which status Dr. Miller testified continued throughout his care and treatment of Petitioner. Dr. Miller testified his treatments through 7/16/13 remained the same and would provide Petitioner with temporary relief, after which the pain would return. He was diagnosed at that time with chronic myofascitis and was improving slower than expected. In Dr. Miller's opinion, Petitioner's condition remained related to the accident. (Px9).

Dr. Miller opined that 10/17/13 thoracic MRI findings of disc bulges at T2/3 and T8/9 could have been caused by Petitioner's fall on the drill. Schmorl's nodes found at multiple thoracic levels, worst at T11/12, are usually caused by axial pressure and can be an incidental finding or can be problematic. At the last visit of 10/14/14, Petitioner complained of moderate to severe left shoulder blade pain at a 9 out of 10 level. Petitioner "just wasn't improving" and his diagnosis remained chronic myofascitis. Dr. Miller doubted Petitioner was going to get much better. While he testified there wasn't anything more he could do for Petitioner, he opined Petitioner had not reached MMI: "He'll need some future care from somebody, either going and getting trigger point injections, you know, find another doc that may have a different protocol for him. I don't know." (Px9).

On cross exam (Joiner), Dr. Miller agreed that his exam findings all have a subjective component to them. He had no knowledge of Petitioner's 2010 work accident or if it involved the thoracic or cervical spine, what treatment he may have had, what diagnostic testing may have been done or if he had been under any work restrictions prior to 7/9/12. He agreed the Petitioner denied having any similar prior symptoms and denied prior injury to the cervical and thoracic spine, indicating his prior complaints only involved the low back. Dr. Miller agreed that if he did have such prior thoracic injuries and treatment or had been on work restrictions, it could impact his opinions. Dr. Miller agreed his records don't indicate complaints of pain radiating into the legs. He also agreed he did not review Petitioner's prior medical records. Despite over 100 treatments, Dr. Miller did not dispute that he ultimately did not have any lasting improvement, and that despite this his treatment plan never changed. While he did not refer Petitioner to an orthopedic surgeon, he testified Petitioner indicated his bills weren't being paid and he didn't want to get stuck with an orthopedic bill. Dr. Miller agreed Petitioner reported he started working for Clifford Howell Construction following the July 2012 accident, but didn't know whether he worked at any point between 9/25/12 and 10/14/14 while he had restricted him from working. He agreed that if Petitioner had been working, such continuing work could have continued to impact his condition. He never advised Petitioner to wear a brace. (Px9).

Neurosurgeon Dr. Teal testified on 11/30/15, indicating he saw Petitioner on referral from Dr. Ghalambor. Petitioner reported a jarring sensation in his back on 10/13/10 which caused lumbar pain. He noted Petitioner reported being put on an ongoing 30 pound restriction and having undergone injection with medication, but that he was not able to get physical therapy. He was laid off in November 2010, started working for a different company in December 2011, then worked intermittently until April 2012. He worked IDOT maintenance for two weeks in June 2012, until he was asked to lift over 30 pounds. He returned to work performing roofing in July 2012, loosening screws on panels, and on 7/9/12 he slipped and fell on his back on a roof, landing on a drill and hitting his neck and back on a roof seam. He reported having some back, neck and leg pain since that time with occasional numbness in his legs. When Dr. Teal saw him, Petitioner reported episodic numbness in his hands, wrists and left thigh, as well as popping in his neck since that fall. He then went back to work with a company building apartments, doing some siding work, and he was treating with local medications. He had some chiropractic treatment, and injections with Dr. Ghalambor in 2013, but this didn't relieve his pain. He had continued left neck, central back and lower back pain. He did not have arm or leg pain, just the numbness. He indicated he did not have leg pain or neck popping before the 7/9/12 incident. (Px12).

Dr. Teal's neurologic exam was normal with regard to sensory and motor components, but he had an antalgic gait and heel to toe testing suggested possible leg weakness. 2013 thoracic MRI showed diffuse degenerative changes that would be expected at Petitioner's age. He found the T11/12 disc bulge to be mild and not significant. 2013 and 2015 lumbar MRI both showed degenerative changes from L2 to L5, which again would be expected, and minimal stenosis. There were no significant herniations. Petitioner's symptoms were consistent with the findings. Dr. Teal diagnosed cervicalgia, lumbago and thoracic spine pain. Petitioner's history was "worrisome for some sort of a chronic sprain or strain in his back and neck area related to his prior traumas." His impression from the October 2010 accident was a back strain with persistent low back pain despite light duty and injections, and from the July 2012 accident an aggravation of the back and a new neck strain and popping and numbness in his hands and wrists at night. Most preexisting degenerative conditions like Petitioner's are asymptomatic, but a trauma can cause it to become painful, and if it doesn't respond to physical therapy and injections after six weeks, it can become a chronic pain syndrome. Dr. Teal recommended a period of physical therapy (conditioning and core strengthening) and possible cervical or thoracic injections (pain reduction), as lumbar injections hadn't really helped him. Dr. Teal testified it's "a little hard to say" whether such treatment would be causally related to Petitioner's work accidents. However, he questioned whether Petitioner had the therapy he needed following the 2010 accident, so it can be argued he still should have it. (Px12).

Dr. Teal believed the low back and leg symptoms track to the 2010 accident, while the neck and thoracic pain was aggravated in the 2012 accident given he had a different area of problems. Dr. Teal recommended a permanent 30 pound restriction in order for Petitioner to avoid further aggravations, and doubted he'd be able to do a job with any significant bending, twisting or climbing involved. He wanted to review a cervical MRI and an EMG test of the upper extremities before coming to any final determinations. Dr. Teal did not believe the Petitioner was a surgical candidate. He testified that a delay in treatment could prolong recovery. To determine MMI, he believed Petitioner would need to manage his pain at a 5/10 level or less and exhaust therapy and injections, if he hadn't already. Petitioner's condition had reached a chronic state and his only recommendation was involvement in pain management and avoiding aggravating activities at work. (Px12).

On cross examination (Solid Platforms), Dr. Teal testified he had not reviewed any of the Petitioner's prior medical records and had no knowledge of how long he treated with Dr. Miller or what that treatment entailed. Petitioner reported he had ongoing back pain after the 2010 injury which continued to limit him leading up to the 2012 accident. Dr. Teal was not certain what activities Petitioner performed at work between 2010 and

2012, or for how long he worked at each job he had. Petitioner didn't discuss any work activities subsequent to the 2012 injury other than building apartments. Questioned by counsel for Respondent Joiner, Dr. Teal testified he did not review Petitioner's 2011 MRI, but that he wouldn't be surprised if the films were similar to 2013 films, and this would not change his opinions. Petitioner did indicate he worked in jobs after the 2010 accident which could have involved activities that could trigger symptoms in someone with degenerative disc disease. Dr. Teal was not aware that the Petitioner complained of mid-back pain after the 2010 accident, and while this could impact his causation opinions, he can't say whether it would or not without knowing how the mid-back condition progressed between 2010 and 2012, and how similar the pre and post 2012 accident symptoms were. He agreed that a T11/12 epidural would indicate Petitioner was having serious thoracic pain issues. As to causation, again, how it would impact his opinions would depend on whether Petitioner improved and how much prior to 2012 accident. He couldn't say Petitioner denied having thoracic pain in 2010, but Teal's sense from their discussion was that the 7/12 incident brought more focal pain on to the thoracic and cervical areas. He agreed the 2012 accident could potentially have been a temporary aggravation of these areas. He had the same opinion when questioned about the initial post-2012 accident ER report noting primarily back pain with some neck pain, and then on his 11/20/12 return there were no neck complaints. As to any gap in neck complaints, Dr. Teal testified he would consider six months after an accident without further complaints to lead to a conclusion that there is no causal connection. Symptoms from a degenerative spine condition can wax and wane, but statistically most times there is a waxing is where there was a triggering activity of some kind. He agreed that Petitioner was performing work after the 2012 injury, and that his belief is Petitioner had learned how to avoid serious aggravations and would self-treat at home. Petitioner also reported he didn't work at all from 9/12 to 6/14. If Petitioner has the recommended therapy and does not improve, Dr. Teal would first try injections before determining if Petitioner has reached MMI. If that occurs, he would likely find him at MMI. Dr. Teal again agreed that he has not reviewed Petitioner's prior medical records, and thus has relied to a great extent on Petitioner's subjective statements and complaints. However, if Petitioner did not have the recommended treatment, he doubts his opinions would change. (Px12).

Petitioner saw orthopedic surgeon Dr. Lange at the request of Respondent Solid Platforms on 9/30/14, and he testified via deposition on 3/12/15. Following his review of Petitioner's medical records and his examination, he opined that Petitioner had a probable T11/12 disc herniation injury related to the 10/13/10 accident. He did appear to have a more tentative diagnosis of a new T2/3 herniation subsequent to 7/9/12. The T11/12 injury appeared to correlate with Petitioner's left sided symptoms, related to both low back pain early on and then in a somewhat belated fashion into the left leg after the 2010 incident. He testified it was difficult to say exactly when he reached MMI as to that 2010 injury, but Petitioner didn't seem to improve much with conservative treatment and it "was not unreasonable to think that he would have reached a treatment plateau at some point along the line." Dr. Lange testified it would be somewhat artificial to make a determination of restrictions, noting the records indicate he was released with a 30 pound restriction, and he saw no evidence this had changed in the medical records. He could not get a good answer from Petitioner as to how much he worked between the 2010 and 2012 injuries other than that it was about 5 months, but Dr. Lange testified he "couldn't get a feel for" whether this work was sporadic or consecutive. Dr. Lange testified it was also hard to say if Petitioner suffered any permanent disability resulting from the 10/13/10 accident, but it wouldn't appear there was any significant permanency if he was able to work his normal full duty job, and by 2012 he did not appear to have ongoing lumbar or lower extremity symptoms." Based on this, he opined that Petitioner did not have any ongoing permanency related to the 10/13/10 accident. (RxD).

On cross examination (Petitioner), Dr. Lange reiterated his opinion that the T11/12 disc was caused by the 2010 accident, and any treatment associated with that was reasonable. Petitioner not receiving therapy or possible facet blocks would not have made him worse, but it also would not make him better. Petitioner reported developing numbness into the left leg and foot in July 2011. Dr. Lange believed the 2012 accident, described as

his feet slipping out from under him and landing on a drill, involved a more significant trauma than the 2010 injury. Petitioner did have a mildly positive Waddell sign for give way in the left extremities, "but it wasn't particularly remarkable." While the 2011 thoracic MRI showed multi-level disc abnormalities, the T11/12 level seemed most relevant to Petitioner's left-sided complaints. The 2011 lumbar MRI showed some mild congenital canal stenosis and multi-level degenerative changes from L2 to L5, and the L2/3 herniation was on the opposite side from Petitioner's left leg symptoms. The findings at T12/L1 could correlate to Petitioner's symptoms. The 2013 thoracic films appeared similar to 2011, with the T3/4 right herniation actually appearing a little smaller, with a newer T2/3 herniation to the left. While he T2/3 disc could have been related to the 7/9/12 accident, he testified there was no way to say for sure. The 2013 lumbar MRI showed no significant change versus 2011. Dr. Lange testified that it was possible the left T2/3 herniation could be related to the 7/9/12 accident. Dr. Lange testified that an increase in left sided symptoms, including in the leg, could be consistent with such a left herniation. Dr. Lange also opined the T12/L1 area was aggravated by the 10/13/10 accident, and that at least some of the left thoracolumbar to lumbosacral paraspinal symptoms were related to the 10/13/10 accident as of 9/30/14. He couldn't say for sure whether the 30-pound restriction would be reasonable at the present time since he hasn't seen Petitioner recently, but he testified it was reasonable during Dr. Gabriel's treatment. It was reasonable at the time of Lange's 9/14 exam, but he noted that was before he had reviewed the records of Dr. Miller. It appeared Petitioner developed hand and bilateral lower extremity complaints, left greater than right, at the time of the 7/9/12 accident – again, this was based on the information Dr. Lange had available on 9/30/14. Dr. Lange opined Petitioner probably reached MMI given he treated for three years after the accident with no surgery recommended, so one would figure he reached a treatment plateau and did not need further treatment. Petitioner's "perception" of his condition was permanent at that point. Dr. Lange testified that surgery is not indicated for thoracic/thoracolumbar disc lesions in the absence of myelopathy. Some people improve without further treatment, others don't. (RxD).

Cross-examined by counsel for Joiner, Dr. Lange testified that a thoracic herniation could cause symptoms lower down on the body, but that such lesions "can be difficult to sort out" in terms of what it may be causing. A disc at that level would not cause cervical or upper extremity symptoms. Based on what Petitioner told him, the 2012 accident was more traumatic than the 2010 accident. He agreed the initial ER report after the 2012 accident did not reflect any low back or upper or lower extremity complaints. Petitioner did report having persistent thoracic and lumbar pain after the 2010 accident, and that the leg symptoms started in July 2011, which was consistent with the medical records. Dr. Lange testified that his subsequent review of Dr. Miller's records starting in September 2012 noted a diagnosis of thoracic sprain/strain and no cervical or lumbar diagnoses. No back, neck or lower extremity complaints were noted, nor were any ulnar complaints. On redirect, Dr. Lange testified that based on Dr. Miller's records noting no low back or leg complaints there would be no reason for any work restrictions. (RxD).

Orthopedic surgeon Dr. Mirkin testified on 12/11/15. When he examined Petitioner on 9/29/14 at the request of Respondent Joiner, he complained of thoracic pain and lumbar pain into his left leg. He reported both the 10/13/10 and 7/9/12 accidents, indicating he had thoracic and lumbar pain after the initial incident, did not have recommended therapy and remained on a 30-pound weight restriction through the time of the 7/9/12 incident. Dr. Mirkin's impression, however, was that Petitioner had been working beyond such restrictions at that time. Dr. Mirkin's review of Petitioner's 2013 MRIs indicated diffuse degenerative thoracic and lumbar bulging discs, which he noted could cause symptoms but that the findings would have to be correlated with the complaints. He did not see any significant differences between Petitioner's 2011 and 2013 MRIs. Following exam and review of Petitioner's medical records, Dr. Mirkin diagnosed thoracic and lumbar degenerative disc disease, relatively mild and common for his age. Symptoms had been intermittently present for a long time. Despite being given restrictions after the first accident, Petitioner "apparently" had returned to full duty. Dr. Mirkin didn't believe Petitioner had any new pathology or significant long-standing disability resulting from the 7/9/12 accident. He

testified that while it was possible it caused a transient aggravation of the preexisting condition at that time, his examination of Petitioner was essentially normal. Petitioner had lumbar and thoracic complaints prior to 7/9/12, and he didn't have any cervical complaints when he saw Dr. Mirkin, either verbally or via the pain diagram he completed. He opined Petitioner did not need any additional treatment or work restrictions related to the 7/9/12 accident, noting his work involving siding work after that incident would be consistent with his essentially normal examination. Petitioner was well-muscled despite the reported injuries. (Rx28).

On cross-exam (Petitioner), Dr. Mirkin testified he had no knowledge of the findings of the arbitrator in the prior workers' compensation hearing. He testified he had no idea if Petitioner's treatment after the 10/13/10 accident was reasonable, necessary and related to that accident. He agreed a trauma can cause an asymptomatic preexisting degenerative condition to become symptomatic. Such symptoms could be considered chronic if they last for six months to a year. While he agreed he saw no record evidencing that Dr. Gabriel discontinued his 30-pound restriction, Petitioner's performance of roofing work ("one of the hardest jobs you can do") proved such restriction was not necessary. He has seen patients work beyond restrictions both because they needed income and because they didn't have pain that required such restrictions. He didn't ask Petitioner if he was pain-free performing roofing. He had no knowledge if Dr. Miller had taken him off work completely. He agreed it is possible for a thoracic disc lesion to cause pain and/or numbness in the legs if its putting pressure on a nerve root. He did not agree with Dr. Lange that films showed a new T2/3 disc and testified that a large herniation at that level would cause symptoms ranging from pain along the course of a rib/chest area to paralysis from that level down. Pressure on the spinal cord at that level would cause myelopathy, which would include leg numbness and pain, and even paralysis. If it pressed on a right sided nerve, you would expect right sided symptoms. Petitioner's symptoms were left sided. Petitioner reported going from being able to work to not being able to work after 7/9/12. He did not find an indication of malingering or symptom magnification. Dr. Mirkin had no opinion as to permanency with regard to the 10/13/10 accident. As to MMI following the 7/9/12 accident, Dr. Mirkin opined he had reached it by the time of his examination but couldn't say when it might have occurred prior to his exam. (Rx28).

On further cross-examination (Solid Platforms), Dr. Mirkin testified there was no objective basis, per review of films, to restrict Petitioner's activities. The most significant MRI finding in Dr. Mirkin's opinion was right-sided (L2), and Petitioner's complaints were left-sided. Petitioner needed no further treatment. On redirect, Dr. Mirkin testified his opinion was Petitioner suffered a temporary strain aggravation of his preexisting condition on 7/9/12. He would have recommended therapy and anti-inflammatories at that time.

Respondent Joiner sought Petitioner's work records from the Petitioner's union, United Brotherhood of Carpenters Local #634. Carpenters' District Council of Greater St. Louis and Vicinity. The union responded on 11/18/13, indicating that the local union does not employ members, and does not maintain employment records, including salary or attendance records. (Rx7).

Respondent Joiner submitted records indicating that the Petitioner was paid from 7/10 through 7/14/12 and 7/16/12 to 7/17/12, 8 hours per day, "due to injured on job" and "being off injured." (Rx1). Further records note he was paid $1385.20 for that initial period, and $554.08 for the second. Additionally, he was paid an additional $9696.40 from 11/25/12 through 1/5/13, working 40 hours per week from 11/25/12 to 12/22/12, and 32 hours per week from 12/23/12 through 1/5/13. Petitioner testified that his recall was that Respondent Joiner paid him wages up to the first week in January 2013. This documentation also notes various bills that were paid from Fairfield Memorial, Richland Radiology, Christopher Rural Health and Flora Chiropractic. Additionally, Petitioner was reimbursed $35.32 for medication. (Rx2).

Respondent Solid Platforms submitted records of Petitioner's reported employment through 3/8/16 via the St. Louis-Kansas City Carpenters Regional Counsel union. These records reflect the Petitioner worked as follows:

Danco Construction from December 2011 through April 2012 (580 hours)
Respondent Joiner in July 2012 (72 hours)
C. Howell Construction from July 2012 through October 2012 (268 hours from July to September, 3 hours in October)
Respondent Joiner from December 2012 through January 2013 (224 hours)
Shores Builders from June 2014 to August 2014 (298.5 hours)
Hoelscher Int. Inc. in August 2014 (32 hours)
Perry County Construction in September 2014 (58 hours)
J&L Acoustics in October 2014 (96 hours)
SA/NAT Ind. Construction in December 2014 (12 hours)
Perry County Construction in December 2014 and January 2015 (38 hours)
Jones-Blythe Construction in February and March 2015 (370 hours)
Berco Industrial in March 2015 (74 hours)
Sangamo Construction in May and June 2015 (138.5 hours)
E-T Simonds Construction in June and July 2015 (147 hours)
Bevis Construction in July and August 2015 (144.5 hours)
E-T Simonds Construction in September and October 2015 (200.5 hours)
Sangamo Construction in October 2015 (38 hours)
A&K Spec Cont. Inc. in December 2015 (88 hours)

Over this period of time, Petitioner worked 2,858 regular hours and 201.5 overtime hours. (Rx29). It should also be noted that the Petitioner testified he worked for IDOT for a short period of time, and that Dr. Miller noted this took place in June 2012 for approximately two weeks, with Petitioner reporting this ended when he was asked to lift over 30 pounds. (Px12).

Petitioner testified that, to his knowledge, there were no orthopedic physicians in his town, which is why he had to travel to see one. Dr. Gabriel worked out of the Bonutti Clinic in Effingham, IL until he moved to Ohio, and Petitioner believed he saw Dr. Gabriel there twice. He testified he may have seen Dr. Miller a few times since 2014 as well.

To Petitioner's recall, after the first two injections, Dr. Ghalambor did not want to do further injections due to a lack of improvement. Petitioner testified that Dr. Teal prescribed therapy and injection, but that this was not authorized by Respondent(s). Petitioner testified he saw Dr. Teal again in 2017 and was referred to Dr. Ogan for pain management. He testified that at the time of the bilateral L5 injections on 3/14/17, Dr. Ogan also recommended physical therapy. Petitioner testified that Dr. Teal also prescribed MRI's, and while they weren't authorized, he did undergo cervical, thoracic and lumbar MRIs in 2017. Th reports from these tests were not noted in the evidentiary record.

Petitioner testified that he would still be undergoing treatment if he could get it authorized. He feels like he has an ice pick stuck in his upper and lower back. He testified that he still has a knotted area around T5 to T7 and the left shoulder blade where he landed on the drill. Petitioner testified he is ready, willing and able to get the treatment recommended by Dr. Teal.

Petitioner testified that he was unemployed at the time of hearing. He created the documentation contained in Px15, reflecting the dates he alleges he was off work, as well as the time periods when he said he was forced

back to work in order to pay his bills and to feed himself and his animals. It also includes his request for mileage expenses for medical visits.

Petitioner was initially cross-examined by counsel for Solid Platforms. He testified that Dr. Miller is located in Fairfield, IL, about 25 miles from Petitioner's home, though he would also see Miller in Flora, IL, where he utilized an office with another chiropractor, and this was about a mile from Petitioner's home. He didn't recall how often he would see Miller but treated with him for approximately a year and a half. The treatment included electrical stimulation and chiropractic adjustment on the left upper back knot. He testified he wouldn't let Dr. Miller touch his low back because he had a pinched nerve with numbness and didn't want it to get worse but also said he sometimes allowed him to use electrical stimulation on the lumbar spine for pain relief, which Petitioner related to the 2010 accident. He indicated Dr. Miller mainly treated him for his 2012 injuries. He noted he did have some upper back problems from the 2010 accident around the T9 to T12 levels.

Petitioner testified that Respondent Joiner sent him to Fairfield Memorial Hospital on 7/9/12, and they advised him to follow up with primary care, i.e. NP Siemer. He testified that he believed NP Siemer referred him to Dr. Gabriel ("because she's the one that recommended him") and to Dr. Miller. He testified that Dr. Gabriel referred him to Dr. Ghalambor and to St. Anthony's Hospital for MRIs, and that Dr. Ghalambor referred him to Dr. Teal.

Petitioner agreed with the report from his union regarding the time periods and hours worked for various employers per RxB and Rx29. As to the hours, he testified that he did not always work full time during these periods, and that he wouldn't say this was normal, but was due to a lack of work for someone who is injured, noting he had been working 7 days a week for Solid Platforms at the time he was injured. Thus, he agreed he is requesting TTD, per Px15, for every day he did not work. He testified he was laid off by Danco Construction because the part he was able to do within his restrictions had ended. Petitioner testified he had no choice but to visit Dr. Gabriel in Ohio because he was his treating doctor.

Further cross-examination by Respondent Joiner notes Petitioner agreed he suffered thoracic and lumbar injuries on 10/13/10, but he testified he did not have consistent treatment after this injury because treatment had been denied. He testified that when he slipped and fell in July 2012 it did make noise, and that Scott Engelmann "saw the whole thing." He testified that Engelmann wouldn't let him go to the doctor and begged him to stay and finish the day. He denied being asked if he wanted treatment and declining it. He did finish the day, testifying he then went to Fairfield because the company "insisted that I go." He had thoracic and neck pain at an 8/10 level, was off work for a week, and then after being paid for a period of time by Joiner, went to work for another company (C. Howell) until September 2012 because "I didn't have no choice." After seeing NP Siemer on 7/11/12, Petitioner agreed he was diagnosed with a strain and testified that he may have seen her again once or twice, but he had no other treatment until seeing Dr. Miller on 9/25/12 other than self-treatment with heat and ice.

With C. Howell Construction, Petitioner testified he "wasn't working outside of my restrictions. It's ultimately left to me to work within my restrictions on any job. . . The people I was directly working with knew because if I needed help with something, I got help with something." His understanding of his restrictions was a 30-pound weight limit, and he agreed this went back to his 2010 injury. As to whether Respondent Joiner was aware of his restrictions, Petitioner testified he did not notify John Joiner about restrictions, "but some of the people I was working with knew." He testified he was only using an impact or a drill with Joiner and did not work outside of his restrictions. When his C. Howell job ended in September, Petitioner testified he contacted John Joiner looking to get his job back. He denied that Joiner offered him light duty work a week after the July 2012 accident and that he declined. He believed Joiner told him in September 2012 that he didn't have any work available within a reasonable distance for Petitioner to drive. He agreed he sought treatment with Dr. Miller

within a few weeks of that conversation, testifying that Joiner agreed to it. Petitioner denied telling Dr. Miller that he had been pain-free prior to the 7/9/12 accident and testified he told Miller about the 2010 accident. Petitioner agreed he saw Dr. Miller over 100 times between September 2012 and October 2014 and received the sane treatment for the same pain throughout, but only had temporary relief. While he agreed he had thoracic injuries in both accidents, he testified that they were to different areas of the thoracic spine. He denied that he had no neck complaints after 7/11/12.

Petitioner testified he was next taken off work following the July 2012 accident, other than the initial week off, when Dr. Miller took him off work on 9/25/12. While he agreed Dr. Miller initially took him off work for a week or two at a time, at some point he took him off work indefinitely. He agreed he nevertheless returned to work because he couldn't pay his bills. He agreed he subsequently worked for many different employers, but that he self-limited himself to his restrictions, and he did not notify the employers such that he received light duty jobs. While he noted he was completely off work per Miller for these jobs, he was limiting himself to the 30 pound restriction. He agreed the restriction didn't prevent him from going back to work but limited him in what he could do. He agreed he was off work in September and October 2012 for 3 weeks for an unrelated hernia repair. Currently, he relates neck pain and upper back pain top the 2012 accident.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner's upper thoracic / cervical condition is causally related to the 7/9/12 accident. The Arbitrator finds that the Petitioner sustained sprains/strains of these area as a result of the 7/9/12 accident. The Arbitrator further finds that the Petitioner's lower thoracic/upper lumbar condition is not related to the 7/9/12 accident, and the Petitioner has failed to show any condition in these areas are result of the accident of 7/9/12. The Petitioner has also failed to show that any symptoms in the upper extremities are related to the 7/9/12 accident.

At the Fairfield ER on 7/9/12, Petitioner reported pain in the right neck and low back, stating he was "unsure" if he has any tingling in his extremities. A pain diagram, however, noted only right neck and left mid-back pain, with no indication of low back symptoms. Only cervical and thoracic x-rays were obtained, and Petitioner was diagnosed with cervical and thoracic strains. On 7/11/12, his primary provider NP Siemer held Petitioner off work for a week with neck and back pain.

Petitioner then returned to work with a company, Clifford Howell Construction, for approximately six weeks, working 268 hours between July and September 2012. No records have been submitted indicating exactly which days were worked, how many days per week, how many hours per day, etc. The Petitioner testified that he was working within his restrictions with Clifford Howell Construction. However, these were restrictions which predated the accident and unrelated to the 7/9/12 accident. He also testified that he did not notify Clifford Howell management that he had restrictions, but that: "Its ultimately left to me to work within my restrictions at any job", and that "The people I was directly working with knew because if I needed help with something, I got help with something." There is no evidence any medical expert took the Petitioner off work following the release by NP Siemer as of 7/18/12 until January 2013, which is six months later. It should be noted that Petitioner also testified that he did not notify John Joiner about any restrictions on his ability to work before starting there in early July 2012.

Petitioner testified Siemer didn't realize how injured he was, and that after he had been held off work, he returned to work for Clifford Howell Construction working on apartment buildings, indicating he continued working for six weeks. He testified he had no choice but to return to work. Mr. Engelmann testified that his understanding was that Petitioner was offered a light duty job in the shop following the accident, and that there is always work to be done at the shop, but that Petitioner declined because the shop was far from his home, about 1.5 to 2 hours away. Petitioner denied being offered a light duty job. Mr. Joiner testified that to his recall he offered Petitioner a job within a few weeks of the injury and that Petitioner declined because it "was not in the extreme vicinity of his living." However, he also testified that Petitioner said that he was already working for a framing company at that time that was a local job.

Petitioner testified that he treated himself with heat and ice between the last visit with Siemer in July and his initial visit with chiropractor Dr. Miller on 9/25/12. When the job with Clifford Howell, ended, Petitioner testified he contacted John Joiner looking to get his job back, and indicated that he was told that Joiner didn't have any work available within a reasonable driving distance for Petitioner. Petitioner denied telling Joiner that his back was hurting again and he needed treatment, but agreed it was around this time that he started treating with Dr. Miller. While Dr. Miller's initial note stated that Petitioner reported being pain free prior to the 7/9/12 accident, Petitioner denied saying this.

The treatment with Dr. Miller lasted for over two years, involving over 100 visits. Despite this, the Petitioner testified, supported by the testimony of Dr. Miller, that Petitioner would essentially have a brief improvement following treatment that would last temporarily. Dr. Miller testified that all of his treatment was directed to the upper thoracic / upper back / neck area, and that while Petitioner at times complained of his low back, he wouldn't let Miller touch the low back because this was related to a prior workers' compensation claim. Petitioner's testimony was basically in agreement with this, but he said that Dr. Miller sometimes would provide electrical stimulation therapy to the low back.

Petitioner saw Dr. Gabriel twice after the 7/9/12 accident, on 5/4/13 and 4/2/14, in Ohio. At the first visit, Petitioner reported chronic thoracic and low back pain, as well as a new onset of left thigh and leg numbness since July/August 2011. Petitioner told him he had thoracic area pain after falling on the drill, and that while he did return to work after 7/9/12 for 6 weeks, he had not worked since September 2012. Dr. Gabriel diagnosed multiple thoracic disc bulges, the worst at T11/12 with disc/spur complex, and lumbar disc bulges that were worst at L3/4 and L4/5 with multilevel facet arthritis, degenerative disc disease and foraminal stenosis. Petitioner also noted an epidural he received in 2011 did not provide much relief. At the 4/2/14 follow up, Petitioner complained of chronic thoracic, lumbar and sacral symptoms as well as numbness into the left leg and an occasional "vibration" feeling in the right leg.

The Petitioner began to work quite steadily in June 2014 and continued to do so through October 2015.

Dr. Gabriel was not deposed subsequent to the 7/9/12 accident and did not provide any causation opinions regarding that accident. It should be noted that his 5/14/13 report references that Petitioner reported some improvement with physical therapy following the 7/9/12 injury. On 4/2/14, Petitioner reported "occasional" chiropractic treatment. Dr. Gabriel did not make any diagnoses at that time other than his prior diagnoses after the 10/13/10 accident, and references to the lumbar spine. Dr. Gabriel's report really doesn't offer any insight into his opinions regarding Petitioner's condition and its relationship to the 7/9/12 accident.

Dr. Ghalambor testified that Petitioner reported on 1/27/14 that he didn't have left leg symptoms until after the 7/9/12 accident, which is clearly not accurate, as he had previously reported to Dr. Gabriel that these symptoms

began in July/August 2011. Dr. Ghalambor noted discrepancies as to whether the prior epidural Petitioner received in 2011 had helped him. Dr. Ghalambor was very equivocal on any causation opinion, and he testified that the difference in his complaints between 1/27/14 and 2/21/14 visits showed Petitioner's pain was changing depending on the day. As noted in the 11 WC 07247 claim, he did not see any "red flag" warnings in Petitioner's MRI films that would reflect a significant or surgical problem, though he left any surgical opinions to Dr. Gabriel.

Dr. Miller testified Petitioner reported pain between his shoulders radiating to the top of the shoulders, mainly in the left shoulder blade area where he fell on the drill. Petitioner indicated his low back problems were related to a previous injury. Dr. Miller's diagnosis was an upper thoracic sprain/strain with associated myofascitis, and that this was related to the 7/9/12 accident. He then proceeded to treat the Petitioner over 100 times in an approximate two-year span, despite his testimony that typically a case like the Petitioner involves 25 to 35 visits. After initially indicating the Petitioner could return to full duty on two dates in January 2013, he then indicated he should be off work indefinitely and never rescinded this or issued light duty restrictions prior to the discontinuation of treatment. His final diagnosis was chronic myofascitis. On cross exam, he testified that Petitioner reported he had no mid back pain prior to7/9/12, just low back pain.

Dr. Teal testified that Petitioner reported having back, neck and leg pain since the 7/9/12 accident with occasional numbness into the legs, and that he had no leg pain prior to the accident. As noted above, Petitioner was complaining of leg symptoms well prior to this accident which started in July/August of 2011. Petitioner was reporting episodic numbness in his hands, wrists and left thigh and popping in his neck since the 7/9/12 accident. However, Dr. Teal testified he didn't review any of Petitioner's prior medical records. The Arbitrator notes there simply were no complaints of neck popping or upper extremity symptoms in the initial months following the 7/9/12 accident. Dr. Teal himself indicated if no symptoms were evident within 6 months of an injury, they would not likely be related. Dr. Teal indicated thoracic x-rays showed changes that would be expected at Petitioner's age. He opined that Petitioner's history was worrisome for "some sort of chronic sprain or strain in his back and neck area related to his prior traumas." He further opined that low back and leg symptoms tracked to the 2010 accident, while neck and thoracic pain were aggravated in the 2012 accident. He did not believe the Petitioner was a surgical candidate. On cross exam, he testified he was not aware that Petitioner had complained of his mid-back prior to 7/9/12 and that this could potentially impact his opinions, and agreed that if an epidural had been performed for the T11/12 level, this would indicate Petitioner had been having significant thoracic complaints at the time. Dr. Teal also indicated, given he had not reviewed any records, that he was relying on Petitioner's subjective statements and complaints to a great degree.

Dr. Lange, Respondent Solid Platforms (11 WC 07247) examining physician, opined that Petitioner's 2013 thoracic MRI showed a new T2/3 herniation that had not been seen in 2011, and that this could be related to the 7/9/12 accident, but on cross exam agreed he could not say for sure. Lumbar films between 2011 and 2013 showed no significant differences. He opined that Petitioner was not a surgical candidate for the thoracic sign given no evidence of myelopathy. Respondent Joiner's examining physician, Dr. Mirkin, testified that Petitioner's spine condition essentially was degenerative disc disease that was relatively common and mild for his age. Petitioner, both verbally and via a pain drawing, indicated only lumbar and thoracic complaints on 9/29/14, with no indication of cervical problems. While he testified that the 7/9/12 accident may have caused a transient aggravation of this preexisting condition, there was no new pathology or longstanding disability that resulted from this accident. His exam was essentially normal. His review of the 2013 MRI was in disagreement with Dr. Lange, as he testified he saw no new T2/3 herniation. While he noted he saw no malingering or symptom magnification, he also testified that it was clear to him from the type of work Petitioner had performed in July 2012 would have been in excess of any 30 pound restriction.

The Arbitrator finds that the greater weight of the evidence indicates that the Petitioner sustained strains to his neck and upper thoracic areas, with pain also emanating from the left shoulder blade area where he fell on a drill. However, after only a week off work, the Petitioner returned to work for 6 weeks with Clifford Howell Construction. While he testified that he was able to limit himself, as noted above, there was no evidence he was under any restrictions related to the 7/9/12 accident. Also, as noted in the 11 WC 07247 decision, the Petitioner's arguments that he is able to work within a 30 pound restriction at numerous construction jobs just does not hold water in the Arbitrator's view. These appear to be mainly union laborer positions, given the information came from the union and generally involved construction companies, where in some cases the Petitioner worked for weeks or months. His indication was that he would stop working when work within his restrictions ended, however in the Arbitrator's experience with reviewing many cases with such union workers, it would be highly unusual that the Petitioner would keep getting hired if he was not indicating to employers that he had restrictions but then would leave the jobs if he was asked to do things beyond 30 pounds. While that may be believable in a short term situation, the jobs listed in Rx29 are numerous and occurred over the course of years. This just not appear to be credible on its face.

The Arbitrator also finds it relevant that the Petitioner reported to PA Siemer on 11/20/12 that he was exercising three to four times per week for a total of 5 to 10 hours

The evidence presented in this case doesn't reflect if or why any treatment after the 7/9/12 accident may have been disputed by Respondent. Petitioner did testify that he had difficulty obtaining treatment throughout the pendency of both of the cases for which this hearing was held. However, it also is unclear why he immediately returned back to work for C. Howell instead of returning to see NP Siemer on 7/18/12 if he felt he was unable to work.

Overall, it appears that the Petitioner sustained the noted strains, and that these strains of the neck and upper thoracic spine, are causally related to the accident.

However, the Arbitrator further finds that these strains should have resolved well prior to the hearing date. The evidence supports that Dr. Miller indicated that a typical treatment protocol for such strains would entail 25 to 35 visits. The Arbitrator finds that Petitioner reached MMI as of the 9/29/14 visit with Dr. Mirkin. The Arbitrator declines, as noted below, to award the Petitioner the expenses of Dr. Miller after the 35th visit, and it is reasonable to conclude that the Petitioner reached MMI before or during the treatment with Dr. Miller. However, the Arbitrator notes the difficulty of choosing a proper date of MMI during that treatment, and gives the Petitioner the benefit of the doubt in this regard. However, while Dr. Miller took the Petitioner off work, and continued him off work through the end of his treatment there in October 2014, the Petitioner had already returned to work in June 2014. The evidence does not support this off work status being reasonable or reasonably related to the 7/9/12 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:

Dr. Miller himself testified that a typical treatment regimen for Petitioner's injuries would involve 25 to 35 visit.

Based on the testimony of Dr. Miller and the Petitioner's indication that the treatment offered no true lasting improvement, the Arbitrator finds that all of Petitioner's visits with Dr. Miller following the 35th visit were unreasonable and unnecessary pursuant to Section 8.2 of the Act. Reviewing Dr. Miller's records and the

testimony of the Petitioner, it is abundantly clear that the treatments of Miller provided almost no significant curative effects. The relief appears similar to what would be attained via massage – immediate relief with no real long term benefit. Given Dr. Miller's testimony, it is hard to understand how he believed that treatment beyond his own stated 25 to 35 visit protocol would have been reasonable given the lack of improvement of the Petitioner over two years time.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner is entitled to TTD from 7/10/12 through 7/18/12. Pursuant to the Act, because this time period covers less than two weeks, the Petitioner is not entitled to the first three days of this TTD period.

First, the Arbitrator notes that any 30-pound restriction alluded to by Petitioner was in existence prior to the 7/9/12 accident date, and therefore is unrelated. The Petitioner himself testified that he did not inform the Respondent Joiner of any work restrictions, and this was essentially confirmed by Mr. Joiner.

The records Petitioner submitted into evidence as Px15 do not specify when he started to work for C. Howell Construction in July 2012. However, the records from the union (Rx29) indicate the Petitioner worked 268 hours for that company between July and October 2012.

It is unclear to the Arbitrator how the Petitioner is claiming TTD in this case beyond July 18, 2012. In order to be entitled to TTD, a claimant must prove not only that he did not work but that he was unable to work. *Freeman United Coal Mining Co. v. Industrial Comm'n*, 318 Ill. App. 3d 170, 741 N.E.2d 1144, 2000 Ill. App. LEXIS 1021, 251 Ill. Dec. 966 (2000).

In this case, the Petitioner has clearly failed to show an inability to work. He worked, as noted, for 3 to 4 months following the injury after being off work for less than two weeks. The only restriction he could have possibly been working under, by his own admission, would be a preexisting 30-pound lifting restriction, and the Arbitrator has already questioned how he could have done this while working for construction companies without informing them of any such restriction. The Petitioner then asked to return to work for Respondent Joiner in September 2012, and when he was not offered work began to treat with a chiropractor.

The chiropractor then held him off work for approximately two years while providing treatment that appears to have provided nothing more then very transient relief, and during this treatment the Petitioner refused any treatment to the low back. Respondent Joiner paid the Petitioner full pay, it appears, during December 2012 and January of 2013. (See Rx2). Further, while being held off work, the Petitioner then returned back to construction work with Shores Builders in June 2014, while still being restricted by Dr. Miller, and continued to work numerous jobs through December 2015.

The Arbitrator finds that the Petitioner has demonstrated a clear ability to work since very shortly after the accident, and does not find the off work note of Dr. Miller issued over two months post-accident to be valid based on the Petitioner's ongoing work reflecting his ability to do so. A review of his work hours for numerous construction companies between July 2012 and December 2015 simply does not provide proof that the Petitioner was unable to work or did not work.

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

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

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

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party has submitted an AMA permanent partial impairment rating or report into evidence. This factor therefore carries no weight in the permanency determination.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a roofing laborer at the time of the accident. While he claims an inability to work as a laborer after the accident, records of Petitioner's employment reflect that he has been able to return to work as a laborer for no less than 13 separate companies since his accident. The only work restriction, 30-pounds, that the Petitioner relies on predates the accident. This factor carries a moderate level of weight in the permanency determination.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 42 years old at the time of the accident. Neither party has submitted any expert evidence indicating how the Petitioner's age may impact any permanent condition resulting from the 7/9/12 accident. That said, the Arbitrator notes that the Petitioner developed a chronic strain as a result of the prior accident involved in the consolidated claim, and this accident does appear to have contributed to his chronic condition at some level. Therefore, this factor does carry some weight in the permanency determination.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner has alleged that he has not been able to work as often as he had prior to being injured, but he generally bases this on the noted 30-pound work restriction which, again, is not the subject of this accident. The Petitioner also did not provide any sufficient evidence that would show the difference in the hours worked prior to these accidents versus subsequent to them, other than to say he was working seven days a week with Respondent

Solid Platforms. The Petitioner just hasn't shown that the 7/9/12 accident has impacted his future earnings capacity. This factor carries some weight in the permanency determination.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner essentially appears to have developed a chronic upper back strain as a result of the accident in this case. This is on top of a chronic mid-to-low back strain that he developed as a result of the prior 10/13/10 accident that is the subject of the companion consolidated case. He had minimal treatment for this injury until 9/25/12, and continued to work. He then was taken off work by a chiropractor for two years. Despite the chiropractor's own testimony that 25 to 35 sessions would be normal for a strain injury, he treated the Petitioner over 100 times. While he held Petitioner off work, this off work is without orthopedic support. While there is evidence in the prior claim that he was not provided with treatment initially, here he was sent for treatment at Fairfield and then sought treatment with his primary care provider at Clay. Instead of continuing to seek treatment, the Petitioner returned to work for C. Howell Construction. While he testified that NP Siemer did not realize how injured he was, Petitioner also did not return to Siemer after 7/18/12. It is not clear why. Once he returned to work for a different company, performing construction work for six weeks, it would be reasonable for the Respondent Joiner to question the degree of injury that resulted from the 7/9/12 incident. Ultimately, the greater weight of the evidence, in the Arbitrator's view, indicates the Petitioner sustained a strain injury to the upper spine and some type of soft tissue myofascial pain to the left shoulder blade area as a result of falling on the drill. These appear to remain chronic problems, but they have resulted in pain that the Petitioner has clearly been able to work through. Any complaints of radicular problems in the arm or arms did not occur until well after the accident date. Ultimately, in both claims the Petitioner appears to have aggravated preexisting degenerative spinal conditions.

Based on the above factors, the record taken as a whole and a review of prior Commission awards with similar injuries similar outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent loss of use of 5% of the person as a whole pursuant to §8(d)2 of the Act.

The Arbitrator notes that while the parties have stipulated to a credit of $12,384.47, it appears that this credit relates to the wages paid by Respondent Joiner to Petitioner in December 2012 and January 2013. These do not constitute workers' compensation benefits, nor do they constitute payments pursuant to Section 8(j) of the Act. As such, they are not creditable against the Petitioner's permanency award, nor are they creditable against any TTD or medical awards in this case. It appears that these benefits were paid by Respondent Joiner to in some way avoid submitting the claim to workers' compensation. The Respondent is not entitled to credit for these payments against any of the awarded workers' compensation benefits. This was a period of time during which Petitioner has been found not entitled to weekly benefits.

WITH RESPECT TO ISSUE (O), IS THE PETITIONER ENTITLED TO PROSPECTIVE MEDICAL TREATMENT, THE ARBITRATOR FINDS AS FOLLOWS:

As the Petitioner reached maximum medical improvement well prior to the hearing date, the Arbitrator finds that the Petitioner has failed to prove entitlement to prospective medical treatment relative to his 7/9/12 accident. As noted in case 11 WC 07247, the parties stipulated that if the Arbitrator determined that the Petitioner had reached MMI prior to the hearing date, the nature and extent of the Petitioner's permanent condition relative to the 7/9/12 accident could be determined.

WITH RESPECT TO ISSUE (O), THE CHOICE OF TWO DOCTORS RULE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner's physician choices did not exceed the two-doctor limit.

He initially treated at the ER at Fairfield, and the Arbitrator does not consider this to be a "choice" within the meaning of the Act. He next chose to treat with NP Siemer at Clay Medical Center, which would be his initial voluntary choice.

His second voluntary choice would have been with chiropractor Dr. Miller.

The only other physicians the Arbitrator notes the Petitioner saw, outside of physicians he was referred to by Respondent for Section 12 evaluations, was Dr. Gabriel, Dr. Ghalambor, Dr. Teal and Dr. Ogan.

Prior to the accident at issue in this case, NP Siemer had referred Petitioner to Dr. Gabriel, who referred Petitioner to Dr. Ghalambor. While there does not appear to have been a specific referral from Siemer to Gabriel in the records subsequent to 7/9/12, there had already been an established referral between these providers going back to Petitioner's 10/13/10 accident. Here, these two cases clearly have intertwining aspects to them in that both involve claims of thoracic and spinal injury, and the Arbitrator does not believe it is unreasonable to conclude that the Petitioner's preexisting established relationship with Dr. Gabriel for spine care would constitute an ongoing referral in this case.

Dr. Gabriel referred Petitioner back to Dr. Ghalambor. Dr. Ghalambor referred Petitioner to Dr. Teal (according to Dr. Teal), and Dr. Teal referred Petitioner to Dr. Ogan. Therefore, the Arbitrator finds that all of the noted treaters fall within the chain of referrals from NP Siemer.

WITH RESPECT TO ISSUE (O), PETITIONER'S ENTITLEMENT TO TRAVEL / MILEAGE EXPENSES, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner has failed to prove entitlement to travel and mileage expenses. As noted in the 11 WC 07247 case, the Arbitrator does not believe that the Petitioner has provided a sufficient showing that he did not have access to treating physicians closer to his home than the ones he ultimately saw. Additionally, the Arbitrator specifically notes that Petitioner's trips to Ohio to see Dr. Gabriel are unreasonable given that there clearly are orthopedic surgeons in significantly closer proximity than Ohio that he could have sought referral to through NP Siemer.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gregory Sefton,
Petitioner,

vs. No. 11 WC 07247

20IWCC0170

Solid Platforms Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that, the Decision of the Arbitrator filed December 5, 2018, is hereby affirmed and adopted.

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.

20IWCC0170

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $62,900.00 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 12 2020

Marc Parker

mp/wj
03/05/20
68

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SEFTON, GREGORY
Employee/Petitioner

Case# **11WC007247**

13WC008516

SOLID PLATFORMS INC
Employer/Respondent

20IWCC0170

On 12/5/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.49% 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:

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CHESTER, IL 62233

0725 LAW OFFICE CRAIG A HANSEN
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8660 S GEYER RD SUITE 340
ST LOUIS, MO 63127

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

GREGORY SEFTON
Employee/Petitioner

v.

SOLID PLATFORMS, INC.
Employer/Respondent

Case # **11** WC **07247**

Consolidated cases: **13 WC 08516**

20IWCC0170

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **August 10, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0170

FINDINGS

On **October 13, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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, but the Petitioner reached maximum medical improvement as of November 30, 2011.

In the year preceding the injury, Petitioner earned $**107,592.16**; the average weekly wage was $**2,069.08**.

On the date of accident, Petitioner was **42** 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 $**66,446.10** for TTD, $**0** for TPD, $**0** for maintenance, and $**6,366.39** for other benefits.

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

ORDER

The Arbitrator finds that the Petitioner's condition at T8/9, T11/12 and T12/L1 is causally related to the October 13, 2010 accident, but that the Petitioner reached maximum medical improvement with regard to this condition as of November 30, 2011. The Arbitrator further finds that the Petitioner has failed to prove that any radicular symptoms in the lower extremities are causally related to the October 13, 2010 accident.

Respondent shall pay Petitioner temporary total disability benefits of **$1,243.00 per week**, the maximum allowable statutory rate, for **16-6/7 weeks**, commencing **August 5, 2011 through November 30, 2011**, as provided in Section 8(b) of the Act.

Respondent shall pay **reasonable and necessary medical services contained in Petitioner's Exhibit 16 which were incurred prior to December 1, 2011**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for any of the awarded medical benefits that have been paid prior to hearing, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$669.64 per week**, the maximum allowable statutory rate, for **62.5 weeks**, because the injuries sustained caused the loss of use of **12.5% of the person as a whole**, as provided in Section 8(d)2 of the Act.

The Petitioner has failed to prove that he is entitled to causally related prospective medical treatment.

The Petitioner did not exceed his two choices of physician pursuant to Section 8(a) of the Act.

The Petitioner has failed to prove he is entitled to travel / mileage expenses related to the October 13, 2010 accident.

Respondent shall pay Petitioner compensation that has accrued from **November 30, 2011** through **August 10, 2017**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

November 27, 2018
Date

DEC 5 - 2018

STATEMENT OF FACTS

The Petitioner testified that while working for Respondent Solid Platforms on 10/13/10, he was moving a heavy load with a hand jack to an outside elevator. While trying to move the jack loose from being stuck in a crack on the floor he testified he injured his spine, mainly the mid to lower back. His first treatment was with occupational medicine on 10/29/10, testifying the Respondent initially didn't want to send him for treatment. He reported moving a 5,000 to 6,000 pound load with the hand jack, and that he had 8 out of 10 level back pain with aching and a "pins & needles" feeling. Examination indicated tenderness from the lower thoracic spine centrally down to the mid-lumbar spine. Neurologic exam was essentially normal, but Petitioner had reduced range of motion. X-rays showed no acute findings but reflected mild multilevel thoracic spondylosis. Petitioner was diagnosed with thoracic and lumbosacral strains, was prescribed Hydrocodone, ibuprofen and a muscle relaxer (Metaxalone), and was given light duty restrictions. The doctor indicated the problem was related to the noted work activities. (Px1). This accident is the subject of case 11 WC 07247.

At an 11/5/10 follow-up, Petitioner reported improvement in his stabbing lower thoracic/upper lumbar pain but ongoing pain and soreness. He had no leg symptoms. He was working light duty and indicated he wanted to return to his regular job if possible. A safety officer was noted to be present with the Petitioner. He was released back to full duty on 11/5/10, with "caution" for reaching below the waist and heavy lifting. Petitioner returned on 11/15/10, again with a company representative, and noted ongoing symptoms in his left spine. He again advised he wanted to return to full duty, and he was again advised he could do so. (Px1).

Despite indicating he was carrying a clipboard and checking people in and out at work, as opposed to regular duty, on 11/30/10 the Petitioner reported he was considerably worse, particularly with prolonged standing, and that he was out of medication. Pain was noted from the left pelvis to the lower rib paraspinals. His work activities were again restricted, medication prescriptions were renewed, and an MRI and physical therapy were prescribed. (Px1). The Petitioner testified he was contacted by the occupational medicine facility and advised that a follow up visit in December was not being authorized by Respondent. Petitioner next sought treatment at Clay Medical Center, his primary care provider, where he saw nurse practitioner (NP) Siemer on 12/1/10 and 12/6/10. Petitioner indicated was his first voluntary choice of physician. The report from 12/6/10 references chest pain and notes increased stress due to a work injury and loss of job. (Px2 & 3).

A 12/7/10 consultation report from the Effingham Clinic notes Petitioner injured his back at home on 10/13/10 with some chronic difficulties since and his use of medications. 12/13/10 and 12/22/10 reports from St. Anthony Hospital indicate the Petitioner reported a history of chest pain and shortness of breath going back to approximately November 30th, for which the Petitioner was worked up. No back complaints were noted. (Px3).

Petitioner testified he then saw NP Siemer in December 2010, and she prescribed MRI testing which was performed on 1/19/11. The thoracic MRI showed: 1) Mild degenerative disc disease in the mid and lower thoracic spine with small Schmorl's node at multiple levels, most significant at T11/12; 2) Diffuse disc bulge at T11/12 causing mild spinal canal stenosis but no evidence of cord compression and mild right T11/12 foraminal stenosis, with no definite evidence of impingement of the nerve root; 3) Mild foraminal stenosis at T1/2 bilaterally; 4) Small disc bulges at T1/2, T2/3, and T8/9 causing indentation of the thecal sac, but no spinal canal stenosis or foraminal stenosis; and 5) Mild degenerative disc changes and degenerative changes at the costovertebral joints at multiple levels in the mid and lower thoracic spine. The lumbar MRI impression was: 1) Disc space narrowing with dehydration of intervertebral discs at L3/4 and L4/5; 2) a Schmorl's node with indentation at the superior endplate of L4/5 with adjacent inflammatory changes; 3) a small Schmorl's node at the superior endplate of L3; 4) Diffuse disc bulge and facet arthropathy at multiple locations, but no spinal canal stenosis; 5) Focally prominent right foraminal disc bulge at L2/3 causing moderate right foramina stenosis with displacement and possible mild impingement of right L2 nerve root; and 6) moderate hypertrophic facet arthropathy at L5/S1 causing moderate bilateral L5/S1 foraminal stenosis, with bony spurs from the facet joint abutting the exiting L5 nerve roots bilaterally. (Px3; Rx17; Rx19). Following the MRI, Petitioner was referred to orthopedic surgeon Dr. Gabriel.

Petitioner initially saw Dr. Gabriel on 2/9/11, where he reported a consistent history of the accident. He noted that medication "helped some" but was "masking" the injury. Following examination and review of the MRIs, Dr. Gabriel diagnosed a thoracolumbar sprain/strain; bulging T11/12 disc protrusion with a disc-spur complex causing spinal stenosis, disc protrusions at T2/3, C8/9 and T1/2 [*Arbitrator's Note*: this appears to be a clerical error, as there is no C8/9, and that this should be T8/9, per the testimony of Dr. Gabriel]; Schmorl's nodes at L4 and L5 with degenerative disc disease, narrowing at L3/4 and L4/5, and multilevel lumbar degenerative disc disease/bulging disc/facet arthropathy. Dr. Gabriel believed that T11/12 appeared to be the most symptomatic level due to a combination of a disc protrusion and spinal stenosis. He prescribed a lumbosacral corset and lumbothoracic physical therapy as well as a T11/12 epidural and restricted Petitioner's work duties. On 3/14/11, Petitioner reported the injection and therapy had not been approved. Norco and Skelaxin were prescribed. (Px4; Rx12).

Petitioner saw pain specialist Dr. Ghalambor for consultation on referral from Dr. Gabriel on 3/31/11. He reported pain in the mid low thoracic lumbar area without radiation to the legs. Lumbar epidural was not performed by Dr. Ghalambor at L1/2 until 4/29/11 because the Petitioner had to stop taking aspirin for at least 7 days. (Px3; Rx13; Rx14). On 4/29/11, Dr. Ghalambor's impressions were: 1) thoracolumbar sprain/strain, 2)

bulging disc protrusion with disc-osteophyte complex causing spinal stenosis T11/12 worst level, 3) disc protrusions at T2/3, C8/9 and T1/2, 4) neuroforaminal stenosis at right L2/3 with foraminal disc and bilateral L4/5 and L5/S1 neuroforaminal stenosis, 5) right kidney lesion, 6) Schmorl's nodes at superior L4 and L5 with degenerative disc disease, narrowing L3/4, L4/5 and multilevel degenerative disc disease and facet arthropathy lumbosacral spine as well as bulging discs. Petitioner reported some tingling in the left leg "only one time." He was neurologically stable and intact in the lower extremities. Dr. Ghalambor noted Petitioner was waiting for therapy authorization and he wanted to see how that went before determining if further epidural injections were indicated. (Rx15).

Petitioner returned to Dr. Gabriel on 5/4/11 and reported the epidural did not help. He continued to complain of thoracic and low back pain. Dr. Gabriel's diagnosis remained the same and he recommended continuing his medications and undergoing physical therapy. Dr. Gabriel noted that Petitioner was having moderate/severe spasm at the thoracic/lumbar area. Petitioner was advised to follow up in 6-8 weeks. (Px4).

Dr. Gabriel testified via deposition on 5/13/11. He noted multiple thoracic disc protrusions (T1/2, T2/3, T8/9 and T11/12) but believed the main cause of Petitioner's symptoms of central and left thoracolumbar pain was T8/9 and T11/12, noting there were no radicular complaints and that these protrusions were most likely caused by the work accident. The other two thoracic discs did not appear to correlate with the symptoms. Facet arthropathy at T11/12 was likely chronic and preexisting, but Dr. Gabriel testified the combination of this with the disc protrusion resulted in a double crush syndrome with stenosis from both the anterior and posterior aspects. Petitioner did not appear to have any myelopathy symptoms. Conservative treatment was recommended. While Petitioner had no benefit from the epidural or corset, Dr. Gabriel noted Petitioner still hadn't undergone physical therapy, and he opined that therapy and facet blocks would be worth trying given Petitioner's pain appeared localized to the paraspinous area. Dr. Gabriel testified here was no surgical indication based on the history and exam findings. He continued Petitioner on work restrictions on 2/9/11. He opined Petitioner had not reached maximum medical improvement and his condition remained causally related. (Px4).

On cross examination, Dr. Gabriel acknowledged he had not reviewed any of Petitioner's prior medical records. He believed Petitioner had been working when he first saw him, given that he issued work restrictions, but didn't know if this would have been full or light duty. Therapy still had not been approved, and Dr. Gabriel was hopeful this would help him back to work: "I mean, he's remained quite stable." If that didn't resolve the symptoms, Gabriel would determine if facet blocks and/or epidurals should be performed. (Px4).

Petitioner testified he didn't have any further treatment until 2012 because the Respondent wasn't authorizing it. He testified to difficulty obtaining treatment from both Respondents throughout the pendency of his claims.

A hearing was held on 8/4/11 pursuant to Sections 8(a) and 19(b) of the Act with regard to the 11 WC 07247 claim. The only issues in dispute involved whether there was Illinois jurisdiction and whether penalties and fees were applicable. The Arbitrator at that time found Illinois jurisdiction and denied penalties and fees. As a result, the Petitioner was awarded TTD benefits from 11/22/10 through the 8/4/11 hearing date and all outstanding medical expenses. Prescribed treatment of Dr. Gabriel and Dr. Ghalambor was also awarded. The decision of the Arbitrator was affirmed and adopted by the Commission in its entirety on review on 5/7/12. (see Jointx1).

On 12/2/11, Dr. Gabriel completed a medical statement for Petitioner's union Defined Contribution Pension Trust Fund. This noted diagnoses of lumbosacral degenerative disc disease, spondylosis/osteoarthritis in the lumbar facets, thoracic disc herniation and spinal stenosis. Symptoms included low back pain and numbness and tingling to the legs. He noted that Petitioner had last been seen on 6/20/11, however the Arbitrator did not locate any report of Dr. Gabriel in the record from this date. Therapy had been prescribed. Dr. Gabriel indicated the

Petitioner was unable to work at any gainful employment, and that he was awaiting authorization for surgery. (Rx16). The Arbitrator notes that no surgical recommendation was noted in the records of Dr. Gabriel, so it is unclear what surgery he was recommending. Additionally, Dr. Gabriel was indicating the Petitioner was unable to work despite not having examined him in at least 6 months.

Petitioner began working for Respondent Joiner starting the week prior to 7/9/12. The job involved replacing panels of a metal roof. On 7/9/12, Petitioner testified he was work on the metal roof with foreman Scott Engelmann. The testified that the roof had a low pitch, but it was slick from prior rain. Engelmann at one point asked him to bring some screw to another part of the roof. As Petitioner walked to deliver the screws, he testified that his feet flew out from underneath him and he fell onto his drill on the upper back and shoulder area, as well as onto a roof seam with his spine and the base of his neck. He testified that Engelmann was present when this happened, but he wanted to finish the job, so he initially didn't want to take the Petitioner for treatment. After his shift ended, Petitioner testified he drove himself to the Fairfield ER. An accident report from Joiner Sheet Metal was included in the Fairfield records which notes Petitioner reported a neck and back injury due to a metal roof being wet from rain, and that he required medical attention. (Px7). This accident is the subject of case 13 WC 08516.

Respondent Joiner presented two witnesses at hearing, Scott Engelmann and John Joiner. Mr. Engelmann agreed that he and Petitioner were replacing 20' metal roof panels in July 2012. He testified that he had gone back to the truck, about 60 yards away, and when he returned the Petitioner reported having slipped on the roof. He denied witnessing the accident and testified he did not hear the Petitioner's fall. He testified he asked Petitioner if he wanted to get treatment, but that Petitioner declined and finished the shift without problem. He denied begging the Petitioner to stay and continue to work. He indicated Petitioner said he'd see how he felt in the morning and if he was hurt he would go and see a chiropractor.

The 7/9/12 records from Fairfield reflect Petitioner reported slipping and landing on his back on the roof. He complained of pain to the right neck and low back. He was unsure if he had any tingling in his extremities. A pain drawing indicated he localized his pain to the right neck and left mid back. X-rays showed mild C5/6 degenerative disc disease, with normal findings at the thoracic level. The diagnoses were cervical and thoracic strains, medication was prescribed, and Petitioner was held off work through 7/11/12. (Px7; Rx4; Rx5; Rx6). The Arbitrator notes that the Respondent submitted a note from Fairfield which indicates that the Petitioner advised the facility not to provide medical records to workers' compensation. He was advised that this could result in a denial of a workers' compensation claim, and Petitioner stated: "Whatever they need they can get from me." (Rx4).

Petitioner followed up with NP Siemer on 7/11/12 at Clay Medical Center. He reported falling at work and landing on his back and neck. He also noted chest and sinus pain. Petitioner reported he was able to turn his head but wasn't ready to return to work. He was held off work due to continued neck and back pain through 7/18/12 and the ER medications were renewed. (Px8). Petitioner testified he didn't think Siemer understood how injured he was and, after being off work initially for about a week after the fall, he worked on an apartment job for Clifford Howell Construction for about 6 weeks.

Mr. Engelmann testified he was aware that Joiner offered Petitioner a light duty job in the shop within a couple of weeks after the incident, where there was always work to do. He wasn't sure why Petitioner declined this but noted Joiner's shop was 1.5 to 2 hours away from Petitioner's location. On cross-exam, Mr. Engelmann testified that he never met Petitioner before they started working on 7/2/12. He testified that they did not work Saturdays or Sundays, but that they otherwise worked through the accident date. On cross from Respondent Solid Platforms, Mr. Engelmann testified that Petitioner was hired out of the union hall, and when that occurs workers

are just sent without any indication if they have work restrictions or not. Petitioner never told him that he had any work restrictions.

John Joiner testified that he owns Respondent Joiner, a roofing company. He was aware Petitioner reported an accident and agreed he didn't challenge it. He paid Petitioner regular wages for a 40-hour week for a period of time after the accident as documented in his records. He testified that, to his recall, he did offer Petitioner a job a few weeks after the injury, but that Petitioner turned it down because it was not "in the extreme vicinity of his living." Petitioner also said he was working locally for someone else, a framing company. Mr. Joiner did not recall Petitioner contacting him after that at any point seeking his job back. Mr. Joiner testified that Petitioner had not indicate prior to the accident that he was unable to do any part of his job and had no back complaints to his knowledge. He "supposed" Joiner did pay Petitioner's medical expenses through 2/4/13.

Petitioner next sought treatment on 9/25/12 with chiropractor Dr. Miller at Flora Chiropractic. The report noted Petitioner reported his employment with C. Howell Construction. The records also state that Petitioner indicated "he had not experienced prior symptoms similar to his current complaints and was symptom free at the time of the aforementioned accident/onset of 7/9/12." Petitioner denied having made this statement in his testimony. The assessment at the time was of a sprain/strain to the upper thoracic spine associated with myofascitis. Recommended treatment included chiropractic adjustments, ultrasound therapy, deep muscle therapy, and electrical muscle stimulation. The Petitioner underwent approximately 107 sessions at Flora Chiropractic through 10/14/14. His complaints generally remained the same, with 7 to 8/10 level pain, and he testified that the treatments he received always remained the same. He testified that he would only feel temporary relief with each treatment over two years. After initially indicating Petitioner could return to work on two separate occasions, Petitioner was taken completely off work by Dr. Miller for an indefinite period of time on 1/22/13. (Px9).

On 9/26/12, Petitioner appeared at Fairfield Hospital for pre-operative testing regarding a right sided hernia repair. Petitioner reported chronic mid to lower back pain. He refused to tell the facility why he was taking a medication called Acyclover, but that he "takes lots of herbs." Petitioner also noted prior surgeries for left biceps tendon repair, left trigger finger release and carpal tunnel and ulnar releases of the right hand. (Rx8). The surgical repair of right umbilical and inguinal hernias was performed by Dr. Molt on 9/28/12. He was noted to have a several month history of hernia, but no cause of onset was specified. Activity restrictions were instituted for three weeks. (Rx9; Rx10).

At an 11/20/12 follow up with NP Siemer, Petitioner reported ongoing mid back pain, and that while he had tried to return to work within his abilities, his pain had recently increased. He reported some relief with chiropractic treatment. He also reported having pain originating from the low back after a fall about a year before this visit. He reported exercising three to four times per week for a total of 5 to 10 hours. He was prescribed a Medrol dosepak and Flexeril. It was noted he was given a work note, but this was not located by the Arbitrator in the evidentiary record. (Px8).

From 7/12 to 12/12, Petitioner testified he originally was off work for a week after the accident, after which he returned to work for about 6 weeks with a non-union employer. Respondent Joiner paid Petitioner his wages for about a week in July 2012, and then paid him off and on from 9/12 to 12/12. He testified when he spoke to Joiner by phone, he was told they didn't want to turn the claim in to workers' compensation, as the insurance company would fight the claim and that this would end up increasing Joiner's rates. Petitioner testified he never received any TTD benefits from Joiner's insurer.

On 12/21/12, Petitioner returned to Clay Medical Center for bronchitis. The report noted no complaints of back or neck pain in the Review of Systems, with normal musculoskeletal findings on exam. (Rx11).

Other than continuing chiropractic care, the next time Petitioner sought treatment for back pain was with Dr. Gabriel on 5/14/13 in Ohio, where the doctor had moved his practice. Petitioner complained of chronic thoracic and low back muscle pain and cramps, as well as a new onset of left thigh and leg numbness since July/August 2011. He reported the 7/9/12 injury when he fell on a drill with his thoracic spine area while working on a roof. He reported some improvement with physical therapy after this incident and that he worked for approximately 6 weeks after it but had not worked since September 2012. Petitioner reported that since the 10/13/10 injury he worked on and off for about 5 months with a 30 pound weight limit that came from the Bonutti Clinic, which is where he had previously seen Dr. Gabriel. Dr. Gabriel diagnosed disc bulges at multiple levels of the thoracic spine, with T11/12 being the worst with disc/osteophyte complex. Disc bulging was also noted in the lumbar spine, with the worst bulging occurring at L3/4 and L4/5. He noted multilevel degenerative disc disease and facet arthropathy in multiple lumbar levels. He noted multilevel foraminal stenosis from L2 to S1. Updated lumbar and thoracic MRIs were ordered, and physical therapy and a muscle relaxer were prescribed. Petitioner reported his 2011 injection from Dr. Ghalambor "did not help him too much." (Px5: Rx21).

The updated MRIs were obtained on 10/17/13. The thoracic interpretation was: 1) Mild degenerative disease at the intervertebral disc, facet joints and costovertebral joints at multiple levels in the thoracic spine as described above; 2) small Schmorl's node in the lower thoracic spine, especially at the T11/12; 3) mild concentric disc bulge at T11/12 causing mild spinal canal stenosis (central thecae sac measuring nearly 9 mm), demonstrated mild interval worsening, but still no evidence of cord compression; 4) mild foramina stenosis but no impingement of the nerve root; and, 5) Mild foramina stenosis at the T1/2 bilaterally. It was also noted that there was a small midline disc bulge T8/9 causing indentation on the thecal sac, but no spinal canal stenosis or foramina stenosis. Also noted was right paramedian T2/3 disc bulge without significant stenosis. Lumbar films showed: 1) Disc space narrowing and dehydration of intervertebral disc at L3/4 and L4/5. Schmorl's node at superior endplate of L4/5 with adjacent inflammatory changes; 2) diffuse disc bulge and facet arthropathy at multiple locations, but no spinal stenosis; and 3) moderate right foraminal stenosis at L2/3 with displacement of nerve root, moderate hypertrophic facet arthropathy with disc bulge at L5/S1 causing moderate bilateral L5/S1 foramina stenosis, and facet joint and the disc bulge abuts existing L5 nerve roots bilaterally with no significant interval changes. (Px10 & 11; Rx18 & 20).

On 1/27/14, Dr. Gabriel prescribed L4 and L5 epidural injections. (Px10).

On 1/27/14 with Dr. Ghalambor, Petitioner reported prior epidural at L1/2 helped his mid-back pain, but the pain was bothering him more and more in the low back and was now in the left leg with numbness that was positional and dependent on how he was sitting of lying down. The 10/17/13 MRI findings were noted, and Dr. Ghalambor's assessment was: 1) clinical left lumbar radiculopathy, 2) lumbar degenerative disc disease with significant endplate changes and Schmorl's nodes at L4 and L5 per the MRI, 3) bilateral lumbar facet arthropathy, multilevel that was more pronounced at L5/S1, 4) lumbar spinal stenosis, right L2/3 foraminal stenosis and bilateral foraminal stenosis at L5/S1, 5) thoracic degenerative disc disease most pronounced at T11/12, 6) lumbar strain at work in late 2010. Dr. Ghalambor also noted that Petitioner "at this juncture is uninterested in seeing a spine surgeon." He recommended a left L4/5 epidural, noting Petitioner would first need to be off aspirin for 7 days. (Px10). An intake form that appears to have been completed and signed by Petitioner on this date notes "Left leg – foot numbness since July-August of 2011."

On 2/21/14, Dr. Ghalambor specifically noted Dr. Gabriel referred Petitioner for left epidurals at L4/5 and L5/S1 due to his complaints of left leg pain. Petitioner noted he had been treating with chiropractor Dr. Miller without significant improvement. He reported pain from the mid back into the low back and left leg numbness. Dr. Ghalambor noted weakness of the left lower extremity that was "grossly nonfocal. It is difficult to assess due to lack of effort and pain contributing." He performed epidural injection at left L4 and L5. He also prescribed a bilateral lower extremity EMG/NCV, which on 2/28/14 showed no evidence of radiculopathy or peripheral neuropathy. (Px10; Rx24; Rx25).

On 4/2/14, Petitioner saw Dr. Gabriel for the first time since 5/14/13. He complained of chronic ongoing thoracic, lumbar and sacral symptoms as well as numbness in his left leg to the foot and an occasional "vibration" feeling in the right leg. Petitioner provided the doctor a two page note regarding his symptoms. This included a knot in his upper back where he fell on the drill, occasional chiropractic treatment, muscle relaxers. He noted the chiropractor consistently found the T5/6 level out of place, occasionally T6/7 as well, and that his rib was out of place where he fell on the drill. He noted difficulty sleeping due to back and neck pain he was having since the fall. Dr. Gabriel diagnosed multiple thoracic and lumbar disc bulges, worst at T11/12 with spur disc complex and spinal stenosis. Multilevel degenerative disc disease was worst at T10/11, L3/4 and L4/5. October 2013 lumbar MRI was noted to show right (moderate) and left (mild) L2/3 neuroforaminal stenosis, mild stenosis at L3/4 and L5/S1 and lateral recess stenosis at L4/5. Bilateral lower extremity radiculopathy was also indicated. Dr. Gabriel did not believe Petitioner was a surgical candidate, and he referred Petitioner to Dr. Ghalambor for an epidural at T11/12 and facet blocks at L3 to L5, with possible radiofrequency ablation at L4 to S1. Prior to any type of surgery, he recommended discogram to be performed from L2 to S1. (Px5; Rx23).

On 9/29/14, Petitioner was examined by orthopedic surgeon Dr. Mirkin at the Respondent's request. Petitioner reported that he suffered severe thoracic and lumbar injuries on 7/9/12 when he fell on a roof on top of a drill. He reported working intermittently since with ongoing thoracic and lumbar pain radiating into the left leg. Petitioner also reported the 10/13/10 incident with severe thoracic and lumbar pain. He reported remaining on a 30-pound weight restriction until the 7/9/12 accident. Petitioner also informed Dr. Mirkin that he had been working intermittently since the injury but was not working at the time of the examination. After reviewing Petitioner's prior medical records, including the prior MRI's, Dr. Mirkin's assessment was that Petitioner had degenerative spine disease. Dr. Mirkin indicated the MRIs revealed mild disc pathology in both the thoracic and lumber spine which were present on the MRI testing both before and after the 7/9/12 injury. After examining Petitioner, Dr. Mirkin opined the Petitioner was at maximum medical improvement (MMI) and did not feel that Petitioner had any signs of pathology or injury related to the7/9/12 injury. Dr. Mirkin noted that this finding was supported by Petitioner's admission that he had worked after the 7/9/12, accident without any restrictions. He testified that he based the conclusion of working with no restrictions on the type pf job Petitioner worked, despite Petitioner stating that he worked within his restrictions. As such, Dr. Mirkin did not believe Petitioner needed any further treatment or restrictions that would be related to the 7/9/12 accident. (Rx26).

The Arbitrator did not see any further treatment in the evidentiary record prior to a 1/26/15 lumbar MRI. This was noted to have stable findings when compared to 10/17/13 films. Noted was degenerative disease with disc bulges from L2 to L5, Schmorl's nodes at L4 and L5 and multilevel facet arthropathy without significant central canal or neuroforaminal stenosis. (Px10).

The Petitioner presented to Dr. Teal at Carle Hospital for a neurosurgical consultation on 3/5/15. Petitioner testified this was on referral from Dr. Ghalambor. Petitioner's complaints at the time were of neck and back pain with hand and foot numbness. Petitioner reported developing neck, back, and left leg pain immediately after the 7/9/12 accident, later developing numbness in both arms. Petitioner also told Dr. Teal that he returned to work shortly after the 7/9/12 accident near the end of July with a different company that was building

apartments and performing siding work. Petitioner told Dr. Teal that he stopped working altogether from 9/6/12 until 6/13/14. Petitioner rated his neck pain at 6-8/10 and his lumbar and thoracic pain at an 8 to 10/10. Dr. Teal read the MRIs, opining that they essentially showed degenerative disc disease. Dr. Teal's assessment was of cervical, thoracic, and lumbar strains with chronic pain and no surgical disease. The recommendation was for physical therapy and consideration for possible cervical, thoracic, and lumbar injections along with an EMG to assess the arm and leg numbness. (Rx12).

Petitioner saw Dr. Ogan on 2/27/17 for evaluation of chronic low back pain with intermittent radiation into the legs and for consideration of lumbar and cervical injections on referral from Dr. Teal. He also noted persistent cervical, thoracic and lumbar pain. It appears that epidural injection was performed bilaterally at L5/S1, and Petitioner was to follow up 2 to 3 weeks after the procedure. (Px14).

Petitioner returned to Dr. Teal on 3/16/17 for consultation following the injections. The Arbitrator notes the doctor indicated 3/14/17 injections, but the only record of injection located in the record is Dr. Ogan's on 2/27/17, so it's unclear if he received a second round of injections. Petitioner reported persistent left anterolateral thigh numbness radiating into the top of the foot with episodic shooting pain. He also noted numbness in the medial fingers in a C8 pattern since falling at work. Petitioner reported he last worked in December 2016 performing construction work as a union carpenter on bridges and fencing. Petitioner stated that he developed lumbar area pain following the initial work accident, and after he initially sought treatment in October 2010 he worked lighter duties until being laid off on 11/22/10, after which he said he remained off work until 12/7/11. He didn't have therapy because there was a dispute over who was going to pay for it, and he reported that lumbar injections in Spring 2011 did not help him. He returned to construction work on 12/7/11 doing metal framing despite his back pain and continued to work intermittently until April 2012. He returned to work in June 2012 doing IDOT maintenance but stopped after two weeks because he was asked to lift over 30 pounds. In July 2012 he returned to work loosening roofing screws to help replace roof panels, and then had his fall on 7/9/12, landing flat on his back and hitting a hand drill on his thoracic spine "and his neck and lumbar area seam [sic] on the roof." Petitioner indicated after he sought treatment he was off work for a week. He had neck, back and left leg pain at that time with numbness in his legs, and reported he later noted episodic numbness in his bilateral hands and wrists and his left thigh, as well as popping in his neck since the fall. He was treated with medication and chiropractic care and said he was off work from 9/6/12 to 6/13/14. Lumbar injections in 2013 provided no relief. He currently complained of left sided neck (6 to 8/10) and central thoracic and lumbar pain (6 to 10/10) "like an ice pick/pressure pain in his lumbar area." Following examination and review of cervical and lumbar MRIs which appear to be from 2017, Dr. Teal recommended a thoracic MRI, continued therapy and consideration of facet blocks with Dr. Ogan. Petitioner was to follow up in 6 weeks. (Px13).

The deposition of Dr. Ghalambor was taken on 9/29/15. When he first saw Petitioner on 3/31/11, his pain was confined to the mid and low thoracic and lumbar region and did not radiate to the lower extremities. Medication, ice and heat had provided only moderate relief. Petitioner was "more frustrated than being in pain." Based on symptoms and the MRI findings, Dr. Ghalambor believed that Petitioner's pain was mainly coming from the T11/12 level and agreed with Gabriel's recommendation for epidural and physical therapy. The epidural was performed at L1/2, not T11/12, because there was more space to insert the needle, but this still should have reached the T11/12 level. Dr. Ghalambor was not involved with Petitioner's work status. He testified that it was not possible to answer whether Petitioner's condition was related to the work accident. He opined that lumbar degenerative disease is a normal finding and that everyone has it at some point in life and can be symptomatic or asymptomatic. He testified: "Whether or not these radiological findings were present before the injury or they happened after the injury, it's impossible to tell." However, Petitioner indicated his symptoms started with the accident, and therefore is a result of that accident. An asymptomatic condition can become symptomatic due to

trauma. He acknowledged that the Commission previously determined the condition was causally related to the accident. (Px6).

Petitioner only followed up with Dr. Gabriel after the 4/29/11 epidural, so Ghalambor didn't see Petitioner again until 1/27/14, which was after the 7/9/12 accident, on referral from Dr. Gabriel for possible left-sided epidural. Petitioner reported his left leg symptoms started after the latter accident. Petitioner reported the prior injection was somewhat helpful, but Dr. Ghalambor noted other medical records indicated Petitioner reported it hadn't helped at all. Petitioner reported left sided lumbar radiculopathy with numbness and possible weakness but did not report any mid-back pain. He also indicated he was not interested in surgery. On exam, Petitioner had new findings of positive straight leg raise on the left and decreased left sensation in the L4 dermatome. Dr. Ghalambor agreed with the recommendation for L4/5 and L5/S1 epidural injections and also recommended EMG testing. On 2/21/14, Petitioner complained of mid to low back pain, pointing to the upper to mid lumbar spine, and the epidural was performed. (Px6).

Dr. Ghalambor opined the findings on MRI between 2011 and 2013 showed a worsening of lumbar anatomical findings. Dr. Ghalambor again testified that there was no way he could attribute Petitioner's symptoms to a work accident, as there can be symptom onset without trauma, but again noted a trauma could have worsened the degenerative condition. Petitioner didn't report a worsening of his mid to low back pain, and EMG testing was normal. To Dr. Ghalambor's knowledge, Petitioner indicated the lumbar epidural didn't help and he returned to Dr. Gabriel. Dr. Ghalambor had no opinion on whether Petitioner was a surgical candidate, but noted both Dr. Gabriel, when he referred Petitioner in 2011 and 2014, and Dr. Teal determined Petitioner was not a surgical candidate. Dr. Ghalambor testified he had no opinion on Petitioner's work status but questioned whether Petitioner could work perform all of the full duties of a carpenter, though he agreed this was based on Petitioner's subjective complaints. He had no opinion regarding MMI other than that Petitioner hadn't reached MMI when he last saw him. (Px6).

On cross examination (Solid Platforms), Dr. Ghalambor acknowledged that while Petitioner initially complained of mid and low back pain in 2011, it was mainly mid-back, and he did not complain of pain radiating into his leg. While Petitioner told Dr. Teal the 2011 epidural didn't help, on 1/27/14 he told Dr. Ghalambor it helped his mid-back pain, but his low back pain was worsening and radiated into the left leg. He didn't complain of mid-back pain to Dr. Ghalambor on 1/27/14 but did to his assistant on 2/21/14. To him, this showed the Petitioner's pain was changing depending on what day it is. (Px6).

On further cross (Joiner), Dr. Ghalambor testified that Petitioner never reported being pain free at any point after the 2010 accident. Petitioner was not very specific as to how much relief he had with the 2011 epidural. If he was not asymptomatic before a work accident, the accident could be "contributing to the worsening of symptoms or not the cause of the pain at all." Most spinal strains/sprains completely resolve with conservative treatment. Dr. Ghalambor agreed his 1/27/14 report states nothing about the July 2012 accident, but testified Petitioner did mention it on 2/21/14. Petitioner didn't say how quickly after the July 2012 accident he developed leg pain. He had no left leg complaints in 2011. Dr. Ghalambor didn't review any of Petitioner's other treating records other than Dr. Teal's 3/5/15 note. He agreed if the initial July 2012 ER report and initial 2012 chiropractor's note did not reflect low back complaints or diagnosis, this would differ from Petitioner's complaints to him of low back and left leg. He agreed that the greater the delay between a trauma and the onset of symptoms, the less likely the trauma is the cause of the symptoms. (Px6).

While Dr. Ghalambor opined the 2013 lumbar study showed a worsening versus the 2011 films, he agreed radiologist Dr. Patel noted no significant interval change between the studies. He could not recall if he reviewed the films themselves or only the reports. He agreed any worsening of degeneration could occur in the absence of

trauma, and it's impossible to say if such worsening would be due to natural aging or a trauma. He also agreed neither set of films showed any "red flag" findings, such as a large disc herniation or severe spinal stenosis. Dr. Ghalambor testified that a spinal strain could be bad enough to impact the discs and joints, but that the majority of such strains get better over time, not worse. While there is a category of patients where a strain can become chronic, he testified this depends on the type of injury, noting that this is more likely with a high impact injury like a car accident than a slip and fall, which would be unlikely to result in such chronic symptoms. While Petitioner's lower extremity EMG was normal, indicating no nerve injury, Dr. Ghalambor testified this would not necessarily rule out a milder degree of sciatica, though in a case like Petitioner's with normal EMG, the "majority of them are reversible" in terms of sciatica. (Px6).

Chiropractor Dr. Miller testified via deposition on 4/30/15. He testified he first saw Petitioner on 9/25/12, but that "he's known me from my previous employment in Flora (IL)." He reported slipping and falling on a roof at work and landing with his backside down onto the drill and hit the roof. He complained of pain between his shoulders that radiated to the top of his shoulders, mostly on the left where he indicated he landed on the drill with his left shoulder blade area. He reported low back problems from a previous injury. Exam noted limited cervical and thoracic range of motion. Following exam, Dr. Miller diagnosed an upper thoracic sprain/strain with associated myofascitis, creating altered biomechanics, and he believed this was related to the reported 7/9/12 accident. Chiropractic manipulation and treatment was instituted. (Px9).

Dr. Miller treated Petitioner between 9/25/12 and 10/14/14. He testified that, typically, treatment for a case like Petitioner's involves 25 to 35 visits, starting initially at three times per week. Treatment was directed at the upper thoracic spine, and while Petitioner would complain of the low back from time to time, he advised Miller to leave that alone since it was involved in another workers' compensation case. Dr. Miller therefore didn't always document when Petitioner complained of the low back. Dr. Miller initially took Petitioner off work when another doctor's off work prescription expired. He released Petitioner to full duty as of 1/8/13, then changed this to 1/22/13, but on that date then took him off work until further notice, which status Dr. Miller testified continued throughout his care and treatment of Petitioner. Dr. Miller testified his treatments through 7/16/13 remained the same and would provide Petitioner with temporary relief, after which the pain would return. He was diagnosed at that time with chronic myofascitis and was improving slower than expected. In Dr. Miller's opinion, Petitioner's condition remained related to the accident. (Px9).

Dr. Miller opined that 10/17/13 thoracic MRI findings of disc bulges at T2/3 and T8/9 could have been caused by Petitioner's fall on the drill. Schmorl's nodes found at multiple thoracic levels, worst at T11/12, are usually caused by axial pressure and can be an incidental finding or can be problematic. At the last visit of 10/14/14, Petitioner complained of moderate to severe left shoulder blade pain at a 9 out of 10 level. Petitioner "just wasn't improving" and his diagnosis remained chronic myofascitis. Dr. Miller doubted Petitioner was going to get much better. While he testified there wasn't anything more he could do for Petitioner, he opined Petitioner had not reached MMI: "He'll need some future care from somebody, either going and getting trigger point injections, you know, find another doc that may have a different protocol for him. I don't know." (Px9).

On cross exam (Joiner), Dr. Miller agreed that his exam findings all have a subjective component to them. He had no knowledge of Petitioner's 2010 work accident or if it involved the thoracic or cervical spine, what treatment he may have had, what diagnostic testing may have been done or if he had been under any work restrictions prior to 7/9/12. He agreed the Petitioner denied having any similar prior symptoms and denied prior injury to the cervical and thoracic spine, indicating his prior complaints only involved the low back. Dr. Miller agreed that if he did have such prior thoracic injuries and treatment or had been on work restrictions, it could impact his opinions. Dr. Miller agreed his records don't indicate complaints of pain radiating into the legs. He also agreed he did not review Petitioner's prior medical records. Despite over 100 treatments, Dr. Miller did not

dispute that he ultimately did not have any lasting improvement, and that despite this his treatment plan never changed. While he did not refer Petitioner to an orthopedic surgeon, he testified Petitioner indicated his bills weren't being paid and he didn't want to get stuck with an orthopedic bill. Dr. Miller agreed Petitioner reported he started working for Clifford Howell Construction following the July 2012 accident, but didn't know whether he worked at any point between 9/25/12 and 10/14/14 while he had restricted him from working. He agreed that if Petitioner had been working, such continuing work could have continued to impact his condition. He never advised Petitioner to wear a brace. (Px9).

Neurosurgeon Dr. Teal testified on 11/30/15, indicating he saw Petitioner on referral from Dr. Ghalambor. Petitioner reported a jarring sensation in his back on 10/13/10 which caused lumbar pain. He noted Petitioner reported being put on an ongoing 30-pound restriction and having undergone injection with medication, but that he was not able to get physical therapy. He was laid off in November 2010, started working for a different company in December 2011, then worked intermittently until April 2012. He worked IDOT maintenance for two weeks in June 2012, until he was asked to lift over 30 pounds. He returned to work performing roofing in July 2012, loosening screws on panels, and on 7/9/12 he slipped and fell on his back on a roof, landing on a drill and hitting his neck and back on a roof seam. He reported having some back, neck and leg pain since that time with occasional numbness in his legs. When Dr. Teal saw him, Petitioner reported episodic numbness in his hands, wrists and left thigh, as well as popping in his neck since that fall. He then went back to work with a company building apartments, doing some siding work, and he was treating with local medications. He had some chiropractic treatment, and injections with Dr. Ghalambor in 2013, but this didn't relieve his pain. He had continued left neck, central back and lower back pain. He did not have arm or leg pain, just the numbness. He indicated he did not have leg pain or neck popping before the 7/9/12 incident. (Px12).

Dr. Teal's neurologic exam was normal with regard to sensory and motor components, but he had an antalgic gait and heel to toe testing suggested possible leg weakness. 2013 thoracic MRI showed diffuse degenerative changes that would be expected at Petitioner's age. He found the T11/12 disc bulge to be mild and not significant. 2013 and 2015 lumbar MRI both showed degenerative changes from L2 to L5, which again would be expected, and minimal stenosis. There were no significant herniations. Petitioner's symptoms were consistent with the findings. Dr. Teal diagnosed cervicalgia, lumbago and thoracic spine pain. Petitioner's history was "worrisome for some sort of a chronic sprain or strain in his back and neck area related to his prior traumas." His impression from the October 2010 accident was a back strain with persistent low back pain despite light duty and injections, and from the July 2012 accident an aggravation of the back and a new neck strain and popping and numbness in his hands and wrists at night. Most preexisting degenerative conditions like Petitioner's are asymptomatic, but a trauma can cause it to become painful, and if it doesn't respond to physical therapy and injections after six weeks, it can become a chronic pain syndrome. Dr. Teal recommended a period of physical therapy (conditioning and core strengthening) and possible cervical or thoracic injections (pain reduction), as lumbar injections hadn't really helped him. Dr. Teal testified it's "a little hard to say" whether such treatment would be causally related to Petitioner's work accidents. However, he questioned whether Petitioner had the therapy he needed following the 2010 accident, so it can be argued he still should have it. (Px12).

Dr. Teal believed the low back and leg symptoms track to the 2010 accident, while the neck and thoracic pain was aggravated in the 2012 accident given he had a different area of problems. Dr. Teal recommended a permanent 30-pound restriction in order for Petitioner to avoid further aggravations, and doubted he'd be able to do a job with any significant bending, twisting or climbing involved. He wanted to review a cervical MRI and an EMG test of the upper extremities before coming to any final determinations. Dr. Teal did not believe the Petitioner was a surgical candidate. He testified that a delay in treatment could prolong recovery. To determine MMI, he believed Petitioner would need to manage his pain at a 5/10 level or less and exhaust therapy and

injections, if he hadn't already. Petitioner's condition had reached a chronic state and his only recommendation was involvement in pain management and avoiding aggravating activities at work. (Px12).

On cross examination (Solid Platforms), Dr. Teal testified he had not reviewed any of the Petitioner's prior medical records and had no knowledge of how long he treated with Dr. Miller or what that treatment entailed. Petitioner reported he had ongoing back pain after the 2010 injury which continued to limit him leading up to the 2012 accident. Dr. Teal was not certain what activities Petitioner performed at work between 2010 and 2012, or for how long he worked at each job he had. Petitioner didn't discuss any work activities subsequent to the 2012 injury other than building apartments. Questioned by counsel for Respondent Joiner, Dr. Teal testified he did not review Petitioner's 2011 MRI, but that he wouldn't be surprised if the films were similar to 2013 films, and this would not change his opinions. Petitioner did indicate he worked in jobs after the 2010 accident which could have involved activities that could trigger symptoms in someone with degenerative disc disease. Dr. Teal was not aware that the Petitioner complained of mid-back pain after the 2010 accident, and while this could impact his causation opinions, he can't say whether it would or not without knowing how the mid-back condition progressed between 2010 and 2012, and how similar the pre and post 2012 accident symptoms were. He agreed that a T11/12 epidural would indicate Petitioner was having serious thoracic pain issues. As to causation, again, how it would impact his opinions would depend on whether Petitioner improved and how much prior to 2012 accident. He couldn't say Petitioner denied having thoracic pain in 2010, but Teal's sense from their discussion was that the 7/12 incident brought more focal pain on to the thoracic and cervical areas. He agreed the 2012 accident could potentially have been a temporary aggravation of these areas. He had the same opinion when questioned about the initial post-2012 accident ER report noting primarily back pain with some neck pain, and then on his 11/20/12 return there were no neck complaints. As to any gap in neck complaints, Dr. Teal testified he would consider six months after an accident without further complaints to lead to a conclusion that there is no causal connection. Symptoms from a degenerative spine condition can wax and wane, but statistically most times there is a waxing is where there was a triggering activity of some kind. He agreed that Petitioner was performing work after the 2012 injury, and that his belief is Petitioner had learned how to avoid serious aggravations and would self-treat at home. Petitioner also reported he didn't work at all from 9/12 to 6/14. If Petitioner has the recommended therapy and does not improve, Dr. Teal would first try injections before determining if Petitioner has reached MMI. If that occurs, he would likely find him at MMI. Dr. Teal again agreed that he has not reviewed Petitioner's prior medical records, and thus has relied to a great extent on Petitioner's subjective statements and complaints. However, if Petitioner did not have the recommended treatment, he doubts his opinions would change. (Px12).

Petitioner saw orthopedic surgeon Dr. Lange at the request of Respondent Solid Platforms on 9/30/14, and he testified via deposition on 3/12/15. Following his review of Petitioner's medical records and his examination, he opined that Petitioner had a probable T11/12 disc herniation injury related to the 10/13/10 accident. He did appear to have a more tentative diagnosis of a new T2/3 herniation subsequent to 7/9/12. The T11/12 injury appeared to correlate with Petitioner's left sided symptoms, related to both low back pain early on and then in a somewhat belated fashion into the left leg after the 2010 incident. He testified it was difficult to say exactly when he reached MMI as to that 2010 injury, but Petitioner didn't seem to improve much with conservative treatment and it "was not unreasonable to think that he would have reached a treatment plateau at some point along the line." Dr. Lange testified it would be somewhat artificial to make a determination of restrictions, noting the records indicate he was released with a 30-pound restriction, and he saw no evidence this had changed in the medical records. He could not get a good answer from Petitioner as to how much he worked between the 2010 and 2012 injuries other than that it was about 5 months, but Dr. Lange testified he "couldn't get a feel for" whether this work was sporadic or consecutive. Dr. Lange testified it was also hard to say if Petitioner suffered any permanent disability resulting from the 10/13/10 accident, but it wouldn't appear there was any significant permanency if he was able to work his normal full duty job, and by 2012 he did not appear

to have ongoing lumbar or lower extremity symptoms." Based on this, he opined that Petitioner did not have any ongoing permanency related to the 10/13/10 accident. (RxD).

On cross examination (Petitioner), Dr. Lange reiterated his opinion that the T11/12 disc was caused by the 2010 accident, and any treatment associated with that was reasonable. Petitioner not receiving therapy or possible facet blocks would not have made him worse, but it also would not make him better. Petitioner reported developing numbness into the left leg and foot in July 2011. Dr. Lange believed the 2012 accident, described as his feet slipping out from under him and landing on a drill, involved a more significant trauma than the 2010 injury. Petitioner did have a mildly positive Waddell sign for give way in the left extremities, "but it wasn't particularly remarkable." While the 2011 thoracic MRI showed multi-level disc abnormalities, the T11/12 level seemed most relevant to Petitioner's left-sided complaints. The 2011 lumbar MRI showed some mild congenital canal stenosis and multi-level degenerative changes from L2 to L5, and the L2/3 herniation was on the opposite side from Petitioner's left leg symptoms. The findings at T12/L1 could correlate to Petitioner's symptoms. The 2013 thoracic films appeared similar to 2011, with the T3/4 right herniation actually appearing a little smaller, with a newer T2/3 herniation to the left. While he T2/3 disc could have been related to the 7/9/12 accident, he testified there was no way to say for sure. The 2013 lumbar MRI showed no significant change versus 2011. Dr. Lange testified that it was possible the left T2/3 herniation could be related to the 7/9/12 accident. Dr. Lange testified that an increase in left sided symptoms, including in the leg, could be consistent with such a left herniation. Dr. Lange also opined the T12/L1 area was aggravated by the 10/13/10 accident, and that at least some of the left thoracolumbar to lumbosacral paraspinal symptoms were related to the 10/13/10 accident as of 9/30/14. He couldn't say for sure whether the 30-pound restriction would be reasonable at the present time since he hasn't seen Petitioner recently, but he testified it was reasonable during Dr. Gabriel's treatment. It was reasonable at the time of Lange's 9/14 exam, but he noted that was before he had reviewed the records of Dr. Miller. It appeared Petitioner developed hand and bilateral lower extremity complaints, left greater than right, at the time of the 7/9/12 accident – again, this was based on the information Dr. Lange had available on 9/30/14. Dr. Lange opined Petitioner probably reached MMI given he treated for three years after the accident with no surgery recommended, so one would figure he reached a treatment plateau and did not need further treatment. Petitioner's "perception" of his condition was permanent at that point. Dr. Lange testified that surgery is not indicated for thoracic/thoracolumbar disc lesions in the absence of myelopathy. Some people improve without further treatment, others don't. (RxD).

Cross-examined by counsel for Joiner, Dr. Lange testified that a thoracic herniation could cause symptoms lower down on the body, but that such lesions "can be difficult to sort out" in terms of what it may be causing. A disc at that level would not cause cervical or upper extremity symptoms. Based on what Petitioner told him, the 2012 accident was more traumatic than the 2010 accident. He agreed the initial ER report after the 2012 accident did not reflect any low back or upper or lower extremity complaints. Petitioner did report having persistent thoracic and lumbar pain after the 2010 accident, and that the leg symptoms started in July 2011, which was consistent with the medical records. Dr. Lange testified that his subsequent review of Dr. Miller's records starting in September 2012 noted a diagnosis of thoracic sprain/strain and no cervical or lumbar diagnoses. No back, neck or lower extremity complaints were noted, nor were any ulnar complaints. On redirect, Dr. Lange testified that based on Dr. Miller's records noting no low back or leg complaints there would be no reason for any work restrictions. (RxD).

Orthopedic surgeon Dr. Mirkin testified on 12/11/15. When he examined Petitioner on 9/29/14 at the request of Respondent Joiner, he complained of thoracic pain and lumbar pain into his left leg. He reported both the 10/13/10 and 7/9/12 accidents, indicating he had thoracic and lumbar pain after the initial incident, did not have recommended therapy and remained on a 30-pound weight restriction through the time of the 7/9/12 incident. Dr. Mirkin's impression, however, was that Petitioner had been working beyond such restrictions at that time.

Dr. Mirkin's review of Petitioner's 2013 MRIs indicated diffuse degenerative thoracic and lumbar bulging discs, which he noted could cause symptoms but that the findings would have to be correlated with the complaints. He did not see any significant differences between Petitioner's 2011 and 2013 MRIs. Following exam and review of Petitioner's medical records, Dr. Mirkin diagnosed thoracic and lumbar degenerative disc disease, relatively mild and common for his age. Symptoms had been intermittently present for a long time. Despite being given restrictions after the first accident, Petitioner "apparently" had returned to full duty. Dr. Mirkin didn't believe Petitioner had any new pathology or significant long-standing disability resulting from the 7/9/12 accident. He testified that while it was possible it caused a transient aggravation of the preexisting condition at that time, his examination of Petitioner was essentially normal. Petitioner had lumbar and thoracic complaints prior to 7/9/12, and he didn't have any cervical complaints when he saw Dr. Mirkin, either verbally or via the pain diagram he completed. He opined Petitioner did not need any additional treatment or work restrictions related to the 7/9/12 accident, noting his work involving siding work after that incident would be consistent with his essentially normal examination. Petitioner was well-muscled despite the reported injuries. (Rx28).

On cross-exam (Petitioner), Dr. Mirkin testified he had no knowledge of the findings of the arbitrator in the prior workers' compensation hearing. He testified he had no idea if Petitioner's treatment after the 10/13/10 accident was reasonable, necessary and related to that accident. He agreed a trauma can cause an asymptomatic preexisting degenerative condition to become symptomatic. Such symptoms could be considered chronic if they last for six months to a year. While he agreed he saw no record evidencing that Dr. Gabriel discontinued his 30-pound restriction, Petitioner's performance of roofing work ("one of the hardest jobs you can do") proved such restriction was not necessary. He has seen patients work beyond restrictions both because they needed income and because they didn't have pain that required such restrictions. He didn't ask Petitioner if he was pain-free performing roofing. He had no knowledge if Dr. Miller had taken him off work completely. He agreed it is possible for a thoracic disc lesion to cause pain and/or numbness in the legs if its putting pressure on a nerve root. He did not agree with Dr. Lange that films showed a new T2/3 disc and testified that a large herniation at that level would cause symptoms ranging from pain along the course of a rib/chest area to paralysis from that level down. Pressure on the spinal cord at that level would cause myelopathy, which would include leg numbness and pain, and even paralysis. If it pressed on a right sided nerve, you would expect right sided symptoms. Petitioner's symptoms were left sided. Petitioner reported going from being able to work to not being able to work after 7/9/12. He did not find an indication of malingering or symptom magnification. Dr. Mirkin had no opinion as to permanency with regard to the 10/13/10 accident. As to MMI following the 7/9/12 accident, Dr. Mirkin opined he had reached it by the time of his examination but couldn't say when it might have occurred prior to his exam. (Rx28).

On further cross-examination (Solid Platforms), Dr. Mirkin testified there was no objective basis, per review of films, to restrict Petitioner's activities. The most significant MRI finding in Dr. Mirkin's opinion was right-sided (L2), and Petitioner's complaints were left-sided. Petitioner needed no further treatment. On redirect, Dr. Mirkin testified his opinion was Petitioner suffered a temporary strain aggravation of his preexisting condition on 7/9/12. He would have recommended therapy and anti-inflammatories at that time.

Respondent Joiner sought Petitioner's work records from the Petitioner's union, United Brotherhood of Carpenters Local #634. Carpenters' District Council of Greater St. Louis and Vicinity. The union responded on 11/18/13, indicating that the local union does not employ members, and does not maintain employment records, including salary or attendance records. (Rx7).

Respondent Joiner submitted records indicating that the Petitioner was paid from 7/10 through 7/14/12 and 7/16/12 to 7/17/12, 8 hours per day, "due to injured on job" and "being off injured." (Rx1). Further records note he was paid $1385.20 for that initial period, and $554.08 for the second. Additionally, he was paid an additional

$9696.40 from 11/25/12 through 1/5/13, working 40 hours per week from 11/25/12 to 12/22/12, and 32 hours per week from 12/23/12 through 1/5/13. Petitioner testified that his recall was that Respondent Joiner paid him wages up to the first week in January 2013. This documentation also notes various bills that were paid from Fairfield Memorial, Richland Radiology, Christopher Rural Health and Flora Chiropractic. Additionally, Petitioner was reimbursed $35.32 for medication. (Rx2).

Respondent Solid Platforms submitted records of Petitioner's reported employment through 3/8/16 via the St. Louis-Kansas City Carpenters Regional Counsel union. These records reflect the Petitioner worked as follows:

Danco Construction from December 2011 through April 2012 (580 hours)
Respondent Joiner in July 2012 (72 hours)
C. Howell Construction from July 2012 through October 2012 (268 hours from July to September, 3 hours in October)
Respondent Joiner from December 2012 through January 2013 (224 hours)
Shores Builders from June 2014 to August 2014 (298.5 hours)
Hoelscher Int. Inc. in August 2014 (32 hours)
Perry County Construction in September 2014 (58 hours)
J&L Acoustics in October 2014 (96 hours)
SA/NAT Ind. Construction in December 2014 (12 hours)
Perry County Construction in December 2014 and January 2015 (38 hours)
Jones-Blythe Construction in February and March 2015 (370 hours)
Berco Industrial in March 2015 (74 hours)
Sangamo Construction in May and June 2015 (138.5 hours)
E-T Simonds Construction in June and July 2015 (147 hours)
Bevis Construction in July and August 2015 (144.5 hours)
E-T Simonds Construction in September and October 2015 (200.5 hours)
Sangamo Construction in October 2015 (38 hours)
A&K Spec Cont. Inc. in December 2015 (88 hours)

Over this period of time, Petitioner worked 2,858 regular hours and 201.5 overtime hours. (Rx29). It should also be noted that the Petitioner testified he worked for IDOT for a short period of time, and that Dr. Miller noted this took place in June 2012 for approximately two weeks, with Petitioner reporting this ended when he was asked to lift over 30 pounds. (Px12).

Petitioner testified that, to his knowledge, there were no orthopedic physicians in his town, which is why he had to travel to see one. Dr. Gabriel worked out of the Bonutti Clinic in Effingham, IL until he moved to Ohio, and Petitioner believed he saw Dr. Gabriel there twice. He testified he may have seen Dr. Miller a few times since 2014 as well.

To Petitioner's recall, after the first two injections, Dr. Ghalambor did not want to do further injections due to a lack of improvement. Petitioner testified that Dr. Teal prescribed therapy and injection, but that this was not authorized by Respondent(s). Petitioner testified he saw Dr. Teal again in 2017 and was referred to Dr. Ogan for pain management. He testified that at the time of the bilateral L5 injections on 3/14/17, Dr. Ogan also recommended physical therapy. Petitioner testified that Dr. Teal also prescribed MRI's, and while they weren't authorized, he did undergo cervical, thoracic and lumbar MRIs in 2017. Th reports from these tests were not noted in the evidentiary record.

Petitioner testified that he would still be undergoing treatment if he could get it authorized. He feels like he has an ice pick stuck in his upper and lower back. He testified that he still has a knotted area around T5 to T7 and the left shoulder blade where he landed on the drill. Petitioner testified he is ready, willing and able to get the treatment recommended by Dr. Teal.

Petitioner testified that he was unemployed at the time of hearing. He created the documentation contained in Px15, reflecting the dates he alleges he was off work, as well as the time periods when he said he was forced back to work in order to pay his bills and to feed himself and his animals. It also includes his request for mileage expenses for medical visits.

Petitioner was initially cross-examined by counsel for Solid Platforms. He testified that Dr. Miller is located in Fairfield, IL, about 25 miles from Petitioner's home, though he would also see Miller in Flora, IL, where he utilized an office with another chiropractor, and this was about a mile from Petitioner's home. He didn't recall how often he would see Miller but treated with him for approximately a year and a half. The treatment included electrical stimulation and chiropractic adjustment on the left upper back knot. He testified he wouldn't let Dr. Miller touch his low back because he had a pinched nerve with numbness and didn't want it to get worse but also said he sometimes allowed him to use electrical stimulation on the lumbar spine for pain relief, which Petitioner related to the 2010 accident. He indicated Dr. Miller mainly treated him for his 2012 injuries. He noted he did have some upper back problems from the 2010 accident around the T9 to T12 levels.

Petitioner testified that Respondent Joiner sent him to Fairfield Memorial Hospital on 7/9/12, and they advised him to follow up with primary care, i.e. NP Siemer. He testified that he believed NP Siemer referred him to Dr. Gabriel ("because she's the one that recommended him") and to Dr. Miller. He testified that Dr. Gabriel referred him to Dr. Ghalambor and to St. Anthony's Hospital for MRIs, and that Dr. Ghalambor referred him to Dr. Teal.

Petitioner agreed with the report from his union regarding the time periods and hours worked for various employers per RxB and Rx29. As to the hours, he testified that he did not always work full time during these periods, and that he wouldn't say this was normal, but was due to a lack of work for someone who is injured, noting he had been working 7 days a week for Solid Platforms at the time he was injured. Thus, he agreed he is requesting TTD, per Px15, for every day he did not work. He testified he was laid off by Danco Construction because the part he was able to do within his restrictions had ended. Petitioner testified he had no choice but to visit Dr. Gabriel in Ohio because he was his treating doctor.

Further cross-examination by Respondent Joiner notes Petitioner agreed he suffered thoracic and lumbar injuries on 10/13/10, but he testified he did not have consistent treatment after this injury because treatment had been denied. He testified that when he slipped and fell in July 2012 it did make noise, and that Scott Engelmann "saw the whole thing." He testified that Engelmann wouldn't let him go to the doctor and begged him to stay and finish the day. He denied being asked if he wanted treatment and declining it. He did finish the day, testifying he then went to Fairfield because the company "insisted that I go." He had thoracic and neck pain at an 8/10 level, was off work for a week, and then after being paid for a period of time by Joiner, went to work for another company (C. Howell) until September 2012 because "I didn't have no choice." After seeing NP Siemer on 7/11/12, Petitioner agreed he was diagnosed with a strain and testified that he may have seen her again once or twice, but he had no other treatment until seeing Dr. Miller on 9/25/12 other than self-treatment with heat and ice.

With C. Howell Construction, Petitioner testified he "wasn't working outside of my restrictions. It's ultimately left to me to work within my restrictions on any job. . . The people I was directly working with knew because if I needed help with something, I got help with something." His understanding of his restrictions was a 30-pound

weight limit, and he agreed this went back to his 2010 injury. As to whether Respondent Joiner was aware of his restrictions, Petitioner testified he did not notify John Joiner about restrictions, "but some of the people I was working with knew." He testified he was only using an impact or a drill with Joiner and did not work outside of his restrictions. When his C. Howell job ended in September, Petitioner testified he contacted John Joiner looking to get his job back. He denied that Joiner offered him light duty work a week after the July 2012 accident and that he declined. He believed Joiner told him in September 2012 that he didn't have any work available within a reasonable distance for Petitioner to drive. He agreed he sought treatment with Dr. Miller within a few weeks of that conversation, testifying that Joiner agreed to it. Petitioner denied telling Dr. Miller that he had been pain-free prior to the 7/9/12 accident and testified he told Miller about the 2010 accident. Petitioner agreed he saw Dr. Miller over 100 times between September 2012 and October 2014 and received the sane treatment for the same pain throughout, but only had temporary relief. While he agreed he had thoracic injuries in both accidents, he testified that they were to different areas of the thoracic spine. He denied that he had no neck complaints after 7/11/12.

Petitioner testified he was next taken off work following the July 2012 accident, other than the initial week off, when Dr. Miller took him off work on 9/25/12. While he agreed Dr. Miller initially took him off work for a week or two at a time, at some point he took him off work indefinitely. He agreed he nevertheless returned to work because he couldn't pay his bills. He agreed he subsequently worked for many different employers, but that he self-limited himself to his restrictions, and he did not notify the employers such that he received light duty jobs. While he noted he was completely off work per Miller for these jobs, he was limiting himself to the 30-pound restriction. He agreed the restriction didn't prevent him from going back to work but limited him in what he could do. He agreed he was off work in September and October 2012 for 3 weeks for an unrelated hernia repair. Currently, he relates neck pain and upper back pain top the 2012 accident.

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 initially notes that the issues of accident and causation were not indicated to be issues in dispute at the prior Section 19(b)/8(a) hearing held regarding this matter, as the parties stipulated to these issues. As a result, once the Arbitrator in that case found in favor of the Illinois jurisdiction, the Arbitrator determined that a compensable accident occurred on 10/13/10 and that the Petitioner's condition was causally related to this accident. In his decision following that prior hearing, the Arbitrator determined that Dr. Gabriel had diagnosed a thoracolumbar sprain/strain; thoracic disc protrusions at T1/2, T2/3, T8/9 and T11/12; spinal stenosis at T11/12 from a disc-osteophyte complex; and, degenerative changes including Schmorl's nodes throughout the lumbar spine. The Arbitrator stated: "Dr. Gabriel testified within a reasonable degree of medical certainty that the T8/9 and T11/12 conditions were related to the accident of 10/13/10. Dr. Gabriel's treatment plan consisted to epidural injections, physical therapy, medication, bracing and possibly facet blocks." The Arbitrator ordered the Respondent to pay for all of the medical expenses submitted into evidence and to pay for "all medical treatment as prescribed by Dr. Gabriel. Respondent is also ordered to pay for all related medical treatment as prescribed by Petitioner's pain management physician." TTD was also awarded through the 8/4/11 hearing date.

The Arbitrator in this case notes that, based on this language, it appears that the only conditions that were found to be causally related to the 10/13/10 accident in the prior decision are the conditions that existed at T8/9 and T11/12. This is consistent with Dr. Gabriel's testimony on 5/13/11. While the prior Arbitrator references

degenerative finding in the lumbar spine, he only references Dr. Gabriel's opinion that the thoracic levels were causally related to the accident.

Based on this, the Arbitrator concludes that the Arbitrator in the prior decision did not specifically determine whether any lumbar spine condition was causally related to the accident or not. In this regard, the Arbitrator notes that the Petitioner made no complaints of symptoms radiating into the left leg to Dr. Gabriel until his 12/2/11 visit. Dr. Ghalambor did have a 3/31/11 note indicating Petitioner did report tingling in the left leg "only one time" and did not reference when this single incident occurred. Regardless, both of these reports occurred significantly after the 10/13/10 accident date. There were no prior reports of radicular-type symptoms in the records that the Arbitrator was able to locate.

The question now becomes whether the T8/9 and T11/12 conditions remain causally related to the 10/13/10 accident, or if causation ended prior to the current hearing, either based on the Petitioner having reached MMI or due to the subsequent 7/12 accident having been an intervening accident terminating the causal relationship. Additionally, there remains an issue as to whether any specific lumbar condition is causally related to the 10/13/10 accident.

It appears that because the prior hearing was appealed to the Commission on a jurisdictional basis, no further treatment was authorized by Respondent after the 8/4/11 hearing prior to the Commission issuing its decision on review on 5/7/12. The records of Petitioner's employment submitted in this case reflect that he worked for Danco Construction for 580 hours from December 2011 through April 2012. On average, that is 116 hours per month.

It was not made clear in this case why the Petitioner did not obtain further treatment in this matter following the 8/4/11 hearing, or if he had any access to treatment via any type of coverage in that time. The Petitioner's testimony is that he had no access to treatment. However, he was able to see Dr. Gabriel and Dr. Ghalambor after the occupational health facility indicated that the Respondent insurer was not covering any further visits. The Petitioner also treated with chiropractor Dr. Miller for approximately two years between September 2012 and October 2014, following the second accident, with no evidence of authorization from either Respondent. Additionally, it appears that he treated for an unrelated hernia in September 2012. There was no testimony regarding whether the hernia involved workers' compensation or whether the Petitioner had some type of group health coverage that the hernia treatment was submitted to. This makes the Petitioner's explanation that he was not allowed to treat further difficult to analyze in terms of its accuracy.

This evidence also makes this case extremely difficult to analyze in terms of ongoing causation. While the prior Arbitration decision is clear, Petitioner underwent no further treatment for his T8/9 and T11/12 areas from the prior hearing date through the 7/9/12 accident while working for Respondent Joiner. During that time, he worked a significant number of hours in a construction job between December 2011 and April 2012.

The Petitioner testified that he returned to work because he needed to have income. This makes sense to the Arbitrator under the circumstances of this case. At the same time, he was able to return to work in what would appear to be a significantly heavy-type job for a construction company and did so consistently for five months. He then went to work for Respondent Joiner in July 2012, performing roofing work, at which time he sustained a subsequent accident. At that point the Petitioner had not undergone any formal treatment for over a year. The decision of the Commission had been rendered in May 2012, and there is no real explanation of why the Petitioner did not obtain treatment between May and July 2012.

Numerous doctors were deposed in this case and provided their opinions on causation. Pain management physician Dr. Ghalambor testified that Petitioner's pain when he saw him in 2011 was in the mid to low thoracic and lumbar regions and did not radiate to the legs, and opined that Petitioner's pain was primarily related to the T11/12 level. He testified Petitioner appeared to be "more frustrated than being in pain." He testified it wasn't possible to say whether Petitioner's condition was related to the work accident, but that since his symptoms started with the 10/13/10 accident, the symptoms were a result of that accident. After he provided the 4/29/11 epidural to Petitioner, he didn't see him again until 2014, after the July 2012 accident. Dr. Ghalambor testified that Petitioner reported his left leg symptoms didn't begin until after the latter accident, but he noted he hadn't reviewed all of Petitioner's medical records, and the Arbitrator notes this would be inconsistent with his 12/2/11 visit with Dr. Gabriel where he reported symptoms radiating into the left leg. Dr. Ghalambor noted that while Petitioner told him (in 2014) that the 2011 epidural had been "somewhat" helpful to his mid-back, he noted Petitioner told Dr. Teal that the epidural did not help at all. Petitioner indicated he was not interested in surgery. He noted Petitioner did not report a worsening of his mid to low back pain with the July 2012 accident, and that EMG testing of the lower extremities was normal. He opined that MRI in 2013 showed a worsening versus 2011 but couldn't say if he reviewed the actual films or just the radiology reports. He acknowledged the radiologist (Dr. Patel) did not see any significant interval change. On cross exam, Dr. Ghalambor acknowledged that given Petitioner did not report mid-back pain on 1/27/14 but did to his assistant on 2/21/14, this showed Petitioner's pain was changing depending on the day. Dr. Ghalambor also testified that there was nothing indicating a "red flag" in MRI films such as any large herniation or any significant stenosis. He did state that the negative lower extremity EMG findings doesn't rule out a mild case of sciatica, but that the majority of such mild sciatica would be reversible.

Chiropractor Dr. Miller testified initially that he first saw Petitioner on 9/25/12, but also noted "he's known me from my previous employment in Flora." This would indicate to the Arbitrator that the Petitioner may have treated with Dr. Miller prior to 9/25/12, however no records of any such treatment were submitted into evidence. He testified that he had no knowledge of Petitioner's 10/13/10 work accident, and as such he had no causation opinions relative to that accident. He acknowledged that Petitioner told him not to touch his low back because it was related to a separate work accident, but Petitioner also testified that Dr. Miller did perform electrical stimulation on his low back at times at Petitioner's request for pain relief. Dr. Miller did not have any knowledge of what treatment or diagnostic testing he may have undergone or if he had been under prior work restrictions prior to 7/9/12. He also testified that Petitioner denied having any similar prior injuries and denied prior injury to the cervical and thoracic spine.

Neurosurgeon Dr. Teal first saw the Petitioner approximately five years post-accident. Petitioner told him the accident of 10/13/10 jarred his low back. Neurologic exam was normal except for possible left leg weakness. He felt the T11/12 disc was mild and not significant, and that Petitioner's MRI degenerative findings were expected for his age, noting minimal lumbar stenosis. His opinion was that the 10/13/10 accident caused a back strain with persistent low back pain. He did recommend the physical therapy and possible thoracic and cervical injections, noting lumbar injection did not help Petitioner, but also testified it would be "a little hard to say" this treatment would be related to the 10/13/10 accident. While he believed that Petitioner's low back and leg complaints tracked back to the 10/13/10 accident, he acknowledged he did not review Petitioner's medical records from prior to his visit and was not aware of what type of activities the Petitioner may have performed at work in 2011 and 2012, but agreed the types of jobs could potentially have involved activities that were capable of aggravating a degenerative spine condition. He was not aware Petitioner complained of mid-back pain in 2010, and while he could not say the Petitioner denied having such pain, his sense from talking to Petitioner was that the July 2012 accident resulted in more focal thoracic and cervical pain.

Respondent Solid Platforms' examining physician, Dr. Lange, opined that Petitioner likely developed a T11/12 disc at the time of the 10/13/10 accident, and that the T12/L1 area may have been aggravated by the accident. The T11/12 injury appeared to him to correlate with the low back symptoms and then, in "somewhat belated fashion", the symptoms into the left leg in July 2011, as it was left-sided. He could not say when Petitioner exactly had reached MMI relative to the 2010 accident, but that it was not unreasonable to think he likely had reached it with a plateau in improvement. He also noted Petitioner had undergone several years of treatment by the time he saw him and probably would have reached MMI at some point prior to seeing him. While he said he couldn't get precise answers from Petitioner as to his post-10/13/10 jobs, he didn't think Petitioner had any significant permanency from the 10/13/10 accident, given he had no indication of ongoing low back or leg complaints when he saw him on 9/30/14, and he had essentially been able to work his full duty job for some period after the accident. On cross exam, he noted MRI findings of an L2/3 herniation was to the right, which did not correlate with his left-sided symptoms. While he could not say if the 30-pound restriction was reasonable at the time he saw him in September 2014, he testified that such restriction was reasonable during the time Dr. Gabriel had treated him.

Respondent Joiner's examining physician, Dr. Mirkin, opined that Petitioner reported thoracic and lumbar pain after the 10/13/10 accident, did not have recommended therapy and remained on a 30-pound weight limit leading into the July 2012 accident. He diagnosed thoracic and lumbar degenerative disc disease that was mild and relatively common for Petitioner's age. He also believed that Petitioner's work after 10/13/10 exceeded the restrictions he indicated he was working under, including his roofing work with Joiner. He agreed that a thoracic disc lesion could cause symptoms in the legs if there was pressure on a nerve root. He, like Dr. Lange, noted the L2/3 disc was the main other point of significance he found, and that this right sided disc would not be related to left sided symptoms.

Obviously, there are a significant number of pieces of evidence and opinions in this case that are relevant to the issues of causation, and there are some discrepancies and/or inconsistencies among them. Overall, taking the prior decision and the current evidence as a whole, the Arbitrator finds that the greater weight of the evidence supports the finding that the Petitioner's T8/9, T11/12 and T12/L1 spine levels are causally related to the 10/13/10 accident. Initial conservative treatment was not provided, as the case was disputed. This lack of treatment appears to the Arbitrator to have resulted in a chronic condition of back pain related to these levels.

At the same time, the Arbitrator believes that the Petitioner reached maximum medical improvement relative to these levels as of December 2011. At that point, the Petitioner had not undergone any significant treatment since 5/4/11, or at least no medical documentation was submitted evidencing any such treatment. The Petitioner then worked and continued to work from December 2011 through April 2012 in what certainly appears to have been a significantly heavy job. He then worked in June and July 2012, sustaining a new accidental injury on 7/9/12 while working for roofing company Respondent Joiner. The Arbitrator did find the Petitioner generally to be credible in his testimony, though not always accurate, which is understandable to some extent given the passage of time in this case. That said, while he testified that he was able to stick to his restrictions in performing such work, this is very difficult to believe, particularly given the assortment of employers he has had since December 2011. While it is certainly possible that the Petitioner was able to avoid some of the harder aspects of construction work, the 30-pound limit was only one part of the restrictions noted by Dr. Gabriel. He also advised Petitioner not to reach below the waist. There is no possible way the Arbitrator can see how this could have occurred at a minimum on the job with Respondent Joiner where he was performing roofing. The Arbitrator cannot see how the Joiner job would not have involved climbing, lifting, bending and twisting in order to get onto the roof and then to replace large 20' metal roofing panels, including screwing and unscrewing them in and out. It is laudable that the Petitioner likely performed this work with a level of pain in order to make sure he had income. However, there has been no doctor who has indicated to date that the Petitioner has a

surgical problem, despite his pain complaints. While he did not undergo the recommended physical therapy, he did undergo an epidural which does not appear to have helped. It is also true to say that he has not had any of the possible facet blocks that Dr. Gabriel had recommended. We are now however almost seven years past the date of accident in this case at the time of hearing, and the idea that this treatment would still be recommended, as indicated by Dr. Teal, despite all that has passed in the meantime makes no sense to the Arbitrator as remaining causally related. Dr. Teal himself testified that it was difficult to say that any current treatment would be related to the 10/13/10 accident.

As noted, however, this lack of treatment does appear to have resulted in a chronic condition to the Petitioner at the noted levels. The Arbitrator's view is the causal relationship occurred as an aggravation of a preexisting degenerative condition at the noted levels, with possible increases in the size or degree of disc protrusions at those levels. However, as noted by Dr. Ghalambor and the lack of any surgical recommendations, there do not appear to have been any severe abnormalities created by the 10/13/10 accident.

With regard to the Petitioner's lower extremity radicular complaints, there is no evidence that the Petitioner had any such complaints prior to 12/2/11. There is a statement of Dr. Ghalambor on 3/31/11 that while Petitioner had no radiation of pain to the legs, Petitioner referenced a single instance of some tingling in his left leg, with no further specificity. This was already five plus months post-accident. The 12/2/11 reference of Dr. Gabriel is taken from a medical statement form completed for Petitioner's union. It does not state when the leg symptoms began, and the Arbitrator notes that no prior reports of Dr. Gabriel reference such complaints. This same form notes the doctor was waiting for surgical authorization, when there was no medical report prior to that which the Arbitrator located in evidence indicating a surgical recommendation. His subsequent records do not indicate such recommendation either. The Arbitrator further notes that Petitioner on 5/14/13 told Dr. Gabriel and on 1/27/14 told Dr. Ghalambor that his left leg numbness began in July/August 2011. Again, this is almost a year post-accident. The greater weight of the evidence does not support a causal relationship of any lower extremity symptoms to the 10/13/10 accident.

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

The Arbitrator, pursuant to the prior hearing, ordered the Respondent to pay for all of the medical expenses submitted into evidence and to pay for "all medical treatment as prescribed by Dr. Gabriel. Respondent is also ordered to pay for all related medical treatment as prescribed by Petitioner's pain management physician."

While the language of the prior Arbitrator is clear, it also cannot be presumed that the Arbitrator's award was meant to continue into perpetuity, i.e. that any treatment recommendations of Dr. Gabriel and Dr. Ghalambor were to be followed forever. At the time of the prior hearing, Dr. Gabriel's deposition had been obtained, and he testified that it was his opinion that the main cause of Petitioner's symptoms were the two noted thoracic discs, in combination with preexisting degenerative changes, and that conservative treatment was recommended. He testified that Petitioner was not a surgical candidate. The conservative treatment he recommended was therapy and facet blocks, as he indicated Petitioner did not receive benefit with the epidural he received or the use of a corset.

In this case, the Arbitrator notes that, prior to the 7/9/12 accident, the Petitioner last received treatment, per the records submitted into evidence, on 5/4/11 with Dr. Gabriel. While the doctor issued a 12/2/11 medical statement for Petitioner, which noted symptoms in the legs and that he was awaiting authorization for surgery,

neither his testimony on 5/13/11 nor any other records in evidence support that Petitioner was seen after 5/4/11 or indicate what surgery he may have been recommending.

The Arbitrator finds that the treatment of Dr. Gabriel and Dr. Ghalambor through the 5/13/11 visit was causally related to the 10/13/10 accident. This would include any related diagnostic testing, including MRI testing. The Respondent is liable for this treatment. The Arbitrator finds that any subsequent treatment would not be related to the accident based on the finding Petitioner had reached MMI as of December 2011, as the records do not reflect any additional treatment until after that date.

The awarded medical would include treatment prior to 12/1/11 provided by Dr. Gabriel, Gibson General Hospital, Clay Medical Center, St. Anthony's Hospital and Dr. Ghalambor. (see Px16).

The Respondent is entitled to credit for any of the awarded medical expenses that were paid prior to hearing pursuant to Sections 8(a) and 8.2 of the Act and shall hold the Petitioner harmless with regard to any credited expenses pursuant to Section 8(j) of the Act.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

With regard to TTD, as noted, the Petitioner was previously awarded TTD through 8/4/11. The Arbitrator finds that the Petitioner is entitled to further TTD from 8/5/11 through 11/30/11.

As noted above, the Petitioner clearly worked a significant number of hours from December 2011 through April 2012. According to Px15, the Petitioner alleges he is entitled to TTD for any days he did not work during these dates, as well as the entire month or May and a portion of June 2012. The Arbitrator finds that the Petitioner has failed to prove entitlement to TTD during these periods.

Ultimately, the Petitioner cannot have it both ways. While the Arbitrator is sympathetic to the fact that the Petitioner did not receive treatment that had initially been recommended for him following the 10/13/10 accident in the form of therapy, the fact of the matter is he has already been awarded over a year of TTD following this accident. Starting in December 2011, the Petitioner was essentially performing full duty work. He testified that he was able to perform construction work within a 30-pound restriction. In the Arbitrator's view, either this is incorrect and there were times he worked in excess of that restriction, or there are a significant number of full duty jobs available to him in the construction industry that he has been able to obtain, and which do not require him to exceed this restriction. There is simply no sufficient evidence that has been presented that would support that the Petitioner worked less than forty hours per week for Danco Construction, for example, which indicate that the reason he did not work 40 hours per week was his restrictions as opposed to the availability of work in the industry he was working in at the time of the accident and which he worked in for Danco. Instead, it would appear more likely than not that any lack of full-time work during that time period was due to a lack of work. It is hard to believe the Petitioner would continue getting hired out of the union with restrictions. His own testimony is that he would not report his restrictions to the employers, but that he would self-restrict himself to no more than 30 pounds. Again, it is hard to see how this would always be possible with construction companies when the company was not working with the Petitioner's restrictions. The Arbitrator would note that the fact Petitioner continued to work for this significant period of time leads to the question of whether he claimed or obtained unemployment during any days he did not work from December 2011 to July 2012. Evidence is lacking in this regard. It would be unclear to the Arbitrator why the Petitioner would not have claimed unemployment given the number of hours he was able to work in this time period, as well as after 2013.

Overall, the greater weight of the evidence indicates the Petitioner was able to work after 12/1/11, and therefore is not entitled to further TTD related to the 10/13/10 accident as of that date.

Credits to the Respondent were stipulated with regard to paid TTD of $66,466.10. The Arbitrator notes that this figure includes monies that are creditable against both the prior award of TTD from the prior Arbitrator's decision, as well as the current award of TTD. The Respondent is not entitled to take this entire amount of credit and apply it against only the current award of TTD.

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

Pursuant to §8.1b of the Act, several criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after 9/1/11. As the accident in this case occurred prior to 9/1/11, §8.1b of the Act is not applicable. The Arbitrator nevertheless acknowledges that some of these factors remain relevant to the determination of permanency.

The preponderance of the evidence supports that the Petitioner sustained an aggravation of his lower thoracic and upper lumbar degenerative spine condition, and may have sustained an injury to the T11/12 disc. The evidence further supports that a lack of prompt treatment has led to what appears to be chronic pain related to these body parts. The Arbitrator finds the Petitioner's complaints of pain to be credible, as well as the self-treatment he would perform in order to keep working. However, he was in fact able to keep working, at least as of 12/1/11. The Arbitrator notes that while most if not all of the physicians involved in this case have agreed more or less with this finding, it is also true that none of the physicians involved have indicated that there are any significantly severe findings at the noted thoracic and lumbar levels, and that the Petitioner is not a surgical candidate. The Arbitrator also feels it is important to take into account that the Petitioner was on work restrictions that were never rescinded prior to 7/9/12 by Dr. Gabriel. At the same time, it is difficult to believe that the Petitioner's work between December 2011 and July 2012 never exceeded this restriction. As noted above, the Arbitrator also notes that the delay in any onset of leg symptoms until well over six months post injury leads to the conclusion that the leg symptoms are not related to the accident. While the Petitioner did reach MMI prior to the second accident, the Arbitrator does believe that the Petitioner has ongoing chronic symptoms of pain as a result of the 10/13/10 accident that he continues to live with.

Based on the record taken as a whole and a review of prior Commission awards with similar injuries similar outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of the loss of use of 12.5% of the person as a whole pursuant to §8(d)2 of the Act.

WITH RESPECT TO ISSUE (O), THE PETITIONER'S ENTITLEMENT TO PROSPECTIVE MEDICAL TREATMENT, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings that the Petitioner reached maximum medical improvement as of 11/30/11, the Petitioner is not entitled to prospective medical treatment. The parties stipulated at the time of hearing that if the Arbitrator determined the Petitioner had reached MMI prior to the hearing date, that the Arbitrator should determine the nature and extent of the Petitioner's causally related permanent condition. This finding is noted above.

WITH RESPECT TO ISSUE (O), THE CHOICE OF TWO DOCTORS RULE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner did not violate the two-doctor rule in this case. He initially was treated at the Respondent's occupational health facility before seeking treatment with his primary care provider at Clay Medical Center. From there, he was referred to Dr. Gabriel, who referred him to Dr. Ghalambor.

There is a 12/7/10 consultation report from the Effingham Clinic which erroneously notes the Petitioner was hurt at home on 10/13/10. It is unclear how the Petitioner reached this facility, but at worst this would be his second choice.

WITH RESPECT TO ISSUE (O), PETITIONER'S ENTITLEMENT TO TRAVEL / MILEAGE EXPENSES, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that any claimed travel expenses (see Px15) which occurred prior to December 2011 were not shown to have involved excessive or unusual travel. While it is accurate that the Petitioner appears to reside in a rural area without access to the same variety of treaters as someone in, say, the St. Louis / Metro East area, there also has been no showing that the Petitioner did not have access to similar treatment closer to home. There has been a failure to prove entitlement to claimed travel expenses.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Melissa Pabst,
Petitioner,

vs. No. 15 WC 00866

20IWCC0171

Phillips 66,
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, temporary total disability, permanent partial disability, medical expenses, and prospective medical care and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that, the Decision of the Arbitrator filed November 13, 2018, is hereby affirmed and adopted.

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

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

Bond for 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 12 2020

Marc Parker

mp/wj
03/05/20
68

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PABST, MELISSA
Employee/Petitioner

Case# **15WC000866**

PHILLIPS 66
Employer/Respondent

20IWCC0171

On 11/13/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4888 THE LAW OFFICE OF KEITH SHORT
1344 BLUFF RD
UNITS C-D
COLLINSVILLE, IL 62234

2091 HEYL ROYSTER VOELKER & ALLEN
AMBER D CAMERON
105 W VANDAILA ST SUITE 100
EDWARDSVILLE, IL 62025

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

MELISSA PABST
Employee/Petitioner

v.

PHILLIPS 66
Employer/Respondent

Case # **15 WC 00866**

20IWCC0171

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 **October 25, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

In the year preceding the injury, Petitioner earned $**81,138.22**; the average weekly wage was $**1,560.36**.

On the date of accident, Petitioner was **35** 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, $**N/A** for maintenance, and $**0** for other benefits.

The parties have stipulated that the Respondent is entitled to a credit, to be shown, for prepaid non-occupational indemnity disability benefits under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner sustained accidental injuries arising out of and in the course of her employment on the manifestation date of August 1, 2013.

The Arbitrator finds that the Petitioner has shown a causal connection of her right upper extremity conditions and the August 1, 2013 accident by the preponderance of the evidence. The Arbitrator further finds that the Petitioner has failed to prove that a causal connection between her left upper extremity conditions and the August 1, 2013 accident by the preponderance of the evidence.

Respondent shall pay Petitioner temporary total disability benefits of $1,040.24 per week for 109-2/7 weeks, commencing February 18, 2014 through March 24, 2016, as provided in Section 8(b) of the Act.

Respondent is entitled to credit for any prepaid non-occupational disability benefits pursuant to Section 8(j) of the Act.

Respondent shall pay reasonable and necessary causally related medical expenses contained in Petitioner's Exhibits 9 through 14 which are related to the right upper extremity in any way, as provided in Sections 8(a) and 8.2 of the Act. Any medical expenses that are related specifically to treatment of the left upper extremity are denied based on the Arbitrator's findings of a failure to prove a causal connection. Any testing or therapy that involved treatment of both extremities is awarded unless there is a way to separate the charges for treatment of each upper extremity.

Respondent shall be given a credit for any and all awarded medical benefits that have previously been paid pursuant to Sections 8(a), 8(j) and 8.2 of the Act, and Respondent shall hold Petitioner harmless from any

claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$721.66 per week**, the maximum allowable statutory rate, for **19 weeks**, because the injuries sustained caused the loss of use of **10% of the right hand**, as provided in Section 8(e) of the Act, with regard to right carpal tunnel due to repetitive/cumulative trauma.

Respondent shall pay Petitioner permanent partial disability benefits of **$721.66 per week**, the maximum allowable statutory rate, for **31.625 weeks**, because the injuries sustained caused the loss of use of **12.5% of the right arm**, as provided in Section 8(e) of the Act, with regard to right radial and ulnar nerve compression conditions.

Respondent shall pay Petitioner compensation that has accrued from **March 24, 2016** through **October 25, 2017**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

September 17, 2018
Date

NOV 13 2018

STATEMENT OF FACTS

Petitioner alleges injuries to her bilateral hands and arms as a result of repetitive trauma, with a claimed 8/1/13 manifestation date. She testified the specific body parts for which she claims injury are the left elbow, right wrist and arm.

Petitioner was employed by Respondent as a full-time quality assurance tester at their Wood River, Illinois petroleum refinery from January 2004 through 10/20/13. She testified she is currently unemployed, and last worked at a place called I Love Juice Bar in Missouri. Petitioner testified she had no problems with her upper extremities prior to starting her employment with Respondent.

Petitioner testified she worked a rotating swing shift, alternating between day and evening schedules every two weeks, and moving between the three different areas of the lab; the analytical, motor and inspection labs. She worked three or four 12-hour shifts per week, each with 30-minute morning and afternoon breaks, and an hour lunch break. Petitioner testified there were approximately seven to eight testers working in the lab during the day shift and a few less than that during the night shift. Respondent witnesses Mr. Henson and Ms. Chenault testified that there were five quality assurance testers during the day and three during the night in the main lab as well as two in the motor lab for both day and night shifts. Petitioner testified she would be stationed in one of the three areas of the lab for three to six months at a time before rotating to another area of the lab in the refinery. Each of the three lab areas involved different duties that a tester would perform with different types of equipment.

Petitioner testified work in the inspection lab involved monitoring tests of the diesel, jet fuel, and other fuel components in liter bottles. This area of the lab did not require use of cylinders or valves. Mr. Henson testified there was up to one hour of computer work in this lab spread out throughout a shift.

Petitioner explained that the duties of a tester stationed in the motor lab consisted mostly of setting up gas chromatography (GC) testing which would involve pipetting samples from larger bottles into smaller vials and crimping a cap on them. Mr. Henson testified that the samples involved jet fuel, diesel fuel or gasoline. The larger liter bottles are roughly the size of a bottled water, 8 inches tall with narrow screw tops. The tester would use a vibrating massager to pack the chromatography columns with silica gel. The gas chromatography tube columns were 4 feet tall and the thickness of a pencil. Besides a handheld massager, there was also a wall-mounted automated massager that would pack 1 to 4 tubes automatically. The massagers were only used in the motor lab for packing the chromatography columns. She testified that she would hold the vibrator with her right hand and would hold the tube with her left. Mr. Henson and Ms. Chenault testified that the tester had the option of using the wall-mounted automated massager or a handheld massager to pack the sample columns. Petitioner testified that she used both of these tools. Mr. Henson testified a tester would only use the handheld or the wall-mounted massager on a sample, and that the samples would be massaged for a total of 20 minutes per shift in the motor lab, broken up into five-minute intervals. No force was necessary while massaging the columns, and while the samples were curing, Petitioner would perform other duties.

Petitioner explained that the duties of a tester stationed in the analytical lab required the use of valves and cylinders and the use of pipettes. She described the pipettes as similar to small turkey basters with a bulb mechanism used for extraction. Some are manual, some are automatic. Samples were portioned by pipetting liquid into the cylinders, which she estimated took place 15 to 20 times a day and required a gentle force, though she testified this would aggravate her symptoms. The pipettes could be bulb suction or electronic preset amounts, depending on the quantity collected, with a touch of her thumb. Petitioner testified that she also would have to pour liquid from liter bottles into testing instruments with her right hand and would do this 50 to 75 times per day.

Petitioner would have to retrieve a number of individual cylinders, weighing 3 to 10 pounds each, cart them to a dumbwaiter and then retrieve them upstairs. Petitioner estimated she would twist and turn valves on 50 cylinders, on average, during a 12-hour shift. She testified she would make the trip to pick up cylinders about 10 times per day. The cylinder valves were the size of a quarter in diameter and would be twisted open using the motion of revving a motorcycle. She testified she would have to twist it a few times, not just once, to open or close the valves, and that this involved approximately 25 opening/closing motions on each cylinder per day. Some cylinder valves were threaded. The liter cylinders were chest high and held vertically. To test them, she would use a thumbwheel to attach it to a pressurized testing device, again generally using her right hand. If tight, she would use a wrench or pliers, "at least a few times with each cylinder." Petitioner estimated having to open

or close a valve approximately 1250 times per day, and that turning the valves would require a forceful grip, usually at or about her shoulder level, but somewhere between her shoulder and chest levels. She noted another 75 or so wrist motions per cylinder to operate the thumbwheels. Petitioner testified that some of the older cylinders had jar-type, threaded screw-off ends, and she estimated that she would unscrew these approximately 6 to 7 times per day. She would sometimes have to use a wrench for this as well.

Petitioner testified that she had no history of diabetes, hypertension or cervical injury involving medical treatment, and that she was a non-smoker, had no recent pregnancies and had no thyroid issues. Her weight fluctuates within 20 pounds of her norm, and she denied having any hobbies which involved the hands/wrists, repetitive activities or vibratory tools, and denied that she currently weightlifts or is involved in anything like CrossFit or similar. She also denied any prior workers' compensation claims.

Mr. Henson testified he had counted rotations when making adjustments to procedures in the lab and found there were 20 cylinders per shift to turn with total rotations, considering the top and bottom valves, ranging between 700-1000 rotations in a shift at maximum. In the analytical lab, gas chromatographs were run through cylinders with a direct injection. The valve usage was mainly on sample cylinders for propane samples with an average of 20 samples per day spread out throughout the shift. Mr. Henson testified the only force used with a valve would be standard rotational force to open it, and if any additional force was needed, wrenches were readily available and used. During her shift in the analytical lab, Petitioner would also have other duties, including reading monitors, moving samples on carts to different areas of the lab, taking cylinders to be cleaned on a steam rack, entering data to verify all results obtained and preparing shift reports. The computer work would total up to one hour, spread throughout the shift. Boxes of cylinders were taken to a dumbwaiter via a cart and dolly. Each cylinder weighed between 3-10 pounds depending on whether they were full. A tester would have to lift boxes of cylinders on a cart 2-10 times a shift.

Petitioner testified that sometimes coworkers would help her with the heavier labor work duties. She testified the heaviest weight she would lift would be 50-pound air pacts for fire and hazmat response crew or canisters of waste. The testers would also change out industrial gas containers similar to the shape and size of a helium tank, with the use of a dolly. Petitioner testified the canisters would be changed every few days, while Mr. Henson and Ms. Chenault testified they would be changed every two weeks. Mr. Henson testified that testers heaviest weight to lift would be SCBA gear for the fire response crew once a quarter in training. Petitioner testified she would only be asked to respond to any calls with the hazmat crew a few times a year. Inside the lab, the heaviest weight a tester would lift would be 12-15 pounds for a full sample cylinder. Each cylinder weighed between 3-10 pounds, depending on whether they were full. Waste canisters were wheeled, and transport carts were available to move cylinders.

Mr. Henson testified that the duties indicated in a Job Analysis for a laboratory tester for Respondent (Rx2) included duties that could be performed by a quality assurance tester working in any portion of the lab, and were not specific to the analytical, motor on inspection labs. As such, it was vague in describing any and all possible activities that could be anticipated to be performed by a tester. Mr. Henson testified, and Ms. Chenault confirmed, that there are periods of downtime interspaced throughout the work shift of a quality assurance tester while waiting for samples to process that could range from 3-7 hours of a total shift. Ms. Chenault testified that the job duties of a quality assurance tester as described by Mr. Henson were accurate.

Respondent presented two witnesses at hearing, Robert Henson and Jennifer Chenault. Mr. Henson testified that he started working for Respondent in April 2011 as a quality assurance chemist His duties included technical resource support of the inspection and analytical labs. Mr. Henson testified he was promoted to his current title of quality assurance production leader on 3/1/15. As the production leader, Mr. Henson oversees the day to day

overall operations of the lab staff, including the first line supervisors and second line supervisors of the quality assurance testers.

Ms. Chenault testified she has been employed with Respondent since 2001, initially working as a quality assurance tester performing the same duties as Petitioner until 2011, when she moved into her current role as the first line supervisor for the quality assurance testers. When she moved into that position, she became Petitioner's immediate supervisor until Petitioner's employment with Respondent ended. As a quality assurance first line supervisor, Ms. Chenault supervises 26 lab technicians as well as overseeing training and procedure revisions of the lab, safety coordination, and scheduling of the testers. She testified that the volume of work between the day shift and the night shift was different, with about 65-70% of the sample testing taking place during the day shift. The volume of work would depend on if the tanks were full and other variables in the refinery.

Petitioner testified that she knew Mr. Henson since high school and that they were in the same course of chemistry study in college. At work, she would see him in the lab and would talk to him from time to time. Mr. Henson testified that shortly after he was hired with Respondent in 2011, Petitioner came to him and told him that she was upset that he took the promotion she felt she deserved. He testified that Petitioner regularly complained to him about work policies and procedures and issues with coworkers.

Petitioner testified that she began to notice hand and elbow problems about a year prior to reporting the problems to Respondent. She testified that she would use a wrench or pliers nearly every time she had to turn a valve on a cylinder, and that she typically would use her right hand for this. When she would switch away from the analytical lab job, her symptoms would go away, but indicated the last time she was switched out of the analytical lab position, the symptoms did not resolve. She indicated she had problems in the left elbow and would be unable to use her left ring or pinky fingers. On the right, with forceful gripping and squeezing of the valves, her hand got to where it would claw around the valve.

A pre-accident note of Dr. Emanuel was contained in Px3. On 10/15/09 she saw Dr. Emanuel for left elbow pain she reported developing from lifting: "The patient performs yoga and has both arms underneath her body and hyperextends her elbow in order to elevate her legs. Swelling that appeared after the injury, sever, nearly gone." Prior bracing, NSAIDs and rest had not helped, with Petitioner noting the elbow swelling would continue to return. She also reported popping and clicking in the elbow and that it felt like it wanted to pop out of place. Dr. Emanuel opined that Petitioner had hyperextended her elbow, but that it was otherwise structurally within normal limits. Left elbow x-ray was within normal limits, but nothing was noted as to an EMG. (Px3).

Petitioner's initial medical visit following the alleged accident date was on 7/29/13 with orthopedic surgeon Dr. Emanuel for her left arm. She reported pain with lifting her left shoulder above shoulder height with popping and grinding, but that this was improved with anti-inflammatories and avoidance of activity. She was noted to be an active weight lifter, and that as a chemist she has physical activities which include lifting up to 50 pounds. The report noted pain "of insidious onset, after a lifting injury, which has gradually progressed. Pain occurred with certain movements, like reaching anteriorly over the shoulder level. Associated symptoms included parasthesias in the hand and/or fingers." Physical exam of the left elbow was essentially normal, while neurological exam noted positive elbow flexion test and positive Tinel's sign at the cubital tunnel. Shoulder exam noted pain at the extremes of motion and slightly positive impingement sign. Normal exams were also noted of the right shoulder and cervical spine. Dr. Emanuel diagnosed left shoulder joint pain, subacromial bursitis, impingement syndrome and cubital tunnel syndrome. An EMG of the left upper extremity was prescribed to determine the severity of cubital tunnel, and it was noted that if Petitioner's shoulder symptoms returned, an injection may be needed. (Px3).

On 8/14/13, Petitioner underwent EMG/NCS testing with Dr. Phillips, who reported Petitioner had a 5-month history of progressive left 4th and 5th finger numbness that had become constant. She had weakness but no elbow pain. She reported neck pain that didn't clearly radiate into the upper extremities. She had a lesser degree of numbness in the right 4th and 5th fingers. The report further states: "His [sic] symptoms started after weightlifting in January. There was no specific recognized trauma to the elbows. She has a history of left shoulder bursitis which is currently being treated conservatively." According to Dr. Phillips, testing reflected a rather severe, but predominantly demyelinative ulnar neuropathy across the right elbow. He indicated that nerve transposition surgery would be reasonable. (Rx5).

On 9/10/13, the plant dispensary noted Petitioner reported diminished grip, wrist and forearm pain due to repetitive motions at work: "Repeated valve opening/closing, thumb wheel rotation, weight of cylinders all contributing. Employee uses wrenches as needed." A 9/13/13 note of Dr. Dirkers states that Petitioner reported a 6-month history of on and off right wrist pain "with job", that she said was from turning valves, thumb wheels, and that she uses wrenches. She indicated she worked there for 10 years and while there was no job change, the volume of work was increased over the last 1.5 years. There was no specific injury. She took a month off work for the pain to go away, but it returned when she returned to work. She had again been off work for two weeks but was uncertain if the pain was fading. The pain started in the mid-wrist and went up the proximal forearm. She had pain with gripping but couldn't point to where it hurts. The report further states: "Has ulnar nerve entrapment left (Had EMG) – told from poor construction – says not work related." She awakens with numbness in the 4th and 5th fingers. She indicated she exercises 3 to 4 times per week, including weightlifting, and she plays piano but is now unable to. She also reported she performed no upper body lifting for the last two months. Tinel's was positive bilaterally at the elbows, right greater than left. Calluses were noted bilaterally where the palms meet the fingers. (Rx3).

On 9/16/13, Dr. Emanuel noted EMG suggested severe cubital tunnel syndrome, left greater than right, and he recommended ulnar nerve transposition surgery. (Px3).

On 10/28/13, Petitioner called Respondent and noted she was having surgery on the left hand ("nonoccupational") but was still having trouble with her occupational injury to the right hand.

Petitioner underwent ulnar nerve transposition surgery at the left elbow on 10/30/13, and Dr. Emanuel's postoperative diagnosis was chronic ulnar nerve palsy. The nerve was noted to be markedly compressed in the cubital tunnel, and the transposition was performed because the nerve would not stay within the tunnel following release. (Px3).

On 11/7/13, Petitioner reported ongoing numbness into the 4th and 5th fingers. On 11/19/13, Petitioner was noted to have vague complaints of right wrist pain and volar aspect forearm. On 12/17/13, Petitioner reported no left elbow pain but ongoing swelling, though this was not detected on exam. Right hand pain and weakness continued that was aggravated by work, and Dr. Emanuel ordered right-sided EMG/NCV. A 12/27/13 phone note from Emanuel's office noted Petitioner was putting the EMG order through workers compensation, and "There is nothing in the patient's chart stating that this was a work-related issue." Petitioner indicated the claim was for the right arm, and the Respondent subsequently informed the provider that the claim was being denied. (Px3).

A 12/27/13 note from the plant dispensary stated that Dr. Dirkers notes Petitioner reported being fully released by Dr. Emanuel, but that he wanted a right EMG due to concern for median nerve entrapment in the forearm: "She feels it is work related. Also states she lifted weights up to time of surgery." The note also states Dr.

Emanuel had not released Petitioner. On 1/6/14, the plant dispensary noted someone from Respondent or the insurer indicated the right arm was not considered to be work related. (Rx3).

On 1/2/14, Dr. Phillips performed EMG/NCS studies of the right upper extremity and determined the findings were normal, noting the previously seen ulnar motor demyelination at the right elbow had resolved. (Rx5).

On 1/13/14, it was noted that right EMG testing was normal, though Petitioner continued to report forearm pain into the hand with spasming and pain into the first three digits. Petitioner reported she used her hand a lot with gripping activities. The note mentions "Overuse phenomenon at work", and a specialized therapy program was prescribed by Dr. Emanuel. (Px3).

A 1/29/14 note from the dispensary indicates Petitioner was released to full duty as of 2/17/14 with regard to cubital tunnel. (Rx3).

Following the initial period of therapy for the right elbow (8 visits) on 2/7/14, the therapist at ProRehab noted Petitioner reported no pain at rest and improved pain with gripping versus pre-surgery. On 2/10/14, Dr. Emanuel noted the pain was getting better, but Petitioner reported weakness in the forearm and with gripping. Dr. Emanuel stated: "In my opinion the arm pain is of unknown etiology." Given improvement with therapy, it was continued with a release from care anticipated after that. In a 3/7/14 therapy note, Petitioner continued to report no pain at rest, but with griping she reported pain in the wrist and in the middle of her hand. She still reported 2/10 to 6/10 pain. She had normal strength and range of motion. (Px3).

A 3/10/14 phone note of Dr. Emanuel's office regarding a conversation with Petitioner's therapist states: "Patient is doing very well. Maybe slight weakness remains in the hand on the right. However, she has been skiing and is doing weight training." On that same date at a visit with Dr. Emanuel, Petitioner reported improvement in therapy but ongoing "predisposition of flexion" of her fingers into the hand. Dr. Emanuel noted Petitioner reported no numbness and that the pain seemed more proximal to the wrist. He stated: "Quite honestly, it is unexplainable to me." The only other possibility was ulnar nerve palsy with weakness of the intrinsic muscles of the hand. Bilateral repeat EMG/NCS testing was prescribed, in part to determine if left-sided surgery resulted in improvement. (Px3).

On 3/18/14, Petitioner underwent repeat EMG/NCS testing with Dr. Phillips. Petitioner noted no substantive improvement 6 months post left ulnar transposition surgery, or with 2 months of therapy on the right with spasms in the right hand and incomplete flexion into a fist. She noted intermittent tingling in the first three left fingers with pain in those fingers with pain in the wrist, flexor and extensor forearms. She reported continued left weakness with constant numbness in the last two digits. Her only left arm pain was what she anticipates from the left ulnar surgery. She had nonradiating neck pain but was concerned the problem may be in her neck or wrist. Testing revealed significant remyelination of the left ulnar nerve with mild residual neuropathy. While motor and sensory velocities were not normal, Dr. Phillips noted they don't necessarily return to normal even with successful decompression, and the left axonal responses were well maintained. On the right there was also improvement in ulnar velocity. He indicated the study did not show evidence of median or ulnar neuropathy at the wrists. Outside of the minor evidence of chronic denervation in the ulnar distributions, the remaining EMG did not show evidence of C8 radiculopathy. (Px3; Rx5).

On 3/24/14, noting the EMG results, Dr. Emanuel indicated there was objective improvement and he was at a loss to explain Petitioner's symptoms. He noted Petitioner believed it was work related, although there was no specific traumatic event, and he advised her to seek a second opinion. (Px3).

Petitioner saw Dr. Lang on 4/8/14 with complaints of a one-year history of right forearm, wrist and hand pain with swelling. Pain went into the palm and 2nd and 3rd fingers, which curled up. She indicated no improvement with therapy. Dr. Lang recommended conservative treatment and recommended against surgery, noting Petitioner understood nothing dangerous was occurring. (Px5).

A Work Hardening Entrance Evaluation was performed on 4/14/14 regarding the right wrist. The testing was noted to be valid and placed Petitioner at the Medium work level. She had a moderate level of self-perceived disability. The main factors limiting her from returning to work included material handling from waist to overhead, bilateral/unilateral carry and subjective complaints with end range right wrist motion. (Px3).

Petitioner saw Dr. Howard, D.O. on 4/17/14. His report is addressed to a Dr. Corder, but indicates Petitioner was referred there for a second opinion by her therapist. Petitioner reported doing a lot of physical activity at work with her right arm. She had been off work since left ulnar transposition surgery because she "could not tolerate" it, and it was currently not a work injury. Her intake form notes she alleges the problem as being due to overuse at work. She had pain in the dorsal forearm and radiating into the palm. Examination was normal except for some production of pain with compression over the radial nerve. Dr. Howard opined that continued strengthening was the best course of action, with no other intervention currently warranted. He advised she follow up with Dr. Lang. (Px7).

At a 4/23/14 Work Hardening re-evaluation, Petitioner demonstrated abilities in the Heavy work level, which met the job duties reported by Petitioner. She did have pain (5/10) with end range right elbow pronation/supination, right wrist flexion/extension and forceful gripping. (Px5).

On 4/24/14, Petitioner indicated no improvement and that the only thing work hardening did "was make her realize she can only go back to work with certain restrictions. Dr. Lang reiterated he did not recommend surgery and advised Petitioner to use her hand and arm as tolerated. Petitioner reported no change on 6/5/14, and that she was there "for more of a formality." Petitioner reported she was planting and digging over the weekend and had pain and swelling in the right wrist. Dr. Lang noted Petitioner was waiting to see if Respondent was going to let her come back to work. He also noted Petitioner denied any family history of multiple sclerosis, and he recommended a right elbow/forearm MRI to rule out a deep mass. (Px5).

On 4/28/14, Petitioner met with Dr. Dirkers. She had been off work for 6 months on restrictions for "joint pain." Petitioner described it as cramping at the base of the thumb, index and ling fingers, into the wrist and up both sides of the forearm. Petitioner noted she had been worked up, including EMG, and "states they aren't sure of diagnosis." (Rx3).

The 7/10/14 right elbow MRI was negative. On 8/7/14, Petitioner reported that Respondent would not allow her back to work with restrictions and wanted to know what Dr. Lang thought she could do. He again said to use her arm as tolerated, but that she has no restrictions and again that he did not see anything dangerous occurring. She was to follow up as needed. (Px5).

On 8/11/14, Petitioner returned to Dr. Dirkers at the plant dispensary. Petitioner reported that neither Dr. Emanuel nor Dr. Lang could find anything mechanically wrong despite extensive testing. She reported her pain varied, mainly in the radial forearm into the thumb and index finger, with tingling after activities. She had been released to full duty by both physicians, as well as Dr. Howard, but was concerned she would not be able to handle or treat her pain while working, will become weaker and will lose her grip. Dr. Dirkers stated: "She has been seen and fully released by 3 competent hand surgeons. However I have concerns with her continued complaints. Will discuss with HR today prior to her release." (Rx3).

On 10/23/14, Petitioner again saw Dr. Dirkers at the dispensary, reporting constant right arm pain, but that the doctors could not find anything wrong. It was noted Petitioner applied for long term disability but was denied. She again noted concerns about being able to do her job when she returned to work and wanted reassurance that she would be able to "back off some" and not be rushed back if needed ("don't want to drop a bottle of benzene"). (Rx3).

Petitioner then followed up with Dr. Lang monthly through 12/18/14 with no real improvement. She indicated she was waiting for a neurology referral and waiting for Respondent to allow her to return to work. She was receiving some sort of forms from Dr. Lang's office, but while his reports note Petitioner should use her arm as tolerated, he also specifically indicated he was not providing her with any work restrictions. On 12/18/14, after reviewing a carpal tunnel "brochure", Dr. Lang recommended a right carpal tunnel injection, and this was performed. (Px5).

On 8/17/15, Petitioner contacted Dr. Emanuel's office with continued symptoms, seeking a referral to Dr. Mackinnon. (Px3).

Petitioner initially saw Dr. Mackinnon on 9/23/15. In her 9/29/15 report, Dr. Mackinnon noted Petitioner reported right forearm pain radiating into the hand in a median nerve distribution and an inability to work as a result for two years. Petitioner reported she "has done a lot of hand working with pipetting, twisting, squeezing, and valve turning. Petitioner had a history of a congenital kidney problem. Gabapentin wasn't helping the right arm symptoms. Review of systems was positive for arthritis in the right knee, back, neck pain and left shoulder pain. Dr. Mackinnon reported that her exam findings indicated evidence of right carpal tunnel, mild on the left, and that she had evidence of right radial sensory nerve entrapment. She recommended right carpal tunnel and radial sensory nerve releases with tenotomy of the extensor carpi radialis brevis tendon. (Px4).

The surgery was performed on 12/16/15. It included carpal tunnel release, decompression of the right median nerve with step lengthening tenotomy of pronator teres tendon and full tenotomy of deep pronator teres tendon, and release and neurolysis of the right superficial sensory nerve with tenotomy of the brachioradialis tendon. Post-operative diagnoses were right median, radial and ulnar nerve compression. The median nerve was noted to be markedly compressed by the pronator teres tendon, the radial nerve was compressed by the brachioradialis tendon and the ulnar nerve was markedly compressed in the Guyon's canal. (Px4).

Dr. Mackinnon issued a 12/19/15 report stating that Petitioner's symptoms "are beyond those nerves" that were operated on. Petitioner had pain at the epicondyles and in the proximal forearm. The doctor indicated that if the surgery did not provide significant relief, Mackinnon would have nothing more to offer surgically. (Px4).

Therapy was ordered on 1/7/16. On 1/12/16, Dr. Mackinnon noted Petitioner was doing well and only needed Aleve for her pain. Sensation was not yet normal on the right, but she was pleased with Petitioner's progress. On 2/9/16, Dr. Mackinnon's report stated: "She is doing well. She does not notice any significant change, but given the operative findings, I will be surprised if this is not a good result for her over time." At the last visit of 3/24/16, Petitioner was noted to be doing well but with evidence of right cubital tunnel and compression of the radial nerve, as well as some lateral epicondyle area tenderness. Dr. Mackinnon advise Petitioner to talk to her therapist about proper modalities, and otherwise they discussed another surgery: right ulnar nerve transposition, tenotomy of the extensor carpi radialis brevis tendon and radial tunnel release. (Px4).

Dr. Emanuel testified via deposition on 5/17/16. He noted 90% of his practice involves shoulders, with the other 10% involving elbows and wrists. He testified that the 2009 visit following a yoga injury involved a

hyperextension injury and a little bit of synovitis in the joint, not neuropathy. Given she never returned despite being advised to do so if it didn't improve, he agreed it would be fair to say her condition went away at that time. Petitioner then didn't return until the July 2013 visit, when she complained of some left shoulder symptoms and ulnar nerve symptoms. He testified: "She didn't get a specific number of onset of her pain, but seemed to be after lifting or work." EMG noted a rather severe left ulnar neuropathy at the elbow, with mild findings on the right. It did not reflect a cervical radiculopathy. There were no known medical comorbidities for a peripheral nerve problem. (Px1).

Dr. Emanuel testified that as of 10/30/13 surgery, Petitioner had been able to work, albeit with some possible symptoms. She could not work following the left ulnar nerve transposition surgery. He testified that Petitioner noted some right sided symptoms following surgery, but that he did not treat the right side and had no diagnosis. She did well post-operatively. While his 12/17/13 note referenced that Petitioner's work activities were aggravating her right hand, Dr. Emanuel testified he didn't think he had released the Petitioner to return to work at that point. He ultimately recommended an EMG for the right upper extremity. Post-surgical EMG of the left upper extremity reflected improvement in ulnar nerve function. Following this EMG, Dr. Emanuel testified the Petitioner would have been at maximum medical improvement (MMI) as to the left elbow and released to return to regular duty. When the EMG did not show a posterior osseous nerve problem, Dr. Emanuel referred the Petitioner to a hand specialist. (Px1).

Dr. Emanuel testified that on 1/13/14, Petitioner indicated she was a chemist and performed a lot of gripping activities bilaterally. He was provided with a hypothetical including Petitioner working for 5 to 10 years as a chemist, which involved: "often has to move materials, pick up boxes weighing 50 pounds. She uses wrenches and pliers to turn valves on an almost continuous basis throughout the day to obtain both readings and chemicals for measurements and analysis. She must move cylinders multiple times. The cylinders can weigh between 5 and 50 pounds. She has to squeeze pipettes, whatever those are. She has to do vial crimping with a crimper. She has to open and close jars and also has to train in HAZMAT and fire crew work, and she uses what's called thumb wheels to turn dials and gauges. That she does this three to four days a week and works 10 to 12 hours per day." Based on this, Dr. Emanuel opined that such work duties could aggravate or even cause cubital tunnel syndrome. Therefore, Petitioner's medical treatment and post-surgical off work period would be related to such work activities. (Px1).

On cross-examination, Dr. Emanuel testified that he was aware Petitioner was involved in yoga and weightlifting but did not inquire as to how involved. He agreed that these activities could contribute to cubital tunnel. He noted that Petitioner, however, "was pretty specific it was her work activities." Outside of the hypothetical he was provided with, he was aware Petitioner lifted some boxes weighing 50 pounds and did some pipetting, but he had no knowledge of the frequency. He agreed that Petitioner's cubital tunnel could have been idiopathic. (Px1).

Dr. Mackinnon's deposition was also obtained by the parties. She is a plastic surgeon who testified that she specializes in nerve surgery. Petitioner was first seen on 9/24/15, and she reported doing a lot of repetitive hand work with pipetting as a bench chemist, which involved using the median innervated fingers as well as ulnar doing twisting back and forth with supination/pronation movements. She reported being unable to work for two years due to right forearm pain, predominantly in a median distribution with some in the radial nerve distribution. Dr. Mackinnon noted the prior surgery performed by Dr. Emanuel and testified that she did not treat the Petitioner's left upper extremity. (Px2).

Clinically, Petitioner had evidence of right carpal tunnel with a bit of irritation of the radial nerve and the median nerve in the forearm. This radial and median nerves in the forearm area can be pinched when doing

repetitive pronation/supination movements. She recommended surgery, which is the only alternative if splinting fails. Surgery was performed on 12/16/15 and involved the release/decompression of the median nerve at the wrist and forearm, and the radial nerve in the forearm. Petitioner did well in follow up as to the symptoms caused by the compression, but still had some pain in the lateral medial epicondyle and symptoms of mild right cubital tunnel and some pressure on the radial nerve in the forearm. Dr. Mackinnon was optimistic that her surgery would settle things down and allow for conservative management of the elbow problems, but if that failed, she would recommend the same surgery on the right side that Dr. Emanuel had performed on the left. As to nerve entrapment in general, "most of these things are caused by repetitive postural issues, in my opinion", so part of the solution is avoiding doing the things that caused the problems in the first place and "balance out whatever issues they are doing at work or how they sleep." (Px2).

Dr. Mackinnon was then also presented with a hypothetical regarding Petitioner's employment: that she worked as a chemist for 5 to 10 years, had no history of comorbid medical conditions, that she often has to move material, pick up 50 pound boxes and containers, uses wrenches and pliers on an almost continuous basis throughout the day, squeezes pipettes and will often use a crimping device on vials, opens and closes jars, performs HAZMAT training and uses thumbwheels to turn dials and gauges, and she does this 10 to 12 hours per day, 3 to 4 days per week. She testified that these is no scientific data to indicate causation, but there is data to suggest association: "So I'm not sure I'd be very helpful with you because there's nothing that I could give you that would say these things caused this problem, but they are associated with it in my opinion." She believes there is an association between repetitive work activities and the symptoms Petitioner had. First, Dr. Mackinnon noted that if Petitioner's symptoms resolved with her surgery, she made the right diagnosis, versus something like radiculopathy or a tumor. If she still has the symptoms, she made the wrong diagnosis. If the diagnosis is correct, she testified that "it makes sense to me that the work that she descried to me and that you're describing to me would be definitely associated with the cause of her problem." She would assume she made the correct diagnosis based on Petitioner noting improvement in the 3 to 4 months she continued to see Dr. Mackinnon following surgery. Since Petitioner never returned after that, Dr. Mackinnon would assume that the other symptoms at the right elbow also got better. (Px2).

On cross, Dr. Mackinnon testified that she saw Dr. Phillips' 3/14/14 EMG testing, and believes she likely saw records from Dr. Emanuel, but could not say for certain. She also wasn't certain if she reviewed Dr. Phillips' 8/14/13 or 1/2/14 EMG testing, or any other medical records outside of Dr. Emanuel. She may have reviewed them but only noted the most important things she reviewed in her report. She didn't recall previously being asked to provide a written causation opinion in this case. Dr. Mackinnon's understanding when she saw Petitioner in September 2015 is that Petitioner had not worked in two years. (Px2).

Dr. Mackinnon testified that all compression neuropathies are multifactorial causes or associations. They are related to positions of the extremities that produce either increased tension on a nerve or increased pressure, and then duration also matters. Some people have tendons or fascia that is closer to nerves and cause more direct pressure. How people sleep in terms of whether their body positions create this tension or pressure can be a big cause of such neuropathy, which is why with carpal tunnel the first onset is usually nocturnal. She testified that her therapist discusses sleep positions with all patients, but Dr. Mackinnon did not testify that she was knowledgeable about what Petitioner may have indicated. Vibration has the strongest association with compression neuropathy. She agreed she also didn't indicate in her report how long Petitioner had been performing her work activities, noting that duration also matters in causation. Petitioner was born with a remarkably tight tendon bands snapping on the median nerve – "She doesn't get that from pipetting. But if you had that and you had to do repetitive hand work, that would be pretty impossible to do. It would be hard. Like I don't even know how someone would do that with that amount of pressure there." Petitioner had some evidence of a little bit of a left thoracic outlet problem, and all of her symptoms could be due to that, but Mackinnon

didn't think she had it on the right. However, if the Petitioner is not improved "then you shouldn't listen to anything I said." Dr. Mackinnon agreed someone can develop compression neuropathy without any repetitive trauma or specific injury. She can't say whether that is the case here or not, but that she believes Petitioner's work contributed to her problem significantly, as repetitive high small intensity hand work causes a lot of pressure in the forearm. (Px2).

Dr. Mackinnon testified that did not recall discussing Petitioner's outside work or hobbies with her, including any weightlifting. She agreed she had no information on the frequency that the Petitioner performed pipetting, as this information would not have been helpful to diagnosis or how to treat her. As to whether the frequency and force involved in Petitioner's work is important to know as it related to causation , Dr. Mackinnon testified: "Well if you would tell me that actually she worked for a year at this, then what I would say – and was completely asymptomatic and then worked it a year and then got this, I would say that the biggest cause of this was the tendon bands around her median nerve in the forearm that just made it impossible for her to do that work. . . So you could say this to me. If she didn't have any tendon bands in the forearm, would she have these complaints? Probably not." Given the Petitioner's congenital tendon band conditions, "I think if you gave someone a pipette job they could know within a couple of months this wasn't going to work." She further testified that both a short or longer work exposure could have triggered the condition, as "her anatomy fit perfectly with this being work related, associated with her work." Dr. Mackinnon acknowledged that if asked why Petitioner didn't improve after being off work for two years, "I don't know the answer to that." She agreed that if the information she was provided regarding Petitioner's job duties was not accurate, "it would depend" as to whether it would impact the accuracy of her opinions. (Px2).

Plastic surgeon Dr. Brown examined the Petitioner on behalf of Respondent on 4/18/17, and his deposition was taken on 8/11/17. He testified that he specializes in hand surgery, along with the wrist and elbow. Petitioner reported she was a lab tester, involving twisting and turning valves, using pliers sometimes up to 1,000 times per day, pouring liter botte samples 60 times per day, picking up and rolling heavy drums, pipetting twenty times per day, using a hand crimper, holding a vibrating tool to pack chromatography columns and intermittent data entry. He didn't believe the Respondent provided him with a written job description for a lab tester (see Rx2), as it isn't referenced in his report. Therefore, his opinions are based on the Petitioner's report of her job duties. (Rx1).

Petitioner reported onset of symptoms in the spring of 2013 with numbness and tingling in the left 4th and 5th fingers. Dr. Brown noted his review of the Petitioner's medical records with Dr. Emanuel and EMG studies (severe left and moderate right cubital tunnel). Petitioner reported left cubital tunnel surgery helped. She first reported right side problems after she had started treating with Emanuel. Subsequent second EMG testing indicated right ulnar nerve problems at the elbow had resolved, with no evidence of carpal tunnel or radial sensory PIN nerve problem. Petitioner reported she was progressively worsening and a third EMG was performed on 3/18/14, which was normal with no evidence of carpal or cubital tunnel. At that point, Dr. Emanuel indicated he could not explain Petitioner's symptoms and recommended a second opinion. She then saw Dr. Lang, who, in Brown's opinion, also didn't provide any definitive diagnosis and opined there was no danger to her to continue working full duty. Dr. Brown also noted Dr. Howard's April 2014 report, where he diagnosed myofascial pain (i.e. pain that "we can't really explain based on anatomical reasons") and found no evidence of compression neuropathy. Petitioner reported to Dr. Brown only slight improvement following surgery with Dr. Mackinnon. (Rx1).

On exam, Petitioner's left upper extremity was unremarkable. On the right was nonspecific diffuse tenderness to palpation from the elbow to the wrist – "Essentially wherever I compressed or palpated caused a response of pain." There was normal sensation, no atrophy and no provocative peripheral compression neuropathy findings.

There were no sympathetic changes to suggest CRPS. Noting he is only an expert from the elbow to the hand, Dr. Brown did not recommend any further treatment. As to whether the treatment to date had been reasonable, Dr. Brown testified that her symptoms were improved on the left, while the right was "a more complicated picture." She had seen multiple surgeons and had multiple diagnostic tests, with only the initial EMG showing an ulnar neuropathy, and this was resolved on the subsequent EMGs. Dr. Mackinnon made a clinical diagnosis of compression neuropathies and performed surgery, which provided slight improvement. Dr. Brown opined there was no indication for further surgery. (Rx1).

Dr. Brown opined that Petitioner's work activities were an aggravating factor that likely led to the need for left cubital tunnel treatment. In terms of causation, he testified the factors to analyze involve the type of activity, frequency, force and duration of exposure. It is also relevant whether the symptoms resolve when the activities are discontinued. Based on this, in his opinion, as to the right upper extremity, Petitioner's symptoms didn't improve when she stopped working, and progressively worsened to where surgery was recommended and performed. Dr. Brown opined that the surgeries performed by Dr. Mackinnon are not causally related to the Petitioner's work duties. Her right sided symptoms began at or near to the time she last worked for Respondent, when her symptoms were worse on the left, and you would have expected the right symptoms to then have improved if work activities were a factor. Additionally, EMG testing by top expert Dr. Phillips initially showed a right cubital tunnel in 2013, but two subsequent studies were normal. Plus, all testing was normal in the areas Dr. Mackinnon operated on. Two other well qualified surgeons examined Petitioner and did not make the same diagnoses as Dr. Mackinnon. At one of the last visits with Dr. Lang he noted possible carpal tunnel based on positive Tinel's, but there is no corroborating EMG, and that finding alone is insufficient to diagnose carpal tunnel. As of the date he examined Petitioner, Dr. Brown so no reason why Petitioner couldn't work as a lab tester. (Rx1).

On cross-examination, Dr. Brown testified that Dr. Mackinnon has a very good reputation as to compression neuropathies, and that he previously worked as her chief resident. He testified he had no basis to disagree with her diagnoses "because I didn't have the opportunity to examine her at the same time Dr. Mackinnon did." He read both her and Dr. Emanuel's depositions. He has operated for carpal tunnel very few times in his 20-year career on people with negative EMG testing. Clinical CTS with no EMG support is uncommon. Cramping of the fingers, as Petitioner reported, is not consistent with cubital or carpal tunnel. The pronator teres problem Dr. Mackinnon operated on is a very uncommon diagnosis, and a compression of that type would have likely been seen on at least one of the EMG tests. Such a diagnosis can't be confirmed at surgery. A pronator teres diagnosis is seen with severe traumatic injuries, but theoretically you can see it in people with very forearm intensive jobs who have big forearm muscles and are lifting weights a lot. Dr. Brown just doesn't see this diagnosis even in jobs more intensive than Petitioner's. He agreed that in pipetting, you would be contracting some of the applicable muscles. In talking to Petitioner, his impression was that her right-sided symptoms went downhill after she last worked and progressively worsened. He agreed that Petitioner did indicate her right symptoms started near the end of her employment with Respondent. Dr. Mackinnon basically testified that if Petitioner improved, she was right, and if Petitioner's didn't get better, she was wrong. Again, Petitioner reported slight improvement to Brown. (Rx1).

On redirect, Dr. Brown testified that weightlifting could be a factor in a pronator teres problem, but again there are no good studies of its etiology. The right sided symptoms Petitioner complained of as existing at the end of her tenure with Respondent were subjective and were not consistent with pronator teres or carpal tunnel syndrome or a radial sensory neuropathy. There also were no positive exam findings that would point to these conditions. (Rx1).

Respondent submitted a written job description into evidence for a lab tester at its Wood River refinery. It notes frequent lifting and carrying of items (metal baskets with handles of sample bottles, one quart cans, boxes of cylinders) weighing 5 to 18 pounds over distances of 10 to 50 feet, 5 to 15 times daily. Infrequent lifting and carrying of items (waste cans, 4 liter chemical bottles) weighing 40 to 50 pounds for distances of 30 to 50 yards, one to two times per week. Infrequent pushing/pulling with force (tilting and moving gas bottles to racks using a hand truck) of 25 to 60 pounds, 1 to 3 times per week. Frequent reaching above shoulder level to place and remove bottles from research engines, taking glass tubes on and off FIA holding racks, and using a vibrator on silica gel tubes 30 to 50 times per shift. (Rx2). However, this document does not appear to differentiate between the motor, inspection and analytical lab duties.

Petitioner testified that currently "I have zero symptoms" in the left elbow, and her left grip symptoms have "improved a lot."

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, and WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator initially notes that in claims involving repetitive trauma, the issues of accident and causal connection can become significantly intertwined, and they are intertwined in the case at bar.

With regard to the issue of accident, there is really no issue that the Petitioner's allegations would fall within the course of her employment. The issue is whether there has been an accident which arose out of the employment. An analysis of this issue involves a determination of whether the job duties were repetitive or cumulative to the point that they constituted an increased risk of injury. To prevail under a repetitive trauma theory, a claimant must establish that his work duties were sufficiently repetitive in nature, occurrence, and force so as to cause a gradual breakdown of the claimant's physical condition. *Williams v. Industrial Comm'n*, 244 Ill. App. 3d 204, 211, 614 N.E.2d 177, 185 Ill. Dec. 43 (1993). A repetitive trauma claim must still show that the injury is work related and not the result of a normal degenerative aging process. Additionally, repetitive-trauma cases typically require medical opinion evidence to establish a causal connection between the claimant's injury and his employment. *Nunn v. Industrial Comm'n*, 157 Ill. App. 3d 470, 477, 510 N.E.2d 502, 109 Ill. Dec. 634 (1987); *Durand v. Industrial Comm'n*, 224 Ill. 2d 53, 67, 862 N.E.2d 918, 926, 308 Ill. Dec. 715 (2006).

The Arbitrator believes that the job duties, as described by Petitioner, involve activities that were repetitive, at least when working in the analytical lab. The Petitioner testified that she would switch areas she worked in every three to six months, which means she would work in the analytical lab for three to six months at a time. While there did not appear to be tremendous force required in terms of pipetting, for example, she also testified that she would have to use wrenches to loosen and tighten valves on cylinders, and this would appear to involve a reasonable amount of force. Additionally, she would use a vibrating tool, albeit on a limited basis time-wise. Overall, the Arbitrator believes that the work activities in the analytical lab involved activities that would be considered repetitive.

The next question is whether such activities caused the Petitioner's condition. While it is rare for an Arbitrator to deny causation in a case where both a treating and examining physician have opined that there may be a

causal relationship, the Arbitrator finds in this case that the Petitioner has failed to prove her left elbow condition is causally related to her work activities. The reason for this is that both Dr. Emanuel and Dr. Brown provided opinions based on hypothetical facts that were presented to them regarding Petitioner's work activities. However, the vast majority of the activities described were testified to by the Petitioner as involving the use of her *right* hand and arm. This includes wrenches, thumbwheels and other valve openings. This makes sense given that she is right hand dominant. The only thing the Arbitrator notes that the Petitioner testified to involving the left hand and arm were holding cylinders with her left arm in a bent position at the elbow and holding a tube with the left hand while holding a vibrator to it with the right. She did not testify with regard to how often she would have to hold the cylinders with the left hand, and the amount of time she spent holding the tube while it was being vibrated was minimal. The Petitioner also agreed she had a number of side activities, most relevantly including weightlifting, as well as a prior hyperextension injury to the left elbow while performing yoga. The Arbitrator simply does not find evidence in the record which supports the presented hypotheticals with regard to left arm use at work, which necessarily negatively impacts the causation opinions of both Dr. Emanuel and Dr. Brown. Any job description that may have been presented to Dr. Brown, if the same as the one presented into evidence, also does not indicate activities in terms of whether they were performed with the left or right upper extremity. The greater weight of the evidence indicated the Petitioner failed to prove that her left elbow condition is causally related to her employment.

With regard to the right upper extremity, the Arbitrator finds that the greater weight of the evidence supports a causal connection of the conditions treated by Dr. Mackinnon to the Petitioner's repetitive work activities. Petitioner's testimony supports that she used the right hand, as noted, in a repetitive fashion while in the analytical lab. While this was only a portion of her duties, she credibly testified that her right sided symptoms would get better when she left the analytical lab and would worsen again when she would return, with the symptoms not resolving after her last stint in that lab.

Dr. Mackinnon acknowledged that the Petitioner has a congenital problem with tightness in the forearm, and her testimony indicated to the Arbitrator that she therefore is predisposed to such compressive neuropathies in these areas. While Dr. Brown was accurate that the EMG testing by Dr. Phillips did not disclose evidence of the conditions that Dr. Mackinnon operated on in the left forearm and wrist, her operative report certainly confirms that the compressions did in fact exist. The Arbitrator believes this is the best evidence of whether such conditions existed. While Dr. Brown credibly testified that these would be relatively rare conditions, other than the carpal tunnel, the Arbitrator believes the evidence supports that the Petitioner may have been predisposed to these conditions, and that the work activities then became at least a cause of the symptoms that led the Petitioner to seek treatment. It is also relevant to the Arbitrator that, following her surgery with Dr. Mackinnon, the Petitioner testified that she felt significant relief, particularly of numbness, on the right, and that as of the hearing date, "I have zero symptoms."

While these may be somewhat disjointed findings in terms of finding one upper extremity's conditions to be causally related to the work duties, while the opposite upper extremity conditions are not, but this essentially is based on the Petitioner's failure to prove same on the left based on the evidence presented. She simply did not testify to performing any significant or significantly repetitive activities with the left hand and arm, particularly when compared to what she did on the right. It is significant to the Arbitrator that the Petitioner has performed what appears to have been significant weightlifting activities leading up to her reporting of problems to the Respondent, as well as yoga that clearly impacted her arms given the circumstances of her prior injury. It is also significant that she appears to be predisposed to upper extremity compression conditions. The evidence, significantly including the Petitioner's credible testimony, supports it being more likely than not that the work activities were a contributing cause on the right, but not on the left.

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 regard to the medical expenses presented into evidence by Petitioner that are alleged to be the liability of Respondent (see Px9 through Px14), the Arbitrator finds that the treatment related to the right upper extremity is awarded, while the treatment to the left upper extremity is denied. The Respondent is entitled to credit pursuant to Sections 8(a), 8(j) and 8.2 of the Act for any of the awarded expenses previously paid by Respondent, and shall hold the Petitioner harmless with regard to same pursuant to Section 8(j).

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:

Pursuant to Arbx1, the Petitioner seeks TTD benefits from 10/30/13 through the present, 10/25/17. Respondent disputes liability for same.

The Arbitrator finds that the Petitioner is entitled to TTD from 2/18/14 to 3/24/16. This is based on the release from care for the left cubital tunnel by Dr. Emanuel on 2/17/14, and Petitioner's last visit with Dr. Mackinnon on 3/24/16. There is no indication from Dr. Mackinnon that the Petitioner needed to be off work subsequent to 3/24/16 or that she needed any work restrictions. She indicated that she had nothing more to offer Petitioner on a surgical basis at that point. Additionally, the Arbitrator notes that the Petitioner testified that she worked at a place called the I Love Juice Bar for some period of time which was not testified to, though she was unemployed at the time of the hearing.

Respondent is entitled to credit for any prepaid non-occupational disability benefits pursuant to Section 8(j) of the Act.

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

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

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

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No

> single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no AMA permanent partial impairment rating or report was submitted into evidence by either party. As such, this factor carries no weight in the permanency determination.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a quality assurance tester at the time of the accident. She is not currently working in that capacity, but there have been no medical restrictions issued which would prevent the Petitioner from returning to the same or a similar job. It is clear that the job involved consistent use of the upper extremities, which were the subject of this claim. This factor carries some weight in the permanency determination.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 35 years old at the time of the accident. Neither party has presented evidence which supports the impact of the Petitioner's age on any causally related permanent disability condition. This factor also carries no weight in the permanency determination.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no significant evidence was presented on this issue. While the Petitioner no longer works for the Respondent, it is unclear to the Arbitrator based on the evidence presented as to why she no longer works for Respondent. It is equally unclear to the Arbitrator if any permanent condition of the Petitioner has resulted in a loss of future earning capacity. It is accurate to state that she no longer is employed by Respondent in a job which paid her significantly above a minimum wage level. However, there has been no indication that the Petitioner has or requires any medical work restrictions. This factor carries some weight in the permanency determination.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner underwent surgery with Dr. Mackinnon for three separate nerve compression conditions in the right upper extremity: ulnar and radial nerve compressions in the forearm, and median nerve compression in the wrist. She appears to have had an uneventful recovery and was released without restrictions. Petitioner credibly testified that she had a good recovery following these surgeries and that "currently I have zero symptoms."

Based on the above factors, the record taken as a whole and a review of prior Commission awards with similar injuries similar outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of the loss of use of 10% of the right hand and 12.5% of the right arm pursuant to §8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Workers' Compensation Commission,
Insurance Compliance Department,
Petitioner,

Vs.

Case # 12 INC 0067
20 WC 05197

Lucian Micu, Individually and President,
and MLV Construction,
Respondents.

20IWCC0172

DECISION AND OPINION RE: INSURANCE COMPLIANCE

Petitioner, the Illinois Workers' Compensation Commission, Insurance Compliance Department, brings this action, by and through the Office of the Illinois Attorney General, against the above-captioned Respondents alleging violation of Section 4(a) of the Illinois Workers' Compensation Act. Proper and timely notice was provided to Respondents, and they were found in default on December 18, 2019. [Px1]. The matter was continued to February 19, 2020 for a final hearing. [Px1]. Proper and timely notice was again provided to Respondents, and a hearing was held before Commissioner Marc Parker in Chicago, Illinois on February 19, 2020. [Px1]. Respondents failed to appear.

Petitioner alleges that Respondents knowingly and willfully lacked workers' compensation insurance coverage from March 15, 2010 to August 24, 2010, December 22, 2014 to January 19, 2015, April 14, 2015 to January 25, 2017 and July 22, 2017 to the date of the NCCI certification, July 25, 2018, in violation of Section 4(a) of the Illinois Workers' Compensation Act. Petitioner seeks the maximum fine allowed under the Act, $500.00 per day for each of the 1,201 days Respondents did business and failed to provide coverage for its employees, or $600,500.00. In addition, Petitioner seeks reimbursement for the liability incurred by the Injured Workers' Benefit Fund in claim 09 WC 48261 in the amount of $170,812.18. Petitioner seeks a total fine and reimbursement of $771,312.18.

This Commission finds that Respondents, after proper and timely notice, failed to appear at the Compliance Hearing on February 19, 2020. Pursuant to Section 9100.85 of the Commission Rules, Respondents' failure to appear constitutes a default and results in a finding that there has been a knowing and willful failure of Respondents to insure their liability to pay compensation in accordance with Section 4(a) of the Act, or to comply with an Order of the Commission under Section 4(c), and an assessment of penalties under Section 4(d).

20IWCC0172

FINDINGS of FACT AND CONCLUSIONS of LAW

The Commission finds:

1. Petitioner offered the testimony of Antonio Smith, an Investigator for the Insurance Compliance Department of the Illinois Workers' Compensation Commission, as a witness at the compliance hearing on February 19, 2020.

2. Investigator Smith testified that his duties include enforcing the Workers' Compensation Act by ensuring that companies without workers' compensation insurance obtain coverage for their employees or are assessed fines for periods of non-compliance with the law.

3. Investigator Smith served Respondents with Notices of Informal Conference and of Non-Compliance on August 2, 2017 for the periods of non-compliance from March 15, 2010 to August 24, 2010, December 22, 2014 to January 21, 2016, and July 23, 2017 to August 2, 2017 (PX2, PX3).

4. The Insurance Compliance Department made an unsuccessful attempt to negotiate a settlement with Respondents.

5. The Department of Self-Insurance certified that Respondents were not self-insured with the State of Illinois. (PX8).

6. The National Council of Compliance Insurance (NCCI) certified that Respondents did not have workers' compensation insurance for the following periods:
   a. 03/15/10 to 08/24/10 (PX10 para 4);
   b. 12/22/14 to 01/21/16 (PX10 para 5);
   c. 08/26/15 to 01/21/16 (PX10 para 7);
   d. 12/22/14 to 01/21/16 (PX10 para 8); and
   e. 07/23/17 to 07/12/18 (PX10 para 5, 11). (PX10).

7. NCCI certification is prima facie proof that Respondents did not have the required workers' compensation insurance for the above periods, and Respondents offered no evidence of coverage during those periods.

8. The Commission takes judicial notice of the Decision and Opinion on Review in claim number 09 WC 48261 / 17 IWCC 662. (PX6). Therein, the Commission held that Respondents were operating under and subject to the Act (PX6, p. 5); that Respondent had employees (PX6, p. 5); and that Respondent was not insured at the time of Respondent's injured worker, Jan Espino's, injury (PX6, p. 7). Mr. Espino was awarded benefits under the Act. (PX6, p. 5).

9. The Injured Workers' Benefit Fund paid petitioner Juan Espino $170,812.18 toward benefits awarded by the Commission in his injury case. (PX7).

20 IWCC0172

10. The Insurance Compliance Department determined Respondent did not have workers' compensation insurance for a total of 1,201 days.

11. Investigator Smith determined Respondent did have workers' compensation insurance for several periods between periods of non-compliance.

In considering the appropriate penalty, the Commission notes that the total period of non-compliance is 1,201 days, that Respondents saved a significant amount of money by failing to pay workers' compensation insurance premiums, and that Respondents knew that they were required to purchase insurance to protect their employees.

For the foregoing reasons, the Commission finds Respondents knowingly and willfully were in non-compliance with Section 4 of the Act for a period of 1,201 days. At the maximum rate of $500.00 per day of non-compliance, Respondent shall pay a total penalty of $600,500.00, plus reimbursement of the Illinois Workers' Benefit Fund in the amount of $170,812.18, pursuant to Section 4 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondents, Lucian Micu and MLV Construction, pay to the Illinois Workers' Compensation Commission the sum of $777,812.18 pursuant to Section 4(d) of the Act.

Bond for the removal of this case to the Circuit Court by Respondents 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 1 2 2020

Marc Parker

Marc Parker

mp/dak
r-02/19/20
68

Deborah L. Simpson

Deborah L. Simpson

Barbara N. Flores

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

Dawn Snyder,

Petitioner,

vs.

NO: 16 WC 3903

20IWCC0173

Southern Illinois University
Edwardsville,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, permanent partial disability, 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 7, 2018, is hereby affirmed and adopted.

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

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

DATED: MAR 13 2020
DDM:yl
o 3/10/20
52

D. Douglas McCarthy

Kathryn A. Doerries

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SNYDER, DAWN
Employee/Petitioner

Case# **16WC003903**

SOUTHERN ILLINOIS UNIVERSITY-EDWARDSVILLE
Employer/Respondent

20IWCC0173

On 11/7/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICE
DAVID M GALANTI
PO BOX 99
E ALTON, IL 62024

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

6147 ASSISTANT ATTORNEY GENERAL
CORI E STEWART
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

NOV 7 - 2018

Brandon J. Chasco, Acting Secretary
Illinois Workers' Compensation Commission

20 IWCC0173

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Dawn Snyder
Employee/Petitioner

v.

Southern Illinois University- Edwardsville
Employer/Respondent

Case # **16** WC **03903**

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 **Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **September 27, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **1/14/2016**, 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*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**$37,434.80**; the average weekly wage was $**$719.90**.

On the date of accident, Petitioner was **53** 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 $**ANY** under Section 8(j) of the Act.

ORDER

The Petitioner failed to prove she was exposed to a risk of injury to a greater extent than the general public on January 14, 2016, and accordingly, her claim for compensation is denied.

All other issues are 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

11/2/18
Date

Dawn Snyder v. Southern Illinois University- Edwardsville

IWCC No. 16 WC 3903

The Arbitrator finds the following facts:

On January 14, 2016, Petitioner was working for Southern Illinois University- Edwardsville (hereinafter, "SIUE") as a custodian. As she was walking on a paved path between buildings after arriving and clocking into work at 4 A.M., she testified that she saw a skunk. She did not testify that she was hurrying or carrying anything. After seeing the skunk, she ran off the path. She tripped and fell when she was returning to the path.

She stated that she was walking from the Student Success Center, which is open twenty-four hours per day, to the Morris University Center. She said that the path is accessible to the public, not just university employees. Petitioner also said that there are trees by the path and she looks for animals because "there is a lot of wildlife." She stated on cross examination that she has seen also deer, raccoons, foxes, and geese.

Petitioner saw Dr. Mark Eavenson at Multicare Specialists, P.C., on January 21, 2016, for pain, swelling, and bruising of her left knee. Dr Eavenson referred Petitioner for an MRI and to physical therapy. Additionally, left knee x-rays were taken, revealing no fracture.

On January 25, 2016, Dr. Eavenson reviewed the MRI with Petitioner. The MRI revealed: 1) a nondisplaced tear in the free margin of the anterior horn of the lateral meniscus that extends to the meniscal root, 2) no acute ligament injury, 3) slight interval worsening in the area of grade 4 chondrosis that extends to the meniscal root, 4) nonspecific bone marrow edema involving the posterior lateral aspect of the proximal tibial metaphysis though it could be degenerative in etiology adjacent to proximal tibiofibular articulation, 5) nonspecific bone marrow edema involving the mid tibial spine, and 6) a small knee joint effusion popliteal cyst. Dr. Eavenson referred Petitioner to Dr. George Paletta at her next appointment on January 26, 2016.

Petitioner saw Dr. Paletta on February 15, 2016. Dr. Paletta stated that the small lateral meniscus tear did not "correlate with her symptoms at all" and that the patellar bone bruising correlated more strongly with her symptoms. He recommended a knee injection and treatment with a compression sleeve, in addition to the anti-inflammatories and physical therapy which Dr. Eavenson had already prescribed. He did not recommend surgery, explaining that arthroscopy could be considered. He explained to Petitioner that "arthroscopy is very unpredictable for pain related to bone bruising and underlying arthritis."

Petitioner continued to seek treatment from Dr. Eavenson. At a physical therapy appointment on February 24, 2016, she stated she was 95% better. She stated she felt 100% better at her appointment on March 7, 2016. At her final appointment on April 7, 2016, she stated she felt 100%, was able to go up and down stairs without any pain or weakness, and had walked nearly 10,000 steps the day before without any issues.

Petitioner testified at trial that she had not sought physical therapy or medical treatment for her knee since her last appointment and that she took no prescription medication for the knee.

Therefore, the Arbitrator concludes:

1. Petitioner failed to prove her accidental injury arose out of and in the course of her employment. She did not prove that the accident occurred due to an increased risk of injury associated with employment or employment premises, when she fell on a path after seeing a skunk.

2. It is the Petitioner's burden to prove each element of his case in order to recover under the Illinois Workers' Compensation Act. *Shelton v. Indus. Com'n.*, 267 Ill. App. 3d 211, 221, 641 N.E.2d 1216, 1224 (5th Dist. 1994). 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. Com'n.*, 129 Ill.2d 52, 58, 541 N.E.2d 665, 667 (1989). There are three categories of risk an employee may be exposed to: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks which have no particular employment or personal characteristics. *Ill. Institute of Technology Research Institute v. Indus. Com'n*, 314 Ill.App.3d 149, 162 (2000). Neutral risks include dog bites, lightning strikes, street risks, hurricanes, and stray bullets. *Id* at 163. However, "the mere fact that claimant was present at the place of injury because of his employment duties will not by itself suffice to establish that the injury arose out of the employment." *Brady v. Louis Ruffolo & Sons Const. Co.*, 143 Ill.2d 542, 551, 578 N.E.2d 921, 924 (1991). If the accident resulted from a risk that the Petitioner would have been equally exposed to apart from his employment, the injury does not arise out of the employment. *Id.*

   Here, Petitioner was not exposed to a risk of injury greater than that of the general public. Neutral risks have no particular employment or personal characteristics. In order for a neutral risk to be found compensable, the Petitioner must prove that that she was exposed to a risk of injury greater than that of the general public. In this case, Petitioner fails to do so. Petitioner saw a skunk and chose to run from it, the skunk did not attack her. Petitioner testified that she was on a public pathway and walking to a building open to the public twenty-four hours per day. She testified that she often saw animals on the tree-lined path. Therefore, Petitioner was not at a greater risk to encounter a skunk. Petitioner testified that she was running to get away from the skunk, which is not "in the course of" her employment. This is clearly a positional risk doctrine case and the State of Illinois has refused to adopt the positional risk doctrine. *Brady v. Louis Ruffolo & Sons Const. Co.*, 143 Ill.2d 542, 578 N.E.2d 921 (1991).

Petitioner testified at trial that she had not sought physical therapy or medical treatment for her knee since her last appointment and that she took no prescription medication for the knee.

Therefore, the Arbitrator concludes:

1. Petitioner failed to prove her accidental injury arose out of and in the course of her employment. She did not prove that the accident occurred due to an increased risk of injury associated with employment or employment premises, when she fell on a path after seeing a skunk.

2. It is the Petitioner's burden to prove each element of his case in order to recover under the Illinois Workers' Compensation Act. *Shelton v. Indus. Com'n.*, 267 Ill. App. 3d 211, 221, 641 N.E.2d 1216, 1224 (5th Dist. 1994). 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. Com'n.*, 129 Ill.2d 52, 58, 541 N.E.2d 665, 667 (1989). There are three categories of risk an employee may be exposed to: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks which have no particular employment or personal characteristics. *Ill. Institute of Technology Research Institute v. Indus. Com'n*, 314 Ill.App.3d 149, 162 (2000). Neutral risks include dog bites, lightning strikes, street risks, hurricanes, and stray bullets. *Id* at 163. However, "the mere fact that claimant was present at the place of injury because of his employment duties will not by itself suffice to establish that the injury arose out of the employment." *Brady v. Louis Ruffolo & Sons Const. Co.*, 143 Ill.2d 542, 551, 578 N.E.2d 921, 924 (1991). If the accident resulted from a risk that the Petitioner would have been equally exposed to apart from his employment, the injury does not arise out of the employment. *Id.*

   Here, Petitioner was not exposed to a risk of injury greater than that of the general public. Neutral risks have no particular employment or personal characteristics. In order for a neutral risk to be found compensable, the Petitioner must prove that that she was exposed to a risk of injury greater than that of the general public. In this case, Petitioner fails to do so. Petitioner saw a skunk and chose to run from it, the skunk did not attack her. Petitioner testified that she was on a public pathway and walking to a building open to the public twenty-four hours per day. She testified that she often saw animals on the tree-lined path. Therefore, Petitioner was not at a greater risk to encounter a skunk. Petitioner testified that she was running to get away from the skunk, which is not "in the course of" her employment. This is clearly a positional risk doctrine case and the State of Illinois has refused to adopt the positional risk doctrine. *Brady v. Louis Ruffolo & Sons Const. Co.*, 143 Ill.2d 542, 578 N.E.2d 921 (1991).

3. Therefore, Petitioner's claim is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Bodine,

Petitioner,

vs.

NO: 17 WC 21301

20IWCC0174

Innovative Staff Solutions,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 28, 2019, 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.

20IWCC0174

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 13 2020
DDM:yl
o 3/10/20
52

D. Douglas McCarthy

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BODINE, MICHAEL
Employee/Petitioner

Case# **17WC021301**

INNOVATIVE STAFF SOLUTIONS
Employer/Respondent

20IWCC0174

On 2/28/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
RICHARD K JOHNSON
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0522 THOMAS MAMER & HAUGHEY LLP
BRUCE E WARREN
30 E MAIN ST SUITE 500
CHAMPAIGN, IL 61820

20 IWCC0174

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MICHAEL BODINE
Employee/Petitioner

v.

INNOVATIVE STAFF SOLUTIONS
Employer/Respondent

Case # **17** WC **21301**

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 **Urbana**, on **October 24, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 23, 2017**, Respondent ***was*** operating under and subject 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 **$9,219.25**; the average weekly wage was **$658.52**.

On the date of accident, Petitioner was **36** 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 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, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent on June 23, 2107. Petitioner's current condition of ill-being is causally related to his work accident. He reached maximum medical improvement on January 16, 2018, that being the last date of medical treatment.

Respondent shall pay reasonable and necessary medical services as reflected in Petitioner's Exhibit 6 that remain unpaid. Specifically, Respondent shall pay **$78,327.35** in consideration of bills itemized in the Arbitration Decision, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. To the extent that Respondent has made payments on said bills, credit shall be given for same.

Respondent shall pay Petitioner temporary total disability benefits of **$439.01/week for 12 weeks**, for the period of **June 26, 2017, through September 17, 2017**.

Respondent shall pay Petitioner the sum of **$395.11/week** for a further period of **32.25 weeks**, as provided in **Section 8(e)** of the Act, because the injuries sustained caused a **15% loss of use of the left leg**; and a further period of **15 weeks**, as provided in **Section 8(d)2** of the Act, because the injuries sustained caused a **3% loss of use of the body as a whole**. Respondent shall pay a total of **47.25 weeks, totaling $18,668.95**.

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

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

Signature of Arbitrator

February 27, 2019
Date

FEB 28 2019

STATE OF ILLINOIS)
) SS
COUNTY OF CHAMPAIGN)

20IWCC0174

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MICHAEL BODINE
Employee/Petitioner

v. Case #: **17 WC 21301**

INNOVATIVE STAFF SOLUTIONS
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Trial Testimony

On June 23, 2017, Petitioner was 36 years old, single, and had two dependent children. He was employed by Respondent, a provider of loaned employees to light industry. He testified that he was assigned to CHI Overhead Doors as an assembler and had been so assigned since April 20, 2017. His job duties required him to walk up and down an assembly line, pull parts, and put garage door panels together on an assembly line belt. He handled 50 to 60 panels per day. He was also required to look at an instruction sheet posted on the wall behind the assembly line, to make sure the panels were being assembled per the specifications for that particular job. He estimated that he checked the list 70 to 80 times a day. He testified that he wore tennis shoes while working and walked on a rubber mat, which was laid on the concrete floor. He worked ten to twelve hours a day and testified that he was on his feet 95% of the day. The Arbitrator notes that Petitioner's testimony is consistent with Respondent's Job Analysis for the position of Assembly/General Labor/Warehouse, Petitioner's Exhibit 7.

Respondent produced seven video clips, which showed a worker demonstrating portions of Petitioner's job duties, including one clip showing the working turning away from the assembly line to check the instructions on a clip board handing on the wall behind him. The video clips were viewed by all parties and the Arbitrator during the hearing. RX3. Petitioner testified that the clips accurately showed the work performed, but did not show the complete job or the actual speed at which he worked. He further noted there was some additional walking in the job to retrieve the parts.

Petitioner testified that on Friday, June 23, 2017, he was performing his normal job duties on the line. At one point he turned away from the assembly line to check the instructions on the clip board hanging on the wall behind him. He testified that as he twisted to look, his body twisted but not his feet, and he twisted his left knee in the process. He was not carrying any tools

or heavy objects at the time, nor was there any defect in the floor or the premises. Petitioner testified that he advised his co-worker of the accident, who then advised their supervisor, and he went to the onsite nurse. Over the weekend he had pain and swelling in his knee. When he returned to work on Monday, he completed an Employee Accident Report. He reviewed Respondent's Exhibit 1, which was a two-page document. He identified page one as the Employee Accident Report that he completed on Monday, June 26, 2017, which was consistent with his testimony as to how the accident occurred. He testified, however, that he had never seen page two, Manager's Assessment of Investigation, and did not know who completed it. RX2.

Petitioner testified that he came under the care of Dr. Newcomer, who performed left knee surgery on July 27, 2017. When he followed up on August 14, 2017, he was sent to the emergency room for a Doppler study, due to swelling in his leg. He remained in the hospital for two days for treatment of a post-operative blood clot. He was eventually released to return to work on September 18, 2017, but did not return to CHI Overhead Doors.

Petitioner testified that he currently experiences pain three to four times a week, has knee swelling two to three times a week, and has permanent swelling in his calf due to the blood clot. He takes Tylenol or Ibuprofen, props his leg up, and ices the knee when he has symptoms. It is harder for him to move around sometimes, and he frequently notices pain in the morning.

Respondent called Debra Hendron as a witness. She is the Risk Manager at Innovative Staff Solutions. She reviewed Respondent's Exhibit 1 and identified page one as the Employee Accident Report completed by Petitioner on June 26, 2017. She identified page two as the Manager's Assessment of Investigation, completed by Candace Pierce. Under the comments section, Ms. Pierce stated, "Employee was discussing medical history. Stated his mother had issues and now he has issues with his knee and it is starting to go downhill. I asked Mike if he did think this was work related, because earlier he understood it was personal. He said the doctor said this was work related." In response to the question of whether the incident fit the type of injury being claimed, Ms. Pierce stated, "Yes, but personal issues as well." RX1.

Respondent called Lindsey Teal as a witness. She is the Environmental Health and Safety Manager at CHI Overhead Doors. She testified that Petitioner reported that he had turned around to read the list, his foot stayed put, and his knee popped. On cross-examination, Ms. Teal conceded that she was not aware that Petitioner had gone to the onsite nurse. She clarified that there was no onsite nurse, but was an onsite EMT. She reviewed Respondent's Exhibit 2 and acknowledged that, as shown on the Supervisor's Report/Part C, she advised Petitioner to "move feet in the direction they are going and not to twist" in order to prevent reoccurrence. RX2.

Medical Records

Following the accident, Petitioner presented to Sarah Bush Lincoln Health Center on Monday, June 26, 2017, and was evaluated by Advanced Practice Nurse Dina Swanson. He reported that the previous Friday he was working on the assembly line at work, twisted to his left to see the list he needed to look at, and felt a pop in the left knee. He was advised at that time to go home and ice it, but stated he did not have much relief with doing that. He rated is pain at 7/10. He admitted to a history of arthritis in the knee but denied any previous injury. On examination, there was tenderness and swelling noted to the medial aspect of the left patella, as

well as tenderness in the patella itself. Valgus/varus testing and McMurray testing were negative. There was full active and passive range of motion, but with pain. PX1.

Left knee x-rays showed tricompartmental degenerative changes with moderate medial compartment narrowing (osteoarthritis), with no fracture. Assessment was left knee pain. Petitioner was instructed to rest, ice, and compress and elevate the left leg. He was to take ibuprofen as needed for the pain and swelling and follow up if pain continued. PX1.

APN Swanson noted that Petitioner reported he had been advised by his job not to file worker's comp, as they did not think it was work-related. She personally spoke to Deb Hendricks in risk management, who advised that Petitioner gave them a different story and they did not believe it was a worker's comp issue. Ms. Swanson noted, "After hearing the story that he had given me they are willing to investigate the situation...." PX1.

On June 30, 2017, Petitioner presented to OSF and was evaluated by APN Jessica Sullivan. He reported that he worked on an assembly line, was at work on June 23 and turned to look at something, and when his body twisted his foot stayed planted. He heard a pop in his left knee and felt immediate pain that radiated up and down the leg. He limped to the office, iced the knee for about 20 minutes, but was still unable to bear weight. He iced and elevated his knee over the weekend. He returned to work on Monday June 26, but could not stand for long and sought medical attention. He further reported that he was told by his employer that it was not work comp, that they could not offer any type of accommodation for that reason, and that he would need to resign if he could not return to work. He complained of continued pain of 7/10 on the medial aspect of his left knee, made worse with standing and walking. He did not feel he was able to return to work due to the pain and was worried he would do more damage. PX2.

On examination, APN Sullivan noted pain to palpation in the medial aspect of the anterior left knee, increased pain with anterior drawer and valgus stress, and decreased range of motion due to pain. There was no swelling. She ordered an MRI and instructed Petitioner to rest and elevate the knee as much as possible, apply ice several times a day, and wear a compression brace or ACE bandage. PX2.

On July 7, 2017, Petitioner underwent a left knee MRI at OSF. It revealed (1) a small oblique tear of the posterior horn of the medial meniscus; (2) patellar tendinitis versus partial proximal patellar tendon tear; and (3) chondromalacia of the patella. PX2.

On July 17, 2017, Petitioner presented to orthopedic surgeon Dr. Joseph Newcomer for a consultation. He reported that on June 23 he was working on an assembly line, went to turn around, pivoted on his left leg, and felt a pop. He had immediate pain, was unable to bear weight, and had swelling. He denied any prior left knee injuries, but did note a previous tibia spiral fracture when he was 10 years old, which healed without sequelae. Dr. Newcomer reviewed the MRI and noted an oblique tear in the medial meniscus. He also noted fairly significant edema in the bone at the patellofemoral joint on the trochlear side of the lateral facet, as well as the lateral facet of the patella, showing significant chondromalacia, which he opined predated the work injury. He further opined that the meniscus tear was probably a direct result of the pivoting mechanisms of the work injury, as Petitioner denied ever treating for a left knee condition and stated he was fine up until that point. Examination of the left knee revealed point tenderness to palpation along the medial joint, positive McMurrays test, and stable varus/valgus

stress and anterior-posterior drawer testing. Dr. Newcomer recommended surgery to address the meniscus tear and noted that Petitioner could do sit down work only in the interim. PX2.

On July 27, 2017, Petitioner underwent surgery on his left knee by Dr. Newcomer. The procedures were arthroscopic partial medial meniscectomy and abrasion chondroplasty of the trochlea. Postoperative diagnoses were anterior horn medial meniscus tear and significant chondromalacia of the trochlea. PX3.

On August 15, 2017, Petitioner returned to Dr. Newcomer and reported he had been having calf cramping and tightness which had moved into the hamstring. He noted he "overdid it" during a darts tournament over the weekend. On examination, there was no knee effusion, but there was some calf swelling and tightness and discomfort in the hamstring. Dr. Newcomer ordered a duplex scan to rule out DVT, instructed Petitioner to take baby aspirin, and referred him to physical therapy for stretching, conditioning, and pain reduction modalities. PX2.

On August 15, 2017, Petitioner presented to St. Joseph Medical Center emergency department, at the request of Dr. Newcomer. He reported that he had a knee procedure several weeks prior and had since developed pain and swelling. Examination showed tenderness and swelling to the left upper leg. Ultrasound of the left lower extremity showed extensive deep venous thrombosis, extending from the left common femoral to the popliteal vein and possibly into the calf veins. CT scan of the chest, abdomen, and pelvis showed pulmonary emboli and a thrombus within the left femoral and profunda femoris veins with surrounding inflammatory reaction. Impression was acute femoral DVT and pulmonary embolus. Petitioner was admitted into the hospital and underwent surgical placement of a removable IVC filter. He was placed on therapeutic enoxaparin and warfarin. Petitioner remained inpatient until August 17, 2017, at which time he was discharged. PX4.

On September 18, 2017, Petitioner returned to Dr. Newcomer for follow up of knee arthroscopy and postoperative complication of a DVT and pulmonary emboli that was treated intraoperatively. It was noted he was on Warfarin and was not complaining of any problems with his left knee. On examination, there was no knee effusion, ligaments were stable, there was functional range of motion, and the foot and toes were neurologically intact. Dr. Newcomer opined that, with regard to the knee, Petitioner was doing well enough to return to work. He noted, however, that Petitioner's cardiologist needed to clear him to work around steel and glass, since he was on an anticoagulant. PX2.

On January 16, 2018, Petitioner returned to APN Sullivan for recheck of left leg swelling due to left leg DVT in August following knee surgery. He reported swelling that extended from the left knee to the ankle and large varicose veins in the left calf since developing the DVT. On examination, there was generalized, non-pitting edema in the left lower leg from the knee to the ankle, along with a large, non-thrombosed and non-tender varicose vein on the medial aspect of the calf. There was no tenderness, increased warmth, or erythema in the leg. APN Sullivan advised Petitioner that it was hard to say if the swelling would be permanent or not, but that it "certainly could" develop into a chronic problem due to possible damage and injury to the valves in the lower leg from the DVT. He was advised to follow up with Dr. Vanle on the swelling and varicose veins. PX2, PX5. The Arbitrator notes that records from Dr. Vanle were not proffered.

Prior medical records from OSF Medical Group-Bloomington Family Medicine were admitted into evidence. They contained various treatment records from 2015, none of which referenced any complaints or treatment referable to the left leg or knee. PX5.

CONCLUSIONS OF LAW

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

In support of the Arbitrator's decision relating to issue (C), whether an accident occurred which arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

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

The "in the course of employment" element refers to the time, place, and circumstances surrounding the injury; that is to say, for an injury to be compensable, it generally must occur within the time and space boundaries of the employment. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 203 (2003). It is undisputed that Petitioner was at his designated work station during his shift when his injury occurred. As such, he was in the course of his employment.

The "arising out of" component is primarily concerned with causal connection and is satisfied when the claimant has shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. *Sisbro, Inc.* at 193. To determine whether a claimant's injury arose out of his employment, we must first determine the type of risk to which he was exposed. *Baldwin v. Illinois Workers' Compensation Comm'n*, 409 Ill.App.3d 472, 478 (2011). There are three categories of risk to which an employee may be exposed: (1) risks that are distinctly associated with one's employment; (2) risks that are personal to the employee, such as idiopathic falls; and (3) neutral risks that have no particular employment or personal characteristics, such as those to which the general public is commonly exposed. *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2013 IL App (4th) 120219WC, ¶27.

The first step in analyzing risk is to determine whether the claimant's injuries resulted from an employment-related risk. *Steak and Shake v. Illinois Workers' Compensation Comm'n*, 2016 IL App (3d) 150500WC, ¶38. Risks are distinctly associated with employment when, at the time of injury, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. *Caterpillar Tractor Co.* at 58. When a claimant is injured due to an employment-related risk, it is unnecessary to perform a neutral risk analysis to determine whether the claimant was exposed to a risk of injury to a greater degree than the general public. *Young v. Illinois Workers' Compensation Comm'n*, 204 IL App (4th) 130392WC, ¶23.

In this case, Petitioner was an assembler on a line at CHI Overhead Doors, upon assignment by Respondent. His unrebutted testimony established that his job was to walk up and down an assembly line, pull parts, and put garage door panels together on an assembly line belt. He handled 50 to 60 panels per day. He was also required to look at an instruction sheet posted on the wall behind the assembly line, to make sure the panels were being assembled per the specifications for that particular job. He estimated that he checked the list 70 to 80 times a day. He testified that he wore tennis shoes while working and walked on a rubber mat, which was laid on the concrete floor. His injury occurred when he was performing his normal job duties on the line. He turned away from the assembly line to check the instructions on the clip board hanging on the wall behind him. As he twisted to look, his body twisted but his feet remained stationary on the rubber mat, causing his left knee to twist in the process.

The Arbitrator finds that Petitioner's injury resulted from a risk distinctly associated with his employment and, thus, that he sustained an accidental injury arising out of and in the course of his employment on June 23, 2017.

In support of the Arbitrator's decision relating to issue (F), whether Petitioner's current condition is causally related to the injury, the Arbitrator finds the following:

A claimant has the burden of proving by a preponderance of the credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. *Parro v. Industrial Comm'n*, 260 Ill.Ap.3d 551, 553 (1st Dist. 1994).

In light of the Arbitrator's findings above with respect to issue (C), the Arbitrator finds that Petitioner's current condition of ill-being is causally related to his work accident of June 23, 2017. In so concluding, the Arbitrator finds significant that the record is consistent throughout with regard to Petitioner's complaints of injury, which began immediately after the accident. Further, the record is void of any indication that he had any prior injuries or treatment to his left knee. Finally, Petitioner's treating physician, Dr. Newcomer, opined that his condition was related to the accident at work and his opinion went unrebutted. The Arbitrator specifically finds, as well, that Petitioner's post-operative DVT and pulmonary emboli are causally related to his work accident, in that these conditions occurred as a result of his left knee surgery.

The Arbitrator further finds that Petitioner reached maximum medical improvement on January 16, 2018, that being the last date of medical treatment, according to the record.

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

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury. *Absolute Cleaning/SVMBL v. Illinois Workers' Compensation Comm'n*409 Ill.App.3d 463, 470 (4th Dist. 2011).

In light of the Arbitrator's findings with respect to issues (C) and (F), the Arbitrator finds that medical services rendered to date were reasonable and necessary in Petitioner's care and treatment relative to his accident of June 23, 2017. The Arbitrator finds that Respondent is liable for outstanding medical bills as set forth in Petitioner's Exhibit 6, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act, and subject to prior payments.

1.	Bloomington Radiology, 8/15/17	$ 97.00
2.	McLean County Anesthesia, 7/27/17	$ 920.00
3.	McLean County Orthopedics, 7/27/17	$10,248.00
4.	OSF Healthcare, 6/30/17-10/14/17	$65,711.35
5.	Sarah Bush Lincoln, 6/26/17-10/18/17	$ 1,351.00
	TOTAL	**$78,327.35**

In support of the Arbitrator's decision relating to issue (K), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

In order to be eligible for temporary total disability benefits, a claimant must prove not only that he did not work, but also that he was unable to work. *City of Granite City v. Industrial Comm'n*, 279 Ill.App.3d 1087, 1090 (5th Dist. 1996). The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, i.e., until the condition has stabilized. *Gallantine v. Industrial Comm'n*, 201 Ill.App.3d 880, 887 (2nd Dist. 1990).

Petitioner claims entitlement to temporary total disability benefits from June 26, 2017, through September 17, 2017. Respondent does not dispute the time period alleged, only liability for benefits related thereto.

In light of the Arbitrator's findings as to issues (C) and (F), the Arbitrator finds that Petitioner was temporary and totally disabled from June 26, 2017, through September 17, 2017, a period of 12 weeks.

The parties stipulated that Petitioner's average weekly wage was $658.52. The Arbitrator finds that his temporary total disability rate is $439.01. The Arbitrator finds that Respondent is liable for temporary total disability benefits of $5,268.12.

In support of the Arbitrator's decision relating to issue (L), the nature and extent of Petitioner's injury, the Arbitrator finds the following:

With regard to the nature and extent of disability, for accidents occurring on or after September 1, 20111, pursuant to Section 8.1b of the Act, in determining the level of permanent partial disability the Arbitrator must look at the following five factors:

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

In regard to factor **(ii) the occupation of the injured employee**, the record reveals Petitioner was employed by a temporary staffing company assigned to work as an assembler at

the time of the accident and was released to return to work without restrictions. The Arbitrator places significant weight on this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 36 years old at the time of the accident and can be expected to work for 30 or so more years. Over the coming years his condition could improve, stay the same, or get worse. There is some indication in the record that the swelling in his leg could develop into a chronic problem due to possible damage and injury to the valves in the lower leg from the post-operative DVT. However, Petitioner presented no further medical evidence with regard to same. There was no evidence to indicate with any degree of likelihood how Petitioner's age would impact his disability. The Arbitrator places some weight on this factor.

In regard to factor **(iv) the employee's future earning capacity**, there was no evidence that Petitioner's future earning capacity has been or will be impacted as a result of this injury. As such, the Arbitrator places no weight on this factor.

In regard to factor **(v) evidence of disability corroborated by treating medical records**, the Arbitrator notes that Petitioner underwent surgery to his left knee, consisting of arthroscopic partial medial meniscectomy and abrasion chondroplasty of the trochlea. Postoperative diagnoses were anterior horn medial meniscus tear and significant chondromalacia of the trochlea. Petitioner subsequently developed acute femoral DVT and pulmonary embolus as a result of the knee surgery, was admitted into the hospital, and underwent surgical placement of a removable IVC filter.

The Arbitrator notes that Petitioner's subjective complaints are well-documented in his medical records throughout his treatment. He credibly testified that he currently experiences pain three to four times a week, has knee swelling two to three times a week, and has permanent swelling in his calf due to the blood clot. He takes Tylenol or Ibuprofen, props his leg up, and ices the knee when he has symptoms. It is harder for him to move around sometimes, and he frequently notices pain in the morning. The Arbitrator places significant weight on the fact that Petitioner's complaints are supported by the treating medical records.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration, and based on the record in its entirety, the Arbitrator finds that as a result of his accident of June 23, 2017, Petitioner sustained a 15% loss of use of the left leg (32.25 weeks), pursuant to Section 8(e) of the Act. The Arbitrator further finds that as a result of the post-operative DVT and pulmonary embolism, Petitioner sustained a 3% loss of use of the person as a whole (15 weeks) pursuant to Section 8(d)2 of the Act. The parties stipulated that Petitioner's average weekly wage was $658.52. The Arbitrator finds his permanent partial disability rate is $395.11.

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 Choose direction	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TIMOTHY R. SCOTT,

Petitioner,

vs.

NO: 18 WC 023223

UNITED CONTRACTORS MIDWEST, INC.,

20IWCC0175

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 4, 2019, 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.

20IWCC0175

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 $16,200.00. 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 13 2020
KAD/bsd
O031020
42

Kathryn A. Doerries

Maria E. Portela

Douglas McCarthy

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

SCOTT, TIMOTHY
Employee/Petitioner

Case# **18WC023223**

UNITED CONTRACTOS MIDWEST INC
Employer/Respondent

20IWCC0175

On 9/4/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.82% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1189 WOLTER BEEMAN LYNCH ET AL
FRANCIS J LYNCH
1001 S 6TH ST
SPRINGFIELD, IL 62703

1337 KNELL LAW LLC
CHARLES D KNELL
504 FAYETTE ST
PEORIA, IL 61603

20 IWCC0175

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

TIMOTHY SCOTT,
Employee/Petitioner

v.

UNITED CONTRACTORS MIDWEST, INC.,
Employer/Respondent

Case # **18** WC **23223**

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 **Springfield**, on **7/30/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **6/30/18**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**87,879.48**; the average weekly wage was $**1,689.99**.

On the date of accident, Petitioner was **42** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**47,319.72** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**47,319.72**.

Respondent is entitled to a credit of $**00.00** under Section 8(j) of the Act.

ORDER

The Respondent shall pay Petitioner temporary total disability benefits of $1,126.60/week for 56-2/7 weeks, commencing 6/30/18 through 7/30/19, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $47,319.72 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services from 6/30/18 through 7/30/19, including Dr. Leutz's treatment of petitioner's right ankle, 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 all reasonable and necessary medical expenses pursuant to Sections 8(a) and 8.2 of the Act, for the right ankle scope, debridement, multiple drilling, possible excision of the talus OCD, and possible modified Brownstrum reconstruction recommended by Dr. Leutz.

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

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

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

Signature of Arbitrator

8/27/19
Date

ICArbDec19(b)

SEP 4 - 2019

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 42 year old machine operator, sustained an accidental injury that arose out of and in the course of his employment by respondent on 6/30/18 when he received a severe electrical shock from an overhead wire, while his hand was on the auger switch of the paver skeed he was operating. Petitioner has worked for respondent for over 20 years. During the 7 years prior to the injury petitioner ran the paver with Moyer and Longfellow. He also operated trackhoes, backhoes, brooms, or whatever equipment he was asked to run. He testified that all these machines require the use of his feet for foot pedals, and climbing on and off the machines. He further testified that the machines had either joy sticks or wheels to operate.

While working the paver, petitioner operated the skeed, or back of the paver. He testified that his job involved leveling the pavement by operating the auger, which feeds the paving material. To run the auger he would stand nearby, unless it was on automatic.

On 6/30/18 he was walking at the back of the paver, on the right side along the shoulder, feeding the material into the paver with his left fingers on the auger toggle switch. The paver pushes the dump truck in front of it. The dump truck loads the paver with paving material. As they were doing this, they came up to power lines that were across the road and stopped. They were going to wait for a flow boy truck that did not need to lift the bed of the truck to load the paver, like the dump truck did. When the flow boy did not arrive, they attached the dump truck back on the paver with the dump truck raised and proceeded. This caused an arc off the power line, and the last thing petitioner remembered was trying to scream. Petitioner felt like something hit him. He testified that that is all he remembers until he was laying in the ditch, which he said was steep.

Petitioner testified that the ambulance had to drive down into the ditch and load him into the ambulance. He testified that he remembered asking the ambulance driver if the ambulance was going to tip over. He testified that he knew he was in a ditch because the EMTs were holding the bed so it would not slide. He testified that the EMTs told him they drove into a ditch to get him.

Petitioner testified that the first thing he remembered was looking at his left hand that was holding the auger switch and it was blistered. He also testified that his right foot had something wrong with it, and when the EMT removed his boot from his right foot, he saw 3 burn spots in his foot.

On cross examination petitioner testified that his body, after the injury, landed near the shoulder of the road. However, he also testified that he recalled waking up in the ditch, and testified that he did not know where he landed in relation to the shoulder and the ditch. He testified that he remembered nothing

from the time he received the severe electrical shock until he was on the ground, other than screaming and turning the opposite way following the shock. He did not recall shaking and being curled up in the fetal position on the ground. Petitioner testified that Moyer and Longfellow could not see him fall, based on where they were working.

On 5/3/19 petitioner presented to respondent's office. While there he ran into Eric Roegge, Regional Manager for respondent, who oversees the asphalt crews. Roegge has known petitioner for a long time, and is familiar with him as an employee. He testified that petitioner, Moyer, and Longfellow all work together with him on various crews that do asphalt work. Roegge schedules the asphalt crews and was familiar with the accident on 6/30/18. Roegge testified that at some point petitioner had undergone a Section 12 examination, conducted at respondent's request, and has been released to return to work. Roegge was interested to see if petitioner could return to work.

On 5/3/19 Roegge saw petitioner in respondent's office and took him to visit the paving crew. He testified that there was no prearranged meeting. Roegge testified that he discussed with petitioner that when he was ready, and felt like it, he could work in the asphalt plant. Roegge offered petitioner a job as an operator at the same pay. He testified that the job would be operating an endloader, bulldozer or excavator. He further testified that petitioner would be required to use his upper extremities, lower extremities, and feet to operate the machinery. Roegee told petitioner that there was work available and he could come out and try it. Roegge told the petitioner to call him when he was ready to give it a try. However, petitioner never called him, nor did he ever come and try the work that was available since 5/3/19. Roegge testified that he was willing to work with petitioner if he had any problems.

On cross examination Roegge testified that petitioner is familiar with the machines that were available for him to operate, and knows what it takes to safely operate the machines and could judge whether or not he could safely operate the machines. Roegge testified that he never contacted Dr. Leutz about what jobs petitioner was able to perform. Roegge testified that he would not expect petitioner to return to work without a release from his doctor, and would not let him return to work without a doctor release. Roegge was not aware that Dr. Leutz had petitioner off work until further notice pending surgery. He testified that if he was aware of this there would be no job offer open to petitioner if Risk Management determined this. Roegge never talked to Risk Management about Dr. Leutz's restrictions. Roegge testified that he does not have a desk job available for petitioner. Roegge was aware that Dr. Holmes, respondent's Section 12 examiner had placed him at MMI, but was unaware of Dr. Leutz's restrictions.

Petitioner testified that when Roegge took him to the asphalt plant he did not offer him any sedentary work or desk work. Petitioner testified that an endloader is very tall and has tires taller than he is. He testified that there are 5-6 steps that he would have to climb to get to the cab. He testified that this machine operates with a steering wheel, and foot and brake pedal. He testified that this was the only job he talked about with Roegge. He stated that he has run this machine before and it required pressure to operate the gas and foot pedals, not the same as operating the gas and brake pedals in a car. Petitioner testified that in March of 2019 Dr. Leutz did not give him sedentary work only restrictions. He stated that he was given restrictions that allowed him to do any work that did not require use of his right foot. Petitioner testified that he also discussed operating an endloader with Dr. Leutz and he did not give him permission to operate this equipment. Petitioner testified that Roegee offered him an ability to return to work when he was able, and that he should call when he felt he was ready to return to work, doing what he felt he could do. He also testified that Roegge told him that the asphalt plant job was available if he did not feel he could return to paving.

David Moyer, asphalt boss for respondent, was called as a witness for petitioner. He had worked for respondent for 22 years, and with petitioner for 7 years. Moyer is petitioner's supervisor. He testified that prior to 6/30/18 petitioner had no difficulty doing his job tasks. He also noted no problems with petitioner's right leg. He testified that petitioner was able to perform all tasks he was assigned. He had no complaints with respect to petitioner. He testified that petitioner could walk, lift and carry. Moyer was on the left side of the paver and petitioner was on the right side of the paver. Moyer was towards the front of the paver looking in the hopper when he heard petitioner scream. When he returned to the rear of the paver he saw petitioner curled up and shaking, similar to convulsing.

Moyer stated that petitioner's job was to walk along the back of the paver. There was toggle switch that was used to distribute material. There was also an auger that controlled the rate of the material being distributed. Moyer testified that just prior to the injury the crew noted over head power lines ahead on the road. When the paver attempted to go under the power lines the machine arched off the power line while petitioner had his finger on the toggle switch and the electrical current went through his finger and out his right foot. Petitioner's finger and right foot were burned. He saw the EMT's working on petitioner. After they pulled off petitioner's boot on his right foot he saw that the sock on petitioner's right foot had 3 burn holes.

On cross examination Moyer testified that he was at the front of the paver when the injury occurred and he could not see petitioner. He did not see petitioner fall. After petitioner fell, Moyer saw him on the grassy shoulder area of the road, 4-5 feet from the paver. Moyer testified that the shoulder sloped

about 4%. He noted that when petitioner fell he was not lying in the ditch, he was on the shoulder of the road. Since he did not see petitioner fall, Moyer did not know if petitioner twisted his ankle.

Moyer was present when Eric Rogee brought petitioner to the job site. He did not talk to either at the job site. He testified that petitioner did not contact him about wanting to come back to work.

Moyer's wife owns Stagecoach Bar and Grill, and on 6/15/19 his wife and the bartender organized a fundraiser there for petitioner. Moyer was presented. Petitioner was also present and Moyer noted that petitioner had a cane and was drinking.

Moyer testified that petitioner would operate back hoes, bobcats, and pavers prior to the injury. He noted that the operator uses foot and hand pedals to operate this equipment. To operate the paver, petitioner would walk behind the paver. Since the injury Moyer has only seen petitioner on the date of injury, at the job site on 5/3/19, and at the fundraiser on 6/15/19.

Josh Longfellow, operator engineer for respondent, was called as a witness by petitioner. Longfellow has worked for respondent for 30 years, and with petitioner for 20 years. Longfellow runs heavy equipment, and on the date of injury was running the paver. He also operated bobcats and back hoes at other times, and operated the equipment with hand controls and foot pedals. He testified that some equipment has wheels, and other equipment has levers. He stated that all have gas pedals and/or hydraulic pedals to operate.

He testified that the petitioner was operating the skeed, or bottom half of the paver, on the date of injury. Longfellow testified that he saw no problems with petitioner's legs prior to the injury, but noticed that petitioner has a limp now.

Longfellow testified that on 6/30/18 he was paving and was stopped at an overhead wire. As the truck dumping the asphalt into the paver machine was raised to dump the asphalt into the paver, he saw the arc, and stopped the paver. He turned around and saw petitioner face down on the grass and ran to him. He testified that petitioner was in the grass 1-2 feet from the back of the paver. He stated that petitioner did not fall into the ditch. He testified that petitioner was face down in a direction opposite to the paving direction on the level portion of the shoulder. Longfellow did not see petitioner fall. He does not know if petitioner twisted his ankle when he fell.

He testified that when petitioner was working his right foot was to the right of the machine. When he saw petitioner on the ground his right foot was closest to the pavement.

Longfellow testified that Jimmy Frances, a laborer, ran to the petitioner at the back of the paver and saw him convulsing and balled up with his fists clenched, and his knees and feet up. He testified that petitioner appeared unconscious on his face with his hands at his side. He testified that Frances tried to roll petitioner over and put him on his side. He testified that petitioner was on his side for a long time and his legs were quivering.

Longfellow also testified that he saw burn holes in petitioner's right sock. He testified that petitioner walks with a noticeable limp now, but did not walk with a limp before the injury.

On 7/5/18 petitioner presented to Dr. Bethany Tschantz for his electrical burns to his left hand and right foot. Petitioner reported numbness, tingling, and soft swelling of the right foot and leg. He reported increasing pain since leaving the hospital. He reported increased pain in the right lateral ankle to the point where he had difficulty bearing weight. He reported that his right leg had swelling to his knee. He also reported occasional shaking in his upper extremities, that had improved. Dr. Tschantz assessed right ankle pain and electrical burn. She ordered x-rays of the right ankle, cleaned petitioner's wounds, and told him to use an ACE bandage on his right ankle for compression, and keep the right leg elevated to help decrease swelling and pain in the right ankle. Petitioner was instructed to dress the burns. Dr. Tschantz took petitioner off work.

On 7/11/18, 7/19/18, 7/26/18, 8/9/18, 8/21/18, 8/30/18, and 9/18/18 petitioner followed-up with Dr. Tschantz. During this period petitioner was treated for his burns on his left hand and right foot. He was also in physical and occupational therapy. During this period he used crutches, had burning pain of the right foot, inability to walk on foot and needed to walk on his right heel, swelling of the right lower extremity, the need to wear a compression sock, had ongoing tremors, stiffness in range of motion at the right ankle, altered gait, and continued off work.

On 10/11/18 petitioner returned to Dr. Tschantz. Petitioner was told he may return to work after follow-up appointment with Dr. Shoudel. He reported that he had continued to work with physical therapy for his right lower extremity. He stated that he was no longer working with occupational therapy. He reported compliance with compression of the right foot. He continued to complained of ongoing burning pain in the foot, as well as tremors. He also complained of neck pain. Petitioner's assessment was electrical burn. His active problems included anxiety with depression, electrical burn, and foot swelling. His gait was also noted as not being normal. She instructed petitioner to continue in physical therapy and follow-up with Dr. Shoudel.

On 11/28/18 Dr. Shoudel drafted a Medical Excuse for petitioner indicating that he was seen in his clinic and could return to work on 11/28/18 without restrictions. He noted that petitioner was cleared for work pertaining to the bony foot portion. Dr. Shoudel's office note for 11/28/18 was not included in the credible medical records.

On 12/31/18 petitioner presented to Dr. Darr Leutz for his right foot, big toe, ankle giving out and neck/shoulder. He gave a consistent history of the injury. He reported that the electricity went in his left hand/arm and out his right foot. He reported severe swelling after the incident. He complained of burning, pins and needles. He also complained of locking/catching/giving way/popping/numbness and tingling. He reported that he fell into a ditch. Petitioner denied any problems prior to the injury. Dr. Leutz performed a physical examination and took x-rays of petitioner's right foot. Dr. Leutz noted that petitioner limped; was ambulating unaided; was tender; had slight crepitation; had positive anterior draw test; and talar tilt test grade 1 with lateral instability. Dr. Leutz recommended that petitioner use a right ankle active brace, and undergo an MRI of the right ankle. Dr. Leutz's assessment was ankle instability, right ankle pain, and subluxation of peroneal tendon. He took petitioner off work.

On 1/16/19 petitioner underwent an MRI of the cervical spine. The impression was moderate cervical disc degeneration resulting in both acquired spinal canal and foraminal stenosis; no compressive disc herniation; and paranasal sinus mucosal disease.

On 1/18/19 petitioner underwent an MRI of the right ankle. The impression was increase in size in osteochondral lesion of the medial talar dome which measured 0.6 x 1.2 cm in size with increased reactive marrow signal; no evidence of fluid signal undermining the osteochondral lesion to suggest instability; prior anterior talofibular ligament tear, likely related to prior strain; and no evidence of tendon tear.

On 1/30/19 petitioner followed-up with Dr. Leutz for his right ankle. He reported that the active ankle brace helped a lot, and gave him more stability. He reported that his condition was unchanged. Following an examination, Dr. Leutz's assessment was the same, an osteochondral defect of the talus was added. He ordered a course of physical therapy for petitioner's right ankle and how to use a cane in his left hand. He continued petitioner in the brace and restricted him to sedentary work.

On 2/5/19 petitioner presented to Dr. William Payne for his neck and arm pain for 7 months. He rated his pain between a 4-8/10. Petitioner had seen Dr. Payne in the past for surgery on his back. Petitioner gave a consistent history of the injury. He reported that his neck was injured as part of the accident. He stated that it had not improved and he underwent physical therapy, but his pain worsened.

He reported that it was mostly on the right side, from the base of the skull down into the right trapezius. He also reported that while in therapy he started having numbness and tingling down the right arm. He denied any left upper extremity symptoms. He stated that he had developed a tremor since the injury, and was going to see a neurologist for this. He rated his pain from a 4-8/10. Following an examination, x-rays of the cervical spine that showed mild to moderate osteoarthritic changes from C3-C7, and MRI of the cervical spine that showed mild central and foraminal stenosis from C4-C7, Dr. Payne's impression was cervical radiculopathy and cervicalgia. Dr. Payne ordered more physical therapy. He was hesitant to think about surgery for more axial neck pain. Petitioner reported that he could not do his usual work, but could drive his car as long as he wanted with moderate pain in his neck.

On 2/14/19 petitioner returned to Dr. Tschantz for his burns. Dr. Tschantz noted that petitioner's skin burns had been healed for some time. She noted that petitioner was being seen by Dr. Leutz for his right ankle and was currently in a brace and 50% weightbearing of the ankle with a cane. She examined petitioner and was of the opinion that his skin burns were well healed, and he could proceed with lotion and massage. She noted that petitioner was released from care for the burns but could follow up as needed for his neuropathy of the right upper extremity. She also noted that petitioner would obtain a work conditioning order from his PCP when he was released by all other specialists.

On 2/20/19 petitioner underwent a physical therapy initial evaluation at Passavant Rehabilitation Services for his right ankle and cervical spine. It was recommended that petitioner undergo 4 weeks of therapy, 3 times a week.

On 3/13/19 petitioner returned to Dr. Leutz. He reported that he was using a crutch in his left hand. He stated that he could not start physical therapy because worker's comp did not approve. Petitioner was still wearing his ankle brace. Petitioner reported that his condition was unchanged. Dr. Leutz noted that petitioner was limping. Following an examination that showed petitioner was limping, had tenderness present, and a positive talar tilt test, Dr. Leutz discussed a right ankle scope, debridement, multiple drilling, possible excision of talus OCD, and possible modified brownstrum reconstruction with petitioner. Dr. Leutz's assessment was osteochondral defect of the talus, tear of the talofibular ligament, ankle instability, and right ankle sprain. He again recommended a course of physical therapy. He continued petitioner on sedentary work restrictions.

On 3/27/19 petitioner was examined by Dr. Benjamin Montgomery, his primary care physician. He noted that there was not much improvement in petitioner's condition. He noted that petitioner had continued right ankle pain, and right arm/fingers. He stated that his shakes were improving, but his burn

sensation was still present. A physical examination included a normal gait and station. His assessment included ankle instability.

On 4/2/19 petitioner presented to Dr. Gregory Blume, a neurologist, for an evaluation for his electrical injury. Petitioner complained of neck pain, numbness of his first three fingers on the right hand, problems with his right ankle giving out, constant burning at his right foot and toes, and cognitive issues. Following an examination, Dr. Blume noted that petitioner had an electrical injury, and had several symptoms that were likely related to a focal neural injury; right hand paresthesias, that could be related to underlying carpal tunnel syndrome, electrical injury, or even CB radiculopathy given petitioner's history of neck problems since his injury; right foot dorsiflexion weakness with loss of abductor digiti minimi bulk, highly suggestive of a peroneal nerve injury that may be due to the electrical\injury or possibly a sequela of the injury (swelling of the right lower leg); right toe numbness and pain that could be part of an electrical injury, either to the peroneal nerve or possibly a radiculopathy; and minor cognitive complaints with "short fuse", that was nonspecific and certainly could be related to depression experienced since the injury, and could be best evaluated with neuropsychological testing. He recommended an EMG/NCS to look specifically at the right median nerve injury versus a C6 radiculopathy; evaluation of the right peroneal nerve; and neuropsychological testing.

On 4/8/19 petitioner underwent Section 12 Section of a right foot and ankle injury, performed by Dr. George Holmes, at the request of the respondent. Petitioner provided a consistent history of the injury. His chief complaint was one of weakness that was in the inframalleolar area, or the lateral aspect of the ankle beneath the fibula. He also complained of burning over the entire foot with some swelling. He reported that it felt like sometimes his ankle is going to give out. Dr. Holmes noted that petitioner used an Aircast and a cane. He also noted that petitioner was off work. Following his examination and review of records dated 6/30/18 7/5/18, 7/11/18, 8/9/18, 9/19/18, 9/28/18, 1/18/19, 1/30/19, and pictures of the right foot, Dr. Holmes was of the opinion that petitioner's burns appeared to have healed nicely. Dr. Holmes noted petitioner's anterior drawer test was normal and he was unable to demonstrate any demonstrable ankle instability. He also noted that most of the changes on the MRI were essentially avascular in nature over the medial dome of the talus. He was of the opinion that petitioner would be a candidate for a right ankle arthroscopy with excision of the talus OCD, and possible modified Brostrom reconstruction, but that this surgery is not related to the injury on 6/30/18. He was of the opinion that his reason for this finding is that the medical records do not reflect any ankle instability, ankle symptomatology after the injury, or any treatment for any ankle symptoms. He also based this opinion on the fact that the OCD is over the medial aspect of the talus, and petitioner's pain absolutely originates on

the lateral side of the ankle. He was of the opinion that the mechanism of injury was more of an electrical arcing shock rather than any sort of eversion or inversion injury of the foot or the ankle. He recommended an EMG/NCV. He was of the opinion that petitioner could return to work. He found no evidence of any structural damage to the foot. He was of the opinion that he would defer to petitioner's neurologist or treating doctors taking care of the electrical burns to be the final arbitrary in what petitioner's work status is. He did not believe petitioner had any specific orthopedic restrictions in terms of instability, motor deficits, swelling, or other structural issues with regards to his right ankle.

On 4/11/19 petitioner followed-up with Dr. Payne for his neck. He reported that physical therapy did not provide him with any lasting relief. He recommended that an inline traction device to use at home would be appropriate. Dr. Payne released petitioner from his care with no restrictions related to his neck. He noted that petitioner was still off work for his ankle, based on Dr. Leutz's orders.

On 5/8/19 petitioner followed-up with Dr. Leutz. Petitioner reported that worker's compensation denied the recommended surgery, but stated that he has BCBS insurance. Petitioner was still using his ankle brace and cane. He reported that his condition was unchanged. Dr. Leutz noted that petitioner was limping and still had a positive talar tilt test and instability of the anterior lateral aspect of the ankle. Dr. Leutz again recommended surgery and took petitioner off work until further notice.

On 5/13/19 petitioner underwent an EMG. The study did not show any residual significant injury to the nerves that could be definitely attributed to his electrocution injury. It was further noted that the study could miss minor neural tissue injury, particularly to sensory nerve fibers. There was no evidence to support radiculopathy, carpal tunnel syndrome, or neuropathy. It was noted that the superficial peroneal responses were abnormal but it was of an undetermined clinical significance. The right medial nerve distal latency was just within normal range. The right superficial peroneal sensory study demonstrated no response.

On 5/20/19 petitioner was seen by Christa Hill, LPN. He reported that he started Lyrica two weeks ago, and stopped taking Gabapentin. He reported some drowsiness with the Lyrica, and no benefit yet. Petitioner stated that he could not return to his old job, but was offered a job running an endloader at work, which he would also not be able to operate. He noted that Dr. Leutz was recommending surgery on his right ankle. He reported increased stress/anxiety/depression while trying to deal with his pain, his work situation, and his workman's comp issue. Petitioner stated that the results of his EMG showed no permanent damage.

On 7/10/19 the evidence deposition of Dr. Leutz, an orthopedic surgeon, was taken on behalf of petitioner. Dr. Leutz testified that petitioner mentioned that he had a previous problem with his right ankle, but it went away and he was doing fine. He testified that he had reviewed all the radiographs and MRIs of the preexisting condition and that petitioner had a small very-benign appearing talar dome osteochondritis, which is an inflammation and edema or fluid in the medial dome of the talus. He noted petitioner had a previous ankle sprain at that time. Dr. Leutz testified that before the injury on 6/30/18 petitioner told him he was able to work with the pre-existing condition. Dr. Leutz testified that petitioner told him that he had no symptoms with respect to his right ankle after the sprain in 2014 and the injury on 6/30/18. Dr. Leutz testified that when he first saw petitioner after the injury on 6/30/18 that the problems petitioner was having with his right ankle were directly related to the electrocution injury. Dr. Leutz was of the opinion that the MRI of petitioner's right ankle after the electrical injury showed an increased size of his osteochondral lesion, which indicated that it was worse than before, and it had edema or reactive marrow signal in it. He was further of the opinion that the anterior talofibular ligament, which is the main ligament of the ankle to stabilize the ankle, was either re-tore or re-injured. He also noted that it showed no evidence of any tendon lesion, which was there on the prior MRI exam.

Dr. Leutz was of the opinion that somehow petitioner had reinjured his right ankle either by the fall in the ditch or that the electricity going through his right ankle and right foot may have caused it to invert. He testified that it was very significant that petitioner was fine before the injury and was not after. He opined that the brace stabilized petitioner's right ankle a bit, and gave him control to be able to turn and walk on uneven ground. Dr. Leutz opined that not only was petitioner's talar dome issue a problem, but also his instability.

Dr. Leutz testified that when petitioner did not improve, remained tender on both sides of the ankle, and continued with a slight instability and talar dome problem, he recommended an arthroscopic debridement and synovectomy and possibly something to do with the dome of his talus, and then stabilize his right ankle instability with a reconstruction.

Dr. Leutz opined that the petitioner sustained more injury to his ligamentous tissues around his ankle, as well as the dome of his talus, that made his pre-existing problem worse, as a result of the electrical injury. He opined that he recommended surgery after petitioner did not significantly improve with bracing and conservative treatment. Dr. Leutz was of the opinion that the abnormality seen on the prior MRI in 2014 was gone on the MRI after the injury on 6/30/18. Dr. Leutz opined that a reinjury of some sort caused the complete disruption of the ligament.

Dr. Leutz reviewed the examination of Dr. Holmes, and was of the opinion that he did not mention the talar tilt sign, and if positive this would show ligamentous injury to that particular side compared to the normal of that person. He stated that he found a positive talar tilt sign on petitioner.

Dr. Leutz testified that the MRI after the electrical injury showed essentially no connection to the ligament. He stated that petitioner could have worked full duty with no connection to the ligament, but in petitioner's case his symptoms became worse after the electrical injury, and therefore he was of the opinion that it was reinjured. Dr. Leutz was of the opinion that the physical activity that happened during the electrocution, which he presuppositioned was that petitioner may have rolled the ankle, or turned it when he was electrocuted, or he reinjured it falling in the ditch.

Dr. Leutz was of the opinion that petitioner would not get better without surgery, and would not be able to return to full duty work without the surgery. He was of the opinion that it would be tough for petitioner to climb in and out of a machine, and that operating a machine safely and with stability would depend on the machine, but he assumed not. Dr. Leutz opined that the work injury is a direct contributory factor of the surgery he is recommending.

On cross examination, Dr. Leutz was of the opinion that petitioner could not operate a piece of machinery based on his current condition. He also thought it would be hard for petitioner to climb in and out of machinery. Dr. Leutz testified that petitioner had always come into his office with a crutch or a cane. He testified that petitioner never came in without any ambulatory assistance. He testified that use of an assistive device is consistent with petitioner's subjective complaints, but probably not necessary all of the time because his symptoms will wax and wane. He testified that he told petitioner he could use his left foot to brake, and his right foot for the gas pedal in a motor vehicle because it did not require a lot of pressure.

Dr. Leutz could not opine if it was the electrocution or the fall that caused the damage to the right ankle, but testified that he knew that petitioner told him he was fine before the injury, and then was not. He opined that the electrocution did not cause the defect to the talar done that was displayed on the MRI. He was of the opinion that the electrical shock would cause an ankle inversion or eversion activity from the electrical activity going through his muscle tissue, and that could cause the instability to become worse, or the dome fragment to get worse. Dr. Leutz was of the opinion that the surgery he was recommending included a repair of the anterior talofibular ligament. He was of the opinion that the MRI from 2014 showed a ruptured anterior talofibular ligament, and the MRI from 2019 showed an absent anterior talofibular ligament. He was of the opinion that this meant that it was worse in 2019 than in 2014. He was also of the opinion that a rupture can, and usually does repair itself on its own without

surgery. Dr. Leutz was of the opinion that the osteochondral lesion within the medial talar was larger on the 2019 MRI than on the 2014 MRI.

On redirect examination Dr. Leutz was of the opinion that he could repair petitioner's absent right anterior talofibular ligament with surgery, given that it was symptomatic. Dr. Leutz was of the opinion that petitioner could perform sedentary work, and would need to review the specific job description to determine if petitioner could do a specific job.

Evan Lillick, insurance investigator, testified on behalf of the respondent. He testified that he video surveillance of petitioner was performed on 4/22/19, 4/25/19, 4/29/19, 5/11/19, 5/13/19, 7/8/19, and 7/9/19. Lillick testified that he performed all video surveillance, except the video surveillance performed on 4/22/19. He testified that on the video surveillance taken 4/22/19 the stop signs in the video were reverted, which indicated that they were reverse images. He testified that these images were most likely taken by directing the camera into a mirror. He agreed that in these images it look like petitioner was limping on the wrong leg, and wearing his brace on the wrong leg. He agreed this was presented on the video without explanation. Lillick testified that no editing of the videos was done, but could not explain how on the video performed on 4/25/19 the beginning of the video was taken at 5:09 PM, followed by video that was taken hours earlier at 12:38 PM, followed by more video at 5:05 PM. Lillick testified that when uploading videos the clips are jumbled. Some of these videos showed petitioner walking without at cane, and without a limp at times.

Laura Hamman, respondent's Administrator and Field Safety Administrator, was called as a witness on behalf of respondent. Hamman said she was on petitioner's case and was aware petitioner was seeing Leutz. She knew petitioner saw Dr. Leutz after his severe electrical shock burns were taken care of. Hamman was aware that Dr. Leutz gave petitioner sedentary work, and then took him off work all together. She testified that she had not read the report of Dr. Holmes, respondent's Section 12 examination. She testified that all off work slips for petitioner would come from the adjustor who would get them from the nurse case manager. She stated that she never got any off work slips from petitioner, and never saw Dr. Leutz's records. Hamman did not know if the adjustor saw Dr. Leutz's notes, but thinks she did. Hamman testified that the nurse case manager went with petitioner to see Dr. Leutz. Then the nurse case manager would communicate with her and she would communicate with the insurance carrier. Hamman was also aware of the video surveillance, but did not recommend that the video surveillance be taken. Hamman testified that every time she saw petitioner after the injury he was always limping and using the cane. She also testified that she had not seen petitioner since he was in the office on 5/3/19.

Hamman testified that her goal was to return petitioner to work, and that respondent wants to take care of him. She stated that although respondent has used volunteer work for people on sedentary work, they never offered anything like that to petitioner because they wanted to put petitioner on equipment based on Dr. Holmes' full duty release. With regard to volunteer work she testified that these job placements don't always go well because the employees don't always do well in that environment. She testified that she had found it is better to put them back to what they know. She testified that any discussions regarding petitioner's return to work were based on a full duty release from Dr. Holmes. She testified that all jobs offered to petitioner were based on Dr. Holmes' full duty release and not Dr. Leutz's restricted work.

Petitioner testified that in February of 2014 he injured his right ankle in the backyard. His primary care physician sent him to Dr. Leutz, who he saw 2 times. He testified that he recalled Dr. Leutz telling him it was sprained. He also testified that he injured his back while working for respondent, but was eventually released to full duty work.

Petitioner testified that Nick created a GoFundMe page for him. He received the money that was raised.

Petitioner testified that he has no restrictions on driving, but does not operate any vehicles other than a car. He testified that he has made no attempt to operate any equipment for respondent since 6/30/18. Petitioner testified that when he has not used his cane he has fallen 3-4 times, but did not need medical treatment.

Petitioner testified that before his injury he was able to walk 3-5 miles behind the paver each day. After the injury, petitioner testified that he has had trouble walking with his right leg. He testified that his ankle gives out and he has trouble climbing and operating foot pedals. Petitioner drives his car with his right foot on the gas pedal. He denied problems operating a car gas pedal with his right foot, but could not do it for long in stop and go traffic, or on long trips because it bothers him somewhat. He testified that operating a car gas pedal is easier than operating pedals on machinery. Petitioner does not feel he could safely operate the same machinery he operated before the injury. He does not feel he could fully control the machinery with the pedals. He testified that there is no machinery that he would not have to climb in and operate pedals with his right foot.

Petitioner claimed an injury to his low back on 9/2/16. He filed a claim for this injury 18 WC 28145. On 9/27/18 petitioner settled this claim for 4% loss of use of his person as a whole.

Petitioner underwent an MRI of his right ankle on 3/28/14. It showed edema in the lateral malleolus related to healing fracture or contusion; no displacement; mild interstitial tearing peroneal longus and brevis tendons with peroneal longus tendinopathy; posterior tibial tenosynovitis; ruptured anterior talofibular ligament with posterior talofibular ligament sprain; mild Achilles tendonitis; and a 6 mm focus of edema medial talar dome likely related to full thickness cartilage defect.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Petitioner claims his current condition of ill-being as it relates to his right ankle is causally related to the severe electrical shock he sustained on 6/30/18. Respondent claims petitioner's current condition of ill-being as it relates to his right ankle is not causally related to the injury he sustained on 6/30/18.

In 2014 petitioner sustained an injury to his right ankle that was diagnosed as a strain by Dr. Leutz. Following his treatment for this injury, petitioner returned to full duty work and worked without any incident or any further treatment for his right ankle until after the severe electrical shock he sustained on 6/30/18. Petitioner's MRI in 2014 included a finding of a ruptured anterior talofibular ligament.

On 6/30/18 petitioner's co-workers included Moyer and Longfellow. Neither saw petitioner sustain the injury, but both testified that they observed petitioner's body on the ground following the severe electrical shock. It is unrebutted that petitioner was walking at the back of the paver, on the right side along the shoulder of the road. He had his left fingers on the auger switch when he sustained the severe electrical shock. Moyer testified that when he first saw petitioner following the injury, he was on the grassy shoulder area of the road, 4-5 feet from the paver. He testified that petitioner was not in the ditch, but was rather on the shoulder of the road. He did not know if petitioner twisted his right ankle. Longfellow also testified he also did not see the petitioner until after he sustained the severe electrical shock. He testified that he saw the petitioner laying in the grass 1-2 feet from the back of the paver. He also testified that petitioner did not fall into the ditch. He did however testify that petitioner was laying face down in a direction opposite to the direction he would have been while holding down the auger switch. Petitioner himself testified that he did remember anything from the time he received the severe electrical shock other than screaming and turning the opposite way following the shock.

Based on the testimony of petitioner, Moyer and Longfellow, the arbitrator reasonably infers that following the severe electrical shock petitioner was spun around and landed on the ground in the opposite direction.

The arbitrator notes that the first medical record offered into evidence following the injury on 6/30/18 was the record of Dr. Tschantz dated 7/5/18. At that time petitioner's complaints included soft

swelling of the right foot and leg. He reported that he had increased pain in the right lateral ankle to the point where he had difficulty weight bearing. Petitioner was given an ACE bandage to use for compression of his right ankle to decrease the swelling in his right ankle and his ankle pain.

Petitioner continued to see Dr. Tshantz through 10/11/18. During this period petitioner continued to use crutches, had burning pain in his right foot, was unable to walk on right foot, had swelling of the right lower extremity, had to wear a compression sock, had stiffness in range of motion of the right ankle, and had an altered gait. Dr. Tschantz told petitioner he could return to work after a follow-up visit with Dr. Shoudel. Although Dr. Shoudel drafted a Medical Excuse form dated 11/28/18 allowing petitioner to return to work without restrictions, that release was only as it pertained to his bony foot portion. Additionally, the arbitrator noted that there was no office note associated with this date of examination offered into evidence. As such, the arbitrator has no idea what the status of petitioner's right foot was on 11/28/18 for anything other than the "bony foot portion" of the right foot.

Petitioner then returned to Dr. Leutz on 12/31/18, and has followed up with him regularly since that time until the date of trial. During this period petitioner continued to complain of his right ankle giving way, an altered gait, instability,y and positive anterior draw test, and Grade 1 talar tilt test. Petitioner was instructed to continued wearing a right ankle active brace. During this period petitioner was also evaluated by Dr. Blume who was of the opinion that petitioner had several symptoms that were likely related to a focal neural injury, including right dorsiflexion weakness with loss of abductor digiti minimi bulk, highly suggestive of a peroneal nerve injury that may be due to the electrical injury or possibly a sequela of the injury. He also saw Dr. Montgomery who noted that petitioner had continued right ankle pain.

On 3/13/19 Dr. Leutz recommended a right ankle scope, debridement, multiple drilling, possible excision of the talus OCD, and possible modified Brownstrum reconstruction.

Petitioner underwent an MRI of the right foot in 2014, and again after the injury on 6/30/18. The MRI from 2014 showed a rupture of the anterior talofibular ligament, and the one after 6/30/18 showed an absent anterior talofibular ligament.

Respondent had petitioner evaluated by Dr. Holmes for his right ankle. Petitioner's complaints were weakness that was in the inframalleolar area, or the lateral aspect of the ankle beneath the fibula. He also felt like his ankle was going to give out, and had complaints of burning over the entire foot. Dr. Holmes noted no demonstrable ankle instability on his examination. Dr. Holmes was also of the opinion that petitioner was a candidate for the same surgery Dr. Leutz recommended, but opined that it was not

causally related to the injury on 6/30/18. He based this opinion on his belief that the medical records did not reflect any ankle instability, ankle symptomatology after the injury, or any treatment for any ankle symptoms. He also based his opinion on the fact that the OCD is over the medial aspect of the talus, and petitioner's pain originated on the lateral side of the ankle. He believed that the mechanism of injury was more of an electrical arcing shock rather than any sort of eversion or inversion injury to the right ankle or foot.

The arbitrator finds the basis of Dr. Holmes opinions are not supported by the credible medical records, or the testimony of petitioner, Longfellow and Moyer who were present when the injury occurred. The arbitrator notes that the credible medical records support a finding that petitioner has had right ankle instability noted in nearly all medical records following the injury. This finding is noted in Dr. Tschantz's records, Dr. Leutz's records, Dr. Montgomery's records, and Dr. Blume's records. Additionally, given that no one actually observed the petitioner from the time of the severe electrical shock until they found him on the ground facing in the opposite direction, the arbitrator finds Dr. Holmes' opinion that petitioner's mechanism of injury was more of an electrical arcing shock rather than any sort of eversion or inversion injury to the right ankle or foot, is supported by the credible record. The arbitrator gives more weight to Dr. Leutz's opinion that the electrical shock would cause an ankle inversion or eversion activity from the electrical activity going through his muscle tissue, and that could cause the instability to become worse or the dome fragment to get worse. The arbitrator finds this opinion is based on the effects of an electrical shock on the muscle tissues, versus Dr. Holmes opinion which is based on his belief of what the mechanism of injury was, which no one knows for sure. Additionally, the arbitrator's decision to give greater weight to Dr. Leutz's opinion is also based on the unrebutted testimony that petitioner was found on the pavement facing the opposite direction from the direction he was facing when the severe electrical shock struck him

The depositions of both Dr. Leutz and Dr. Holmes were taken with respect to their findings and causal connection opinions as they relate to the petitioner's current condition of ill-being as it relates to his right ankle and the injury on 6/30/18.

Based on these depositions the arbitrator finds it significant that petitioner received no treatment for his right ankle for at least 4 years prior to the injury; that petitioner was able to perform his full duty job without restriction prior to the injury; that petitioner did not have a limp prior to the injury; that after the injury petitioner's right ankle showed an increased size of his osteochondral lesion, which indicated that it was worse than before; that the anterior talofibular ligament was ruptured before the injury, but was totally absent after the injury; that petitioner sustained more injury to his ligamentous tissues around the

ankle and dome of the talus, that made his preexisting problem worse; and that the abnormality seen on the 2014 MRI was not seen on the MRI after the injury; that Dr. Holmes never made mention of the talar tilt sign in his records, and that if he had, and it was positive as Dr. Leutz found, that would show ligamentous injury to that particular side.

The arbitrator finds that is unrebutted that at times on the video surveillance the petitioner is seen ambulating without an assistive device, and without an altered gait. However, given Dr. Leutz's opinion that petitioner's use of an assistive device is consistent with petitioner's subjective complaints, but probably not necessary all of the time because his symptoms will wax and wane, the arbitrator does not find the images on the video surveillance inconsistent with Dr. Leutz's opinions.

Based on the above, as well as the credible evidence, the arbitrator finds the opinions of Dr. Leutz more persuasive, and consistent with the credible evidence, than those of Dr. Holmes. As such, the arbitrator adopts the opinions of Dr. Leutz and finds petitioner's current condition of ill-being as it relates to his right ankle causally related to the injury petitioner sustained on 6/30/18.

J. WERE 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 causally related to the injury he sustained on 6/30/18 the arbitrator finds all medical treatment petitioner received from 6/30/18 through 7/30/19 for the injuries he sustained as a result of the severe electrical shock he sustained on 6/30/18, including Dr. Leutz's treatment for his right ankle, was reasonable and necessary to cure or relieve petitioner from the effects of his injury.

Based on the above, as well as the credible record, the arbitrator finds the respondent shall pay reasonable and necessary medical services from 6/30/18 through 7/30/19, including Dr. Leutz's treatment of petitioner's right ankle, 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. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Having found petitioner's current condition of ill-being as it relates to his right ankle causally related to the injury he sustained on 6/30/18, the arbitrator finds the right ankle scope, debridement, multiple drilling, possible excision of the talus OCD, and possible modified Brownstrum reconstruction

recommended by Dr. Leutz is reasonable and necessary to cure or relieve petitioner from the effects of his injury.

Based on the above, as well as the credible evidence, the arbitrator finds the respondent shall pay all reasonable and necessary medical expenses pursuant to Sections 8(a) and 8.2 of the Act, for the right ankle scope, debridement, multiple drilling, possible excision of the talus OCD, and possible modified Brownstrum reconstruction recommended by Dr. Leutz.

L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner alleges that he was temporarily totally disabled from 7/1/18 through 7/30/19, representing 56-2/7 weeks. Respondent claims petitioner was only temporarily totally disabled from 7/1/18 through 4/8/19, representing 40-2/7 week. The parties stipulate that respondent has paid $47,319.72 in temporary total disability benefits.

The respondent terminated petitioner's temporary total disability benefits on 4/8/19 based on the findings and opinions of Dr. Holmes. Dr. Holmes was of the opinion that petitioner could return to full duty work. Roegge offered petitioner full duty work based on the full duty release of Dr. Holmes. He testified that he did not offer petitioner any work within Dr. Leutz's restrictions.

Having found the opinions of Dr. Leutz more persuasive than those of Dr. Holmes, the arbitrator adopts the opinions of Dr. Leutz and finds the petitioner has remained unable to return to his regular duty job from 7/1/18 through 7/30/19.

The Respondent shall pay Petitioner temporary total disability benefits of $1,126.60/week for 56-2/7 weeks, commencing 6/30/18 through 7/30/19, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $47,319.72 for temporary total disability benefits that have been paid.

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 Choose direction	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SPENCER TALBERT,

Petitioner,

vs. NO: 18 WC 02194

DOT FOOD INC.,

Respondent.

20IWCC0176

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 4, 2019, 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.

20IWCC0176

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $17,700.00. 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 13 2020
KAD/bsd
O031020
42

Kathryn A. Doerries

Maria E. Portela

Douglas McCarthy

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

TALBERT, SPENCER
Employee/Petitioner

Case# **18WC002194**

DOT FOOD INC
Employer/Respondent

20IWCC0176

On 9/4/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.82% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0834 KANOSKI BRESNEY
CHARLES N EDMISTON
129 S CONGRESS
RUSHVILLE, IL 62681

0265 HEYL ROYSTER VOELKER & ALLEN
DANIEL R SIMMONS
3731 WABASH
SPRINGFIELD, IL 62711

20 IWCC0176

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

20IWCC0176

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

SPENCER TALBERT,
Employee/Petitioner

v.

DOT FOOD INC.,
Employer/Respondent

Case # **18** WC **2194**

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 **Springfield**, on **7/31/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **12/13/17**, 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*** 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 $**72,598.24**; the average weekly wage was $**1,396.12**.

On the date of accident, Petitioner was **48** 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 $**61,562.46** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**61,562.46**.

Respondent is entitled to a credit of $**00.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $930,75/week for 34-2/7 weeks, commencing 12/14/17 through 8/10/18, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of $930.75/week for 50-5/7 weeks, commencing 8/11/18 through 7/31/19, as provided in Section 8(a) of the Act.

Respondent shall provide vocational rehabilitation services to petitioner pursuant to Section 8(a) of the Act, consistent with the findings of the FCE, and within the Medium Physical Demand Level.

Respondent shall be given a credit for TTD and for maintenance benefits paid.

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

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

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

Signature of Arbitrator

8/24/19
Date

ICArbDec19(b)

SEP 4 - 2019

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 48 year old tractor trailer driver, sustained an accidental injury that arose out of and in the course of his employment by respondent on 12/13/17 when he drove his truck off the road. The issues in dispute are casual connection, wages, maintenance, and vocational rehabilitation.

Petitioner began working for respondent in February of 2012. On 12/13/17 at approximately 4:00 am, petitioner was about 5 miles southwest of Pittsfield, driving back to respondent's main warehouse in Mount Sterling, when a deer came up on the right side of the road. Petitioner swerved to miss the deer on the curved road and his truck went straight down an embankment through a drainage ditch and into a corn field approximately 50 yards from the road. The truck did not overturn. As the truck went off the road and into the field petitioner was bounced up and down in his seat. He was wearing his seatbelt. Petitioner was able to exit the truck after the accident, but testified that the truck was totaled. Petitioner did not notice anything at that time because he was numb and in shock.

Petitioner was transported to Illini Community Hospital in Pittsfield, IL by ambulance. Petitioner's chief complaint was back pain. He reported a history of scoliosis and back problems. At the hospital he complained of lower back pain. Petitioner underwent x-rays of the cervical spine, pelvis, and lumbar spine, as well as a CT scan of the head and lumbar spine, blood tests and an examination. Positive findings on x-rays included moderate bilateral hip osteoarthritis, bilateral femoral head neck bumps which can predispose to Cam type femoral acetabular impingement, age indeterminate compression deformities L1, L2 and L5. A CT of the lumbar spine revealed acute obliquely oriented fracture through the anterior 1/3 of the superior endplate of T12 and L2. The fractures were nondisplaced. Also noted was slight anterior wedge deformity of L1 which was technically age indeterminate, chronic in appearance, and chronic bilateral pars defect of L5 with slight anterolisthesis of L5 on S1. Petitioner's diagnosis upon discharge was nondisplaced fracture of T12 and L2.

On 12/15/17 petitioner presented to his PCP, Dr. Jennifer Schroeder for his emergency room follow-up. Petitioner denied any lower extremity pain/radiculopathy or paresthesia, weakness, saddle anesthesia, or incontinence. He wanted to see a specialist and a refill on his hydrocodone. Following an examination, Dr. Schroeder assessed a T12 compression fracture, and closed compression fracture of L2 lumbar vertebra with routine healing. She also referred petitioner for an orthopedic surgeon evaluation.

On 12/15/17 petitioner also underwent a Return to Work Fit for Duty Evaluation at MOHA. Petitioner was continued on temporary disability status secondary to medication that included

hydrocodone. It was noted that he would need to reach MMI regarding his fractures before a followup evaluation could take place.

On 1/12/18 petitioner underwent x-rays of the thoracic spine. The impression was mild compression at T12 that was similar in appearance to the prior examination. The vertebral bodies were actually better demonstrated on the lumbar spine plane film examination performed the same day. X-rays of the lumbar spine were also performed. The impression was slight lateral increase in compression deformity at the super endplate of L2. T12 and L1 were stable in appearance compared to the previous examination. Lumbar spondylosis was also noted.

On 1/12/18 petitioner presented to Dr. William Payne for an orthopedic evaluation. Petitioner complained of numbness and tingling in his buttock down to his hamstring since the accident. He complained of some difficulty walking and leg swelling since the accident. Following an examination and review of the x-rays, Dr. Payne's impression was L1 and L2 compression fractures, and numbness in bilateral legs. Dr. Payne ordered an MRI of the lumbar spine. Dr. Payne was of the opinion that the fractures were significant and it would probably be 3 months before he was able to have his pain controlled and begin moving forward again. He was also of the opinion that physical therapy would not help for at least another month. Dr. Payne authorized petitioner off work for 2 months.

On 1/26/18 petitioner underwent an MRI of the lumbar spine. The impression was mild anterior wedging compression fracture L2 vertebral body with less than 25% loss of vertebral body height, and possible nondisplaced microtrabecular fracture of the right T12 vertebral body; multilevel degenerative changes in the lumbar spine, partially imaged, with patient only able to tolerate sagittal sequences; and Grade 1 anterolisthesis L5 on S1, and possible bilateral L5 spondylolysis.

On 2/8/18 petitioner returned to Dr. Payne. He reported that he was felling a little bit better. He stated that he was ready to try physical therapy. He reported that his back bothers him every day. Repeat x-rays showed no change in the amount of compression. Dr. Payne's impression was thoracolumbar fractures. He also prescribed a course of physical therapy. He continued petitioner off work.

Petitioner began a course of physical therapy on 2/22/18.

On 3/29/18 petitioner followed-up with Dr. Payne. He continued to complain of pain in his back. He reported that some of the exercises in his therapy made his back much worse. He noted that he cannot stand for more than 5 minutes unsupported, before his back hurts him and then he has to sit down. He stated that he was sleeping well at night. X-rays were taken, and Dr. Payne's impression was low back pain and healed fractures at T12, L1 and L2. Dr. Payne recommended that petitioner start work

hardening 2 hours a day, 4 days a week, with increases as petitioner could tolerate. Dr. Payne recommended 3 months of work hardening. Dr. Payne gave petitioner restrictions on no repetitive bending, lifting, or twisting of the back or waist. He told petitioner to work as tolerated outside of work hardening.

On 4/13/18 petitioner underwent a Section 12 examination with Dr. Jesse Butler, at Spine Consultants, LLC. Petitioner gave a consistent history of the accident. He noted pain from the collision and worsening back pain with time. He stated that he stopped the medication and was currently in therapy for the injury, and it was recommended that he start work hardening. He complained of a strip of numbness in the back and some intermittent tingling. He noted difficulty with lifting and bending. He stated that he takes Celebrex, and has some arthritis in the hips. He noted worsening of pain with certain exercises, and has had some massage therapy with difficulty getting up afterwards. Dr. Butler performed a physical examination and assessed a traumatic T12 and T2 compression fracture of the thoracic vertebra from the work injury. He was of the opinion that the injury on 12/13/17 directly caused the petitioner's present condition, and the mechanism of injury was reasonable and appropriate to cause a thoracic compression fracture. He was further of the opinion that the petitioner needs to transition into a home exercise program and continue with anti-inflammatory medicine as needed. Dr. Butler was of the opinion that petitioner did not require surgery or work hardening. He was also of the opinion that petitioner cannot return to work in his regular duty capacity. He indicated that petitioner would remain off work until 6/13/18, and at that point he should submit for an updated DOT physical and be considered to return back to work at that time at a regular duty capacity. Dr. Butler did not feel the petitioner had reached a healing plateau yet in regards to his 12/13/17 injury, but would by 12/13/18.

On 5/2/18 petitioner returned to Dr. Schroeder and requested an evaluation for Veteran's Disability verification. Petitioner reported that his bilateral hip pain had been progressive. Schroeder noted that petitioner had this complaint when she first met him in February 2016. Petitioner reported that his hip pain was related to his service career as he would jump in his service. This has led to the capsule syndrome/compartment syndrome issues of his legs. Dr. Schroeder had fasciotomies on both sides in the past, that were getting worse. Petitioner reported that he drove a semi-truck for a living and noted it was progressive and he could not drive long without sensory-motor deficits of the legs. He reported that he would have to stretch/change positions/stop driving as much as he could. Dr. Schroeder noted that petitioner was never given driving restrictions at the time of the DOT physicals. Petitioner also reported trouble with venous varicosities, that have been progressive over time. He also noted that he has tinnitus and bilateral hearing loss due to service related loud noises. This also was noted on the VA evaluation

form. Petitioner reported that he still struggles with pain in his back from T12 compression fracture he sustained on 12/13/17. Petitioner also reported that while doing some extra work while preparing for his wife to return from the hospital, he heard a pop in his back and has had more pain since then. Petitioner was given a referral to an orthopedist for his hip problems and Tramadol for his back pain. Dr. Schroeder indicated that she would complete the VA forms.

On 5/11/18 petitioner returned to Dr. Payne. He complained of pain every day, and reported that he had not been able to do normal activities. Dr. Payne thought petitioner needed to be doing some activities to stretch and strengthen his back and then he was going to need a functional capacity evaluation. He was hopeful that the respondent would give him some work hardening. Petitioner reported that he felt like he was getting worse instead of better. Dr. Payne took petitioner off work until his next evaluation.

On 5/30/18 petitioner was examined by Dr. Brett Wolters for his bilateral hip pain that he has had for many years. He also gave a history of his accident on 12/13/17 and his ongoing back pain. X-rays of the hips showed no acute osseous abnormalities. He was examined and assessed with mild primary localized osteoarthritis of both hips, and bilateral hip impingement.

On 6/7/18 petitioner presented for a DOT exam. He was unable to tolerate much effort due to his back pain from his previous fractures. Petitioner was found not fit to drive a semi/commercial vehicle.

On 6/8/18 petitioner underwent x-rays of his lumbar spine. They were compared to the x-rays taken 1/12/18. The impression was a very mild anterior compression of T12 that appeared slightly increased. Also noted was that the mild to moderate compression of L1 and L2 had definitely not changed. Bilateral L5 spondylolysis was unchanged with nearly grade 2 spondylolysis.

On 6/8/18 petitioner followed-up with Dr. Payne. He reported that he still had pain in his back every day. He stated that the pain prevented him from turkey hunting. Dr. Payne was of the opinion that petitioner was as good as he was going to get with respect to his fractures at L1 and L2. He recommended a functional capacity evaluation (FCE). Dr. Payne continued petitioner off work pending approval and scheduling of the FCE.

On 8/2/18 petitioner underwent an FCE. Petitioner gave maximal effort. Petitioner was found capable of functioning at the Medium DOL category for all material handling. Petitioner reported pain in his back, buttocks and thighs with all testing items. Petitioner demonstrated limitations in his walking/standing ability, elevated work ability, sustained forward bending ability, kneeling and crouching ability and stair climbing. Limited walking and standing ability also limited all related

standing and walking abilities. He demonstrated a good gripping ability. He was able to sit 30 minutes during subjective history being taken. He also reported that he needs to get out of his car every 45-60 minutes and stretch when driving long distances. Petitioner met partial pushing and pulling requirements, and sitting ability. It was noted that his limited standing and walking ability will limit his ability to push and pull based on the duration of the activity.

On 8/10/18 petitioner followed-up with Dr. Payne to review the results of his FCE. Dr. Payne provided petitioner with permanent restrictions consistent with the FCE recommendations. Petitioner reported that the FCE test made his back worse. Dr. Payne discharged petitioner from his care and placed him at maximum medical improvement.

On 10/15/18 petitioner followed up with Dr. Schroeder for a disability evaluation for social security. Petitioner asked for a correction to the 5/2/18 office notes. He stated that he was not jumping, but was running for his duty posting. He was examined and his diagnoses were T12 compression fracture, tinnitus, and traumatic compartment syndrome of the left lower extremity.

On 1/3/19 Dr. Butler performed a record review of petitioner's medical records from 12/7/17 through 8/10/18 and issued a report. His assessment remained the same. Following his record review, Dr. Butler noted that his opinions had not changed and petitioner could return to work. He was of the opinion that petitioner did not need an FCE after he concluded treatment for his thoracic and lumbar compression fracture. Dr. Butler was of the opinion that petitioner should have reached maximum medical improvement by 6/13/18. Dr. Butler noted that petitioner failed his DOT physical, and the examining physician said that someone with a compression fracture should not be considered eligible for driving. Dr. Butler did not believe there is any concern regarding the need for permanent restrictions which would prevent him from obtaining a DOT driving certification due to a healed compression fracture. He was of the opinion that this was an inappropriate application of the driving certification, but Dr. Butler admitted that he was not a certified driving examiner and if this issue is of relevance to petitioner's return to work, the petitioner should have a 2nd opinion with a physician who performs DOT certifications to determine the rationale for this decision. He reiterated that he did not personally agree with this but, again, he was not a certified examiner.

On 1/10/19 petitioner followed up with Dr. Schroeder for his Type 2 Diabetes. His blood work was consistent with a provisional diagnosis of Diabetes Mellitus.

On 3/8/19 petitioner underwent a 2nd Section 12 examination performed by Dr. Butler, at the request of the respondent. Petitioner continued to complain of pain in the middle back to the back of the

knees. He reported difficulty standing to clean dishes. Petitioner also reported difficulty walking and was using a cane for assistance. He stated that he has to lean on a shopping car at Walmart. He reported an inability to lift. He reported that he tried to shovel the ramp for his wife with an increase in pain. Petitioner stated that he lost 50 pounds since the injury. He denied he had diabetes but takes Metforim as it helps his weight. He stated that he has been given permanent restrictions of 20 pounds lifting and limited sit/stand/walk to 15 minutes. He stated that he has to elevate his feet and can only drive for an hour. Following a physical examination and record review, Dr. Butler's impression was compression fracture of L2 lumbar vertebra. Dr. Butler did not believe there was any objective basis for the patient to be unable to return to regular duty work as it relates to the work incident on 12/13/17. Dr. Butler was of the opinion that petitioner had other medical comorbidities including his obesity and deconditioning. He also noted that petitioner had a non-work related spondylolisthesis at L5-S1 and retrolisthesis at L4-L5, that were not aggravated or injured during his work accident. He was of the opinion that the work accident affected the L2 vertebra and created a superior endplate fracture that had healed and does not require long term restrictions.

On 4/1/19 petitioner called Dr. Schroeder's office and reported that the tramadol and muscle relaxers were not helping his back pain as much as it used to. He asked if the dosage needed to be increased or his medication be changed. Petitioner was told he could increase his dosage to 2.

On 5/16/19 the evidence deposition of Dr. Payne, an orthopedic surgeon, was taken on behalf of the petitioner. Dr. Payne opined that the fractures and petitioner's low back pain are casually related to the injury on 12/13/17. He further opined that the restrictions placed upon petitioner as a result of the FCE were causally related to the work injury and the compression fractures he sustained. Dr. Payne was of the opinion that petitioner's condition on the last time he saw him was going to be that way for the rest of his life. He believed that petitioner was always going to have more pain than other people, and be limited in what he can do in the workplace or around his house. He was of the opinion that he expected petitioner's limitations to remain as set forth in the FCE.

On cross-examination Dr. Payne testified that he believed the fractures at L1 and L2 were the main culprits. He noted that the findings at T12 were very mild, and if it is acute, he was not really worried about it. He believed these fractures were about 5 weeks old when he saw them on the MRI. He was of the opinion that the total loss of height was due to the compression fractures and not normal wear and tear. Dr. Payne was of the opinion that as of 3/29/18 the fractures had healed. Dr. Payne testified that he did not believe petitioner was able to undergo the recommended work hardening. Dr. Payne noted that

petitioner weighed 340 pounds and was morbidly obese. Dr. Payne was of the opinion that petitioner needed the work hardening that was not recommended by the IME.

On redirect examination Dr. Payne was of the opinion that with the type of fractures petitioner had. having pain radiate down over the sacrum is really common, so the pain he had in his hips could be related to the compression fractures.

On recross examination Dr. Payne was of the opinion that petitioner could have pain because of bilateral hip impingement or primary osteoarthritis in his hip that Dr. Wolters diagnosed him with in addition to the pain from a compression fracture.

On 5/23/19 petitioner underwent an initial vocational assessment performed by David Patsavas at Independent Rehab Services, Inc., at the request of his attorney. Patsavas met with petitioner and gathered personal/socioeconomic information; a medical history; his current medical status; his education/military/training information; and his vocational/military history. Patsavas also performed a transferable skills analysis. Patsavas identified 251 matches that were listed in the sedentary to light category of physical demands. Based on petitioner's other restrictions in the FCE, Patsavas did not utilize the Medium category as petitioner does not meet all of the requirements in the Medium level, according to the DOL standards. Some of the jobs identified included an order caller, industrial order clerk, route delivery clerk, routing clerk, QC clerk, procurement clerk, community service office patrol, gate guard, assembly-press operator, ceiling-machine operator, electric motor assembler, group leader, printed circuit board QC, and electrical assembly supervisor. The wages were between $24,000-$55,000. Patsavas determined that the entry level hourly wages for these positions in petitioner's area were between $9-$15 per hour, with a median range between $10-$12.

On 5/31/19 the evidence deposition of Dr. Jesse Butler, an orthopedic surgeon, was taken on behalf of the respondent. Dr. Butler testified that on 4/13/18 he thought petitioner had gone through some work hardening and he felt that petitioner needed to transition to a home exercise program, take his medications as needed, and obviously optimize his physical fitness. He believed petitioner would have reached maximum medical improvement by 6/13/18 because compression fractures take 3 months to heal, and 3 months of physical therapy and/or fitness training. He was of the opinion that petitioner's pain and dysfunction is not related to the uneventful healing of the fracture, but is related in large part to his comorbidities of obesity and deconditioning. Dr. Butler opined that petitioner's spondylolisthesis and retrolisthesis were not aggravated by the work accident.

On cross examination, Dr. Butler did not attribute petitioner's use of a cane to his work injury. He was of the opinion that petitioner had a strong pain that was atypical for someone who had a healed compression fracture. He was of the opinion that pain is a subjective phenomenon. He was also of the opinion that it would be very rare for people to have ongoing chronic pain related to compression fractures. Since most of petitioner's day as a truck driver is not with material handling he did not see the value of work hardening since the repetitive lifting and what not, in many cases just aggravates their situation. Dr. Butler admitted that the FCE revealed that petitioner could not perform all the functions of his job. Dr. Butler was of the opinion that the reason for petitioner losing the ability to perform all the functions of his job after the accident was because he was in such poor fitness and health at that time. He believed petitioner was at a very high risk for losing his functional independence because of his own lack of self-care, letting himself go with his obesity and poor fitness. He believed petitioner's fitness changed significantly from before the accident and after the accident because he wasn't active. He believed petitioner's fitness declined when he was off work because he was not walking, was not able to climb in and out of his vehicle, and do the basic activities required of his occupation. Dr. Butler testified that when he tested petitioner's Waddell signs they were negative.

Respondent offered into evidence petitioner's wage statements from 12/22/16 through 12/7/17. Petitioner claims he earned $73,604.80 in the year preceding his injury, and his weekly wages were $1,415.48. Respondent claims petitioner earned $72,598.24 in the year preceding his injury, and his weekly wages were $1,396.12. Respondent claims petitioner's safety bonuses should not be included in the wages. Petitioner claims they should be.

Petitioner testified that he did not undergo work hardening because he was not physically able and respondent did not authorize.

Petitioner testified that he was fired by respondent in January of 2018 because that was respondent's policy.

Currently, petitioner testified that he is not able to do a whole lot of stuff he used to be able to do. He testified that he no longer fishes, and cannot participate in sexual relations with his wife. He also testified that he does not hunt like he used to. He stated that he cannot walk more than a couple blocks. He stated that he cannot sit in one place for more than 15-20 minutes. He feels everything gets tight and he has shooting, stabbing pain. The tightness is in his lower back and sometimes down the back of his legs, as well as the center of his hips. He stated that his pain is always present and never gets better than a 4/10, and the worst is 10/10. Petitioner takes Tramadol and Flexeril for his pain. He takes it as needed or if he has to travel more than an hour in one direction. Petitioner also testified that he no longer goes to

the racetrack because it's painful to walk up and down the ramp. He stated that he limits his lifting to 30 pounds. He reported some difficulty sleeping at night at times.

Petitioner's jobs prior to his work for respondent included running a mixer truck and hauling gravel for Strata Corporation; driving a semi taking grain out of the farm, and doing farm work for Jerry Miller; and an over 20 year career in the Air Force as a security specialist, supply field and electrician. Petitioner also did work on his dad's farm when before he went into the Air Force.

Petitioner has a high school degree. He also went to college and took some classes, but did not get a degree.

Petitioner testified that he had looked for work since he received his permanent restrictions. Some jobs were floor manager for Farm and Home, and Buchheit. He also applied for work in the pharmacy at Caseys. Petitioner applied for a teller position at West Central Bank, but it exceeded his restrictions because he would have to lift up to 50 pounds, and walk 5 miles a day.

Petitioner testified that Dr. Schroeder performed a DOT physical on him, but he failed due to his back problems. He testified that he never failed a DOT physical in the past.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

As a result of the injury on 12/13/17 petitioner sustained nondisplaced compression fractures at T12, L1 and L2. For these injuries, petitioner treated conservatively with Dr. Payne. This treatment included physical therapy. Petitioner reported that some of his therapy exercises made his back much worse. By 3/29/18 Dr. Payne's impression was low back pain and healed fractures at T12, L1, and L2. Since petitioner was still experiencing pain when standing, Dr. Payne gave petitioner restrictions, and recommended that he undergo a course of work hardening to improve his tolerances.

Based on this request respondent had petitioner examined by Dr. Butler. Dr. Butler was of the opinion that the injury on 12/13/17 directly caused the petitioner's present condition, and the mechanism of injury was reasonable and appropriate to cause a thoracic compression fracture. He also believed petitioner needed to transition into a home exercise program and continue with anti-inflammatory medication as needed. He did not believe petitioner needed work hardening, but also did not believe petitioner could return to regular duty work.

Petitioner continued to follow-up with Dr. Payne and reported that he had pain every day and had not been able to do his normal activities. Given that work hardening had not been authorized by respondent, Dr. Payne told him to do some activities to stretch and strengthen his back. When petitioner did not improve Dr. Payne ordered an FCE.

Respondent had Dr. Butler perform a record review from 12/7/17 through 8/10/18, and also had him reexamine petitioner on 3/8/19. At that time petitioner still had complaints of pain in the middle of his back to the back of his knees. He also reported difficulty standing to clean dishes, difficulty walking, and an inability to lift. Dr. Butler was of the opinion that the reason for petitioner losing the ability to perform all the functions of his job after the accident was because he was in such poor fitness and health. He also believed petitioner was at a very high risk for losing his functional independence because of his own lack of self care, letting him go with his obesity and poor fitness. However, Dr. Butler believed petitioner's fitness changed significantly from before the accident to after the accident because he was not active. He also believed that petitioner's fitness declined when he was off work because he was not walking, was not able to climb in and out of his vehicle, and not able to perform the basic activities required of his occupation. However, when given the opportunity to give petitioner some help regaining these abilities, Dr. Butler was of the opinion that petitioner did not need work hardening to get back to a point where he could perform the basic activities required of his occupation.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner's current condition of ill-being is causally related to the injury on 12/13/17. The arbitrator finds it significant that the petitioner was able to perform his regular duty without incident prior to the injury, and has been unable to return to his regular duty job since the accident. The arbitrator not only finds the opinions of Dr. Payne more persuasive, but also finds Dr. Butler's testimony on cross-examination inconsistent with his own opinions rendered as part of his final examination, especially as it relates to petitioner's inability to perform the duties of his job, and his opinion that petitioner was not in need of any work hardening.

G. WHAT WERE PETITIONER'S EARNINGS?

Petitioner and respondent offered differing earnings for petitioner in the year preceding the injury. The difference between the two wages comes down to whether or not petitioner's safety bonus amounts should be included in his earnings. The petitioner claims these bonuses should be included because they are based upon his own performance and safety records and not a company-wide safety record.

The arbitrator notes that Section 10 of the Worker's Compensation Act states that "The compensation shall be computed on the basis of the "Average weekly wage" which shall mean the actual earnings of the employee in the employment in which he was working at the time of the injury during the period of 52 weeks ending with the last day of the employee's last full pay period immediately preceding the date of injury, illness or disablement excluding overtime, and bonus divided by 52." The arbitrator finds it significant that there is nothing in the Act that states that some bonuses are to be allowed and

other bonuses are to be excluded. The arbitrator finds the Act does not put any qualifiers on bonus to indicate which bonuses are to included and which are to be excluded.

Based on the above, as well as the credible evidence the arbitrator finds the petitioner's bonuses should not be included in the calculation of his earnings. The arbitrator finds the petitioner's earnings in the year preceding the injury on 12/13/17 were $72,598.24, or $1,396.12 a week.

L. WHAT TEMPORARY BENEFITS (MAINTENANCE) ARE IN DISPUTE?

The parties stipulate that petitioner reached maximum medical improvement when he last saw Dr. Payne on 8/10/18. At that time Dr. Payne placed permanent restrictions on petitioner consistent with the FCE findings. Dr. Butler finds petitioner is not in need of any maintenance benefits.

The arbitrator notes that petitioner was able to perform his full duties without incident prior to the injury. As a result of the injury, the petitioner sustained compression fractures at T12, L1 and L2. Petitioner treated conservatively with Dr. Payne. This included a course of physical therapy. When petitioner was still having difficulty returning to his pre-accident status, Dr. Payne recommended a course of work hardening to get him back to his full duties. Respondent had petitioner evaluated by Dr. Butler, who was of the opinion that petitioner did not need work hardening. As a result, Dr. Payne had petitioner undergo an FCE. The FCE, which was valid, found that petitioner was only capable of functioning at the Medium Physical Demand Level, which did not meet the requirements of his regular duty job for respondent. Dr. Payne adopted the findings of the FCE with respect to petitioner's ability to return to work.

Given that petitioner was found incapable of returning to his regular duty job by Dr. Payne and the FCE evaluator; that no treating or examining provider found petitioner showed any signs of malingering; and, that Dr. Butler himself was of the opinion that petitioner's fitness declined when he was off work because he was not walking, was not able to climb in and out of his vehicle, and do the basic activities required of his occupation, yet did agree with Dr. Payne's recommendation for work hardening, the arbitrator finds the petitioner is not capable of returning to his regular duty job for respondent, and is therefore entitled to maintenance benefits beginning 8/11/18 through 7/31/19. The arbitrator further finds the respondent is entitled to a credit for the maintenance benefits paid from 8/11/18 through 3/8/19.

O. IS PETITIONER ENTITLED TO ANY VOCATIONAL REHABILITATION?

Having found the petitioner's current condition of ill-being is causally related to the injury on 12/13/17, and that he is entitled to maintenance, the arbitrator further finds the petitioner is entitled to vocational rehabilitation services consistent with the FCE that found petitioner was capable of performing at the Medium

Physical Demand Level. The arbitrator finds the jobs David Patsavas has identified for petitioner thus far are in the Sedentary to Light Physical Demand Level, and not consistent with the FCE findings and those adopted by Dr. Payne. The findings of the FCE and Dr. Payne state that petitioner is capable of working at the Medium Physical Demand Level. If petitioner is going to continue to use the vocational rehabilitation services of Patsavas, Patsavas will need to begin identifying jobs for petitioner within the Medium Physical Demand Level as determined by the FCE and adopted by Dr. Payne. It is not Patsavas' place to unilaterally identify jobs for petitioner in a physical demand level that is not referenced in the FCE or adopted by Dr. Payne.

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

BILLY BELTZ,
Petitioner,

vs.

NO: 15WC 39826

AMERICAN COAL,
Respondent.

20IWCC0177

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, 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 June 17, 2019, 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 13 2020

D. Douglas McCarthy

L. Elizabeth Coppoletti

Stephen Mathis

DDM/jrc
o030320
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BELTZ, BILLY
Employee/Petitioner

Case# **15WC039826**

AMERICAN COAL
Employer/Respondent

20IWCC0177

On 6/17/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.14% 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:

5326 CULLEY FEIST KUPPART & JORDAN
ROMAN P KUPPART
3 S MAIN ST SUITE 2
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
JULIE A WEBB
115 N 7TH ST PO BOX 1545
MT VERNON, IL 62864

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

BILLY BELTZ
Employee/Petitioner

v.

AMERICAN COAL
Employer/Respondent

Case # **15** WC **39826**

Consolidated cases: **n/a**

20IWCC0177

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **April 17, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of 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 **Disease, Causation and Sections 1(d)-(f) of the Occupational Diseases Act**

FINDINGS

On **August 29, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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.

Per the stipulation of the parties, in the year preceding the injury the average weekly wage was **$2,186.53**.

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

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

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

ORDER

Petitioner failed to prove that he suffered from any occupational lung disease, including coal workers' pneumoconiosis, that his condition of ill-being was causally related to his employment or that he suffered a timely disablement as defined in Section 1(e) of the Occupational Diseases Act. All benefits are denied.

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

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

Signature of Arbitrator

6/13/19
Date

JUN 17 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Billy Beltz
Employee/Petitioner

Case # **15** WC **39826**

v.

Consolidated cases: **N/A**

American Coal
Employer/Respondent

20IWCC0177

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he lives in Energy, Illinois. He testified that he was 65 years old and married as of the time of arbitration. He testified that he has a Bachelor's Degree in Education from McKendree College and that he also took some mining classes at SIU. He testified that he worked for approximately 39 years in coal mining employment, with all those years being underground. He testified that while working in the mines he was regularly exposed to coal and rock dust, that the fly ash that was used on the travel roads as well as the diesel fumes bothered his breathing, and that he was even involved with fighting a coal fire in 1996.

Petitioner testified that he last worked a shift in coal mine employment on August 29, 2015 for Respondent at its Galatia mine. He testified that he was 61 years old on that date and that his job classification was that of a mine manager. He testified that on that date, he was exposed to and breathed coal dust. He testified that his employment ended on that date because the mine was shutting down and that people were getting laid off, and that he had younger people under him that he knew could work a little longer if he would leave so he just took his retirement. He testified that he did not get a layoff notice. On cross examination, however, Petitioner identified Respondent's Exhibit No. 9 as a notice from Respondent that he was being laid off as of August 29, 2015. Petitioner testified that he has not worked anywhere since leaving the mine.

Petitioner testified that he graduated from high school in 1972. He testified that he attended John A. Logan College and McKendree, where he played basketball. He testified that from 1976 to 1987, he worked for Freeman Coal and that for a few months in 1987, he worked at the Miracle Mine. He testified that from 1988 to 1989 he worked for Amax Coal and that he worked for Kerr-McGee from 1989 to 1998, at which time it became Respondent. He testified that he worked for Respondent until 2005 and that for a few months in 2005, he worked for White County Coal. He testified that later in 2005 he went back to work for Respondent, where he stayed until his retirement in 2015. He testified that his job classifications in the mine included an environmental engineer, which had to do with dust control in the mine. He testified that he was a miner operator at Freeman, the Miracle Mine and Amax, and that at Respondent he operated a miner for approximately 16 years. He testified that he was assistant mine manager/face boss at Respondent for three years, and then became a mine manager for the last three years of his mining career.

Petitioner testified that all his job classifications at the mine were quite physical. He testified that in the early days he was subjected to a lot of dust just because the federal regulations were not quite as strict. He testified that every day he was at the face of the mine. He testified that as mine manager he had the responsibility to take care of any problems and that he would have to use whatever tools or equipment

were needed to make things right. He testified that while working in the mines he had to bend, stoop, and squat to do his job, and that those activities caused him to have breathing problems.

Petitioner testified that he first noticed he was having trouble with his breathing five years prior to his retirement. He testified that at the end of his mining employment with Respondent, he was working 12 hours a day, seven days a week. He testified that as mine manager he had to walk roughly five miles a day, and that the terrain in the coal mine was rough. He testified that conditions were wet and muddy, and that there were inclines and declines. He testified that he had to walk out of the mine several times and that walking up the slope to get out caused him problems. He testified that Respondent was a long wall mine, and that they had to have a lot of intake air to maintain the longwall face. He testified that it was a dusty mine and that a lot of fly ash was used on the travel roads because they were muddy. He testified that with all the air everything was airborne including coal dust, rock dust, and diesel fumes.

Petitioner testified that building stoppings, shoveling and other duties as mine manager caused him problems with his breathing. He testified that his breathing problems also affected his activities of daily living. He testified that he enjoyed hunting and fishing, but that those activities have slowed down considerably. He testified that he still hunts, but that he cannot go at it as hard as he used to. He testified that he had to slow down and catch his breath. He testified that he mows his yard with a rider, but was not able to do it all at once. He testified that he periodically works in his yard and that he will work 15-20 minutes and then has to take a break because of his breathing. He testified that he weed eats his own yard which takes a little time, but that he eventually gets it done.

Petitioner testified that he coughs and that this was present during the last five years of his career. He testified that his cough usually occurs in the morning and is worse depending on what he is doing. He testified that physical activity of any kind makes it worse. He testified that he could walk about 100 yards on level ground at a normal pace before noticing that his breathing is getting harder. He testified that he feels his breathing has gotten worse over the last several years. He testified that he walks on the track three days a week and that he tries to walk a mile each time. He testified that he usually walks three laps on that particular track which is about 200 yards, and then he usually has to stop and rest for 7-8 minutes. He testified that he can go up eight or nine steps before he has to stop. He further testified that from the onset of his breathing problems until the time of arbitration, it had gotten a lot worse. He testified that he does not take any breathing medication.

Petitioner testified that in the last few years of his employment in the coal mine, he would have to stop and take breaks because of his breathing. He testified that he was able to complete his job duties as a mine manager, but that it was not easy. He testified that the mine manager job was not as physical as his other jobs in the mine and described it as more mental stress. He testified that by the end of his career, he probably would not have been able to do the other physically demanding jobs that he had held in the mines. He testified that as of the time of arbitration, he would not be able to perform his last job in the coal mine.

Petitioner testified that that his treating physician is Dr. Buckman at Logan Primary Care. He testified that he has seen Dr. Buckman for breathing problems. He testified that he has been treated for bronchitis and respiratory infections by Dr. Buckman, and that he does not go to the doctor a lot. Petitioner testified that he has never had a job where he would just sit at a desk and that he has not had a job other than manual labor. He testified that he does not smoke and has never smoked, that he has a couple of bulging discs in his back, and that he has some neck problems. He testified that he takes medication for cholesterol.

On cross examination, Petitioner agreed that but for his layoff on August 29, 2015, he would have reported for his next shift at Respondent. He testified that he collected unemployment benefits for a period of time after he was laid off. He further testified that he started collecting his 401(k) from Respondent after he collected unemployment benefits, and that he began receiving Social Security benefits in March 2016.

He also testified that the reason he gave the unemployment office for his claim for benefits was that he had been laid off.

On cross examination, Petitioner testified that while he was employed as a coal miner he did at times undergo chest x-ray screening for Black Lung that was offered by NIOSH. He testified that after an x-ray was taken he was sent a letter to advise him what the x-ray revealed, and that he did not bring any of those letters with him to the arbitration hearing. Petitioner further testified that he deer hunts from a stand and that he likes to fish. He testified that he and his wife like to travel and that they like to camp locally.

The transcript of the deposition of Dr. Suhail Istanbouly dated July 28, 2017 was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Dr. Istanbouly testified that he is a physician that specializes in pulmonary medicine and critical care medicine. He testified that roughly 30% of the patient census of his practice dealt with the care and treatment of coal miners. He testified that he has done, and is currently still doing, Black Lung examinations for the U.S. Department of Labor and that he is currently the medical director of the Pulmonary Department at Herrin Hospital, a position that he has held since 2005. He also testified that he is the Director of the Intensive Care Unit at Carbondale Memorial, and in the past has been the director of the Intensive Care Unit at Herrin Hospital. (PX1).

Dr. Istanbouly testified that he examined Petitioner on February 16, 2016 on a referral by Petitioner's attorney. He testified that he took a detailed history and performed a detailed physical examination. As to the history taken from Petitioner, Dr. Istanbouly testified that he indicated that he was a retired coal miner, that he worked as a coal miner for a total of 39 years, all of which were underground, that he never smoked in the past, that he denied being diagnosed with asthma during childhood or early adulthood, and that he mentioned a clinical history of occasional cough triggered by strenuous activities or brisk walking. He testified that Petitioner's cough was mild to moderate in intensity and productive of mild white/yellowish sputum, with few episodes of blood-tinged sputum. He further testified that Petitioner mentioned mild exertional dyspnea and that at a slow pace he was able to walk for one mile. He testified that Petitioner also mentioned having acid reflux disease which was mild, twice a week, and that he was treating it as needed. When asked why it was important to him that Petitioner had a cough triggered by activity, Dr. Istanbouly responded that it sometimes reflected underlying obstructive lung disease like asthma or COPD. When asked how the lack of history of asthma affected the relevance of Petitioner's cough, Dr. Istanbouly responded that he would consider other possible causes of COPD, and that it would be long-term coal dust exposure as Petitioner never smoked before. (PX1).

Dr. Istanbouly testified that the relevance of the fact that Petitioner's cough produced sputum was that it may indicate underlying chronic bronchitis which was a form of COPD, and that it could be seen in coal worker's pneumoconiosis as well. When asked of the relevance of the fact that Petitioner got mild exertional dyspnea, Dr. Istanbouly responded that it was related to the underlying lung disease. He testified that in this case there was evidence of obstructive lung disease which was COPD, and that the x-ray showed mild interstitial fibrosis consistent with coal worker's pneumoconiosis. When asked what he would expect in terms of symptoms from a person with simple coal worker's pneumoconiosis radiographically, Dr. Istanbouly responded general respiratory symptoms including chronic cough, sputum production, chest tightness, exertional dyspnea, and wheezing. He agreed that the symptoms Petitioner displayed were symptoms he might expect. He testified that a person with a positive chest x-ray for coal worker's pneumoconiosis could also be asymptomatic and that it would not be unusual if it was early stage. (PX1).

Dr. Istanbouly testified that the physical examination that he performed of Petitioner's chest was normal. He testified that a person did not have to have abnormalities on physical examination of the chest in order to have coal worker's pneumoconiosis. He testified that it was not unusual to find no abnormalities on physical examination of the chest in a person with simple coal worker's pneumoconiosis. He testified that the pulmonary function tests revealed mild obstructive defect with no good response to bronchodilator treatment, and that Petitioner gave a good effort during the testing. When asked of his opinion as to the

cause of Petitioner's mild obstruction, Dr. Istanbuly responded that the only risk factor in Petitioner's history was long-term coal dust inhalation. (PX1).

Dr. Istanbouly testified that a person with coal worker's pneumoconiosis could have pulmonary function tests that were normal if it was early stage and that it would not be unusual. When asked whether having pulmonary function testing within the range of normal meant that the lungs had not been damaged, Dr. Istanbouly responded that it was not necessarily the case. He testified that spirometry was a measure of the global impairment of both lungs versus a focal impairment of a portion of the lung, and that it was true that a person could have a certain amount of their lungs with focal areas of pulmonary impairment yet their global function was normal. He testified that a person could have shortness of breath yet still have normal pulmonary function. (PX1).

Dr. Istanbouly testified that chest x-rays were taken at Herrin Hospital on November 4, 2015, and that he personally reviewed and interpreted the films. He testified that in general, he liked to review any x-ray or CT scan first then develop his own opinion before reading the radiologist's report and the B-reader report. He testified that he relied on both his own interpretation of the chest x-rays as well as the B-reader report, and that there had been very rare incidents where he disagreed with the B-reader. He testified that he did not have to be a B-reader to diagnose coal worker's pneumoconiosis and that as part of his practice he did not always have the benefit of a B-reader when he was making his diagnosis, and that most of the time he got general interpretation for the x-rays or the CT scans. He testified that if he saw any interstitial changes or any abnormality suggestive of coal worker's pneumoconiosis in someone who worked in the coal mine for a long time, he did make the clinical correlation. (PX1).

Dr. Istanbouly testified that there were not any B-readers at any of the hospitals that he was affiliated with, nor were there any B-readers that he was aware of in a close geographic area. He testified that the chest x-rays taken of Petitioner were of diagnostic quality and that the findings revealed mild interstitial fibrosis bilaterally, with small tiny bilateral opacities consistent with coal worker's pneumoconiosis. He testified that the profusion was 1/1 by the B-reader and that he classified it as a primary p, secondary s, all lung zones. He testified that he diagnosed Petitioner with simple coal worker's pneumoconiosis related to a long history of coal dust inhalation and COPD "which legal coal worker's pneumoconiosis" related to a long history of coal dust inhalation. When asked of the cause of Petitioner's condition Dr. Istanbouly responded that the only explanation was long-term coal dust inhalation, and that this was based on the history, chest x-ray findings, and the pulmonary function test findings that he reviewed. (PX1).

Dr. Istanbouly testified that pulmonary function testing findings were one of the factors considered when diagnosing someone with coal worker's pneumoconiosis. He testified that not every coal miner who was exposed to coal dust would develop coal worker's pneumoconiosis. He testified that coal worker's pneumoconiosis could cause scarring and a form of emphysema to occur, and that this was one of the forms of coal worker's pneumoconiosis. He testified that the scar tissue was sometimes referred to as a fibrosis. He testified that the scarring and fibrosis was permanent and that it could not carry on the function of normal, healthy lung tissue. He testified that, by definition, if one had coal worker's pneumoconiosis then there was an impairment of the function of the lung, at least at the site of the scar or fibrosis. He testified that coal worker's pneumoconiosis meant that it was coal dust inhalation and that there were other forms of pneumoconiosis which was not related to coal dust, such as silicosis or asbestosis. He testified that there was no cure for coal worker's pneumoconiosis and that it was a chronic disease that could sometimes be slowly progressive. (PX1).

Dr. Istanbouly testified that it was his opinion that Petitioner had fairly significant pulmonary impairment based on his cough. He testified that it was clinically significant, that there was lung damage that was confirmed per his symptoms and the abnormality on the chest x-ray and pulmonary function testing, and that it was still considered mild and not disabling. He testified that "clinically significant"

implied a higher level of significance. and that as long as there were symptoms he would call it "significant." He testified that "significant" did not mean that it disabled him. When asked for clarification, Dr. Istanbouly testified that to him Petitioner did not qualify for total disability due to coal worker's pneumoconiosis, but that he did have coal worker's pneumoconiosis and that his symptoms could be correlated to coal worker's pneumoconiosis. When asked whether he thought that Petitioner could safely return to working in a coal mine with this condition, Dr. Istanbouly responded "definitely not" because the damage had started. He testified that the first step of treating the damage was cutting the "vicious cycle" of continuous exposure to coal dust inhalation. He further testified that if Petitioner were to have additional exposure, it would endanger his health. (PX1).

Dr. Istanbouly testified that according to the ATS there was no safe level of dust exposure for someone with coal worker's pneumoconiosis. When asked whether Petitioner had damage to his lungs as a result of his occupational exposure to coal mine dust, Dr. Istanbouly responded in the affirmative. When asked whether he had an option as to whether Petitioner should be disabled from coal mining, Dr. Istanbouly responded that medically speaking it was unadvisable for him to have any further coal dust exposure, which meant more coal mine work. He agreed that it was his medical recommendation as a pulmonologist that Petitioner avoid further exposure to coal dust. He testified that coal worker's pneumoconiosis and COPD made an individual more susceptible to respiratory infections and pneumonia. (PX1).

On cross examination, Dr. Istanbouly agreed that he saw Petitioner on one occasion and that the purpose of the visit was evaluation for his state Black Lung claim. He agreed that, on average, he performed 5-7 exams a month at the request of attorneys, and that they were always at the request of the claimants' attorneys. He testified that he started performing exams for attorneys 3-4 years ago and for the Department of Labor since 2004. (PX1).

On cross examination, Dr. Istanbouly testified that Petitioner reported that in the last year of employment in 2015, his job was that of a supervisor and that according to him it was a fairly physical job requiring him to stay up on his feet. He testified that generally speaking when one was a supervisor one was up on their feet walking a few miles, helping out in everything possible including shoveling, lifting and repairing, and that this was based on his experience. When asked whether he knew what Petitioner actually was required to do physically, Dr. Istanbouly responded that he knew staying up on his feet and walking, but that he did not know anything else. (PX1).

On cross examination, Dr. Istanbouly agreed that Petitioner did not relate chronic cough. He agreed that in the exams he tried to take a fairly good history of what triggered an individual's symptoms, and that Petitioner mentioned occasional cough. He testified that Petitioner indicated possible triggering factors of strenuous activities or brisk walking, and that he did not relate any other triggers. He agreed that Petitioner indicated that he had mild exertional dyspnea. He agreed that there were causes for mild exertional dyspnea other than respiratory disease. He agreed that Petitioner was not taking any breathing medication, and further testified that he did not relate to him having ever done so in the past. He testified that Petitioner did not tell him that he left the mine at the time that he did due to respiratory problems. He agreed that Petitioner did not relate to him an inability to carry out the duties of his job. (PX1).

On cross examination, Dr. Istanbouly agreed that he indicated in his report that Petitioner was 6 feet, 5 inches. He agreed that in the testing that was performed, Petitioner's height was recorded as 69.5 inches. He testified that he did not know what the discrepancy was due to and that he thought the 177 cm was more accurate, which was 5 feet 9 inches. He agreed that if Petitioner were 69.5 inches in height and weighed 216 pounds, he had a BMI over 30 which was obese. He agreed that Petitioner's "pulse ox" was 96% and that it was normal. He testified that Petitioner's physical examination of the chest was normal, and that he would not exclude any disease based on a normal exam. (PX1).

On cross examination, Dr. Istanbouly agreed that he ascribed to the GOLD (*i.e.*, Global Initiative for Chronic Obstructive Lung Disease) Standard for determination as to whether an individual suffered from COPD. He testified that Petitioner met that standard given his reduced FEV1 and reduced FEV1 to FVC ratio. When asked whether he agreed that the GOLD standard indicated the presence of a post-bronchodilator FEV1/FVC of less than 70% confirmed the presence of airflow limitation and thus COPD, Dr. Istanbouly responded that it was not true and that they assessed abnormality before bronchodilator treatment. (PX1).

On cross examination, Dr. Istanbouly agreed that he also subscribed to the American Thoracic Society Interpretive Strategy for Spirometry. When asked if Petitioner met the criteria for them for obstruction either, Dr. Istanbouly responded that he did. When asked of the lower limit of normal for Petitioner's FEV1/FVC in the testing that he performed, Dr. Istanbouly responded that it was "around 68." He agreed that using NHANES III Predictives one could calculate the lower limit of normal for Petitioner in the testing he performed. When asked of the specific number Dr. Istanbouly responded that he did not know what it was, but that for Petitioner's age he was "quite positive" that it was an abnormal ratio. He agreed that the calculated ratio was one of the factors that he used to make his diagnosis of obstruction. (PX1).

On cross examination, Dr. Istanbouly agreed that he did not perform a diffusion capacity on Petitioner. He testified that if it had been performed and was abnormal it would have confirmed underlying obstructive or restrictive defect, but that it did not reflect the gas exchange at the capillary alveolar barrier level. He agreed that if there was scarring of the lung no matter the cause and it had some clinical significance, it could affect the gas exchange. (PX1).

On cross examination, Dr. Istanbouly agreed that he was neither an A- or B-reader. He agreed that he did not provide profusion ratings on his films. He agreed that he had his own classification scheme that he used by classifying the film if positive as being either early, moderate or severe disease. He agreed that in Petitioner's case it was mild using his classification scheme. When asked whether he could say that the profusion for Petitioner's film was 0/1 or 1/0, he responded that he would not use this numerical system. (PX1).

On cross examination, Dr. Istanbouly testified that to his knowledge Dr. Youssef was not an A-reader. He agreed that he saw the B-reading of Dr. Smith for the November 4, 2015 film. He testified that he did not see any other B-readings. He agreed that he was given that B-reading when he met with Petitioner. He agreed that he thought the film quality was good. He testified that this was important because the level of penetration and position could be sometimes misleading. When asked what caused a film to be misleading, Dr. Istanbouly responded with the position of the patient having been rotated or the level of penetration. He testified that he did not know what mottle was. He testified that he knew what contrast on a film was. He testified that poor contrast could affect a film's quality and could lead to misinterpretation. He agreed that the Department of Labor required B-readings for their films. (PX1).

On redirect, Dr. Istanbouly agreed that the Department of Labor required B-readings for federal Black Lung claims. When asked if he received a film that he felt was of poor diagnostic quality and whether he would attempt to diagnose someone as having or not having coal worker's pneumoconiosis or whether he would ask for a better quality film, Dr. Istanbouly responded that he would ask for a better quality film. (PX1).

The transcript of the deposition of Dr. Henry K. Smith dated January 29, 2019 was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Dr. Smith testified that he is a diagnostic radiologist and that he is certified as a B-reader through July 31, 2019. He testified that he has been board-certified in radiology since 1973, and that he first took the B-reader exam in 1987 and has been continuously certified since that time. (PX2).

Dr. Smith testified that he reviewed a chest film dated November 4, 2015 from Ferrell Hospital at Petitioner's attorney's request. He testified that the date of his report was that of November 13, 2015. He testified that the film was of diagnostic quality and that he did not note any mottle. He testified that he called the films a quality Grade I. He testified that after having reviewed the films, he found that there were small opacities, primary p, secondary s, upper, middle and lower zones involved bilaterally, profusion 1/1. He testified that there were thickened interlobar fissures, and that there was mild spurring of the thoracic spine. He testified that Petitioner had simple coal worker's pneumoconiosis according to the x-ray. He testified that Petitioner had damage to his lungs as a result of his coal worker's pneumoconiosis by definition. (PX2).

On cross examination, Dr. Smith testified that he has not been involved in any clinical practice since 2016, but that as a medical director he was involved on a regular basis. He testified that he has not provided patient care since 2016. He testified that at the osteopathic hospital in Harrisburg, he was a clinical assistant professor for Philadelphia College of Osteopathic Medicine and New England School of Medicine between the years of 1974 and 1987. He testified that he has not sat on any committees with NIOSH. He testified that he has not held office in any capacity with either the College of Osteopathic Medicine or the Osteopathic Board of Radiology. (PX2).

On cross examination, Dr. Smith testified that he has not published anything on pulmonary disease. He testified that he has not served as a manuscript reviewer for any treatise or journal. He testified that he was aware that a new syllabus had been authored for NIOSH and that he believed that Dr. Meyer was one of the authors. He testified that he agreed with the reference in the current syllabus that small opacities associated with the exposure to silica and coal dust were usually rounded. He testified that that had been his experience for the most part, but not exclusively. (PX2).

On cross examination, Dr. Smith agreed that scarring that was reflected by opacities on chest imaging was permanent. He agreed that profusion would not regress and he further agreed that opacity size would not regress. He agreed that the small, rounded opacities usually involved the upper lung zones first, and that as the dust exposure continued all zones could become involved. He further agreed that this had been his experience. He also agreed that with underinflation you could accentuate the pulmonary vasculature, especially in the lower lung zones, and that this could mimic disease. (PX2).

On cross examination, Dr. Smith agreed that simple pneumoconiosis was unlikely to progress once the exposure ceased. He agreed that pulmonary impairment was determined by appropriate valid pulmonary function testing and not by chest x-ray, but further testified that you could see changes that were consistent with chronic obstructive pulmonary disease, hyperinflation and diminished vascularity, as well as shunting of vascularity. He agreed that if one wanted to know whether there was any functional impairment and, if present, the degree of same, one wanted to have valid pulmonary function testing. (PX2).

On cross examination, Dr. Smith testified that he has two monitors but that he did not know whether they met the guidelines that were set forth in the Code of Federal Regulations. He further testified that he did not know whether they met the DICOM standard set forth in the Code of Federal Regulations. (PX2).

The transcript of the deposition of Dr. Cristopher Meyer dated March 10, 2017 was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Dr. Meyer testified that he is a radiologist and is certified as a B-reader through December 31, 2018. He testified that he has been board-certified in radiology since 1992. He testified that he has taught at multiple universities including the University of Maryland, where he taught subjects such as chest imaging, including interpretation of conventional chest radiograph and interpretation of films in the intensive care unit, as well as high resolution CT of the chest.

Dr. Meyer testified that he is currently the Vice Chair of Finance and Business Development and Professor of Diagnostic Radiology at the University of Wisconsin Hospital and Clinics in Madison,

Wisconsin. He testified that he clinicaled in radiology 50% of the time, and that, in an average week, he reviewed 200-250 chest x-rays and 20-40 chest CT scans. He testified that he became a B-reader in 1999 and has remained a B-reader ever since. (RX1).

Dr. Meyer testified that he reviewed films of Petitioner for Respondent's counsel and that he reviewed a PA chest radiograph dated November 4, 2015 from Ferrell Hospital. He testified that the film was of barely diagnostic quality and that it was a Quality 3 due to poor contrast and mottle. He testified that "poor contrast" meant that instead of having a wide range of gray scale things were very black and white and that it could make the lung parenchyma/lung fields look too dark, and that it could also bring out the mediastinal structures as being too white. He testified that coal worker's pneumoconiosis affected the lung parenchyma. He testified that his interpretation of the film beyond quality was that the lungs were clear, that the mediastinum, cardiac silhouette and soft tissues were normal, and that there were some degenerative changes of the spine. He testified that it was essentially a normal PA chest without findings of coal worker's pneumoconiosis. (RX1).

On cross examination, Dr. Meyer agreed that he reviewed Dr. Smith's B-reading report in this case and that he and Dr. Smith disagreed on the quality of the film. He further agreed that Dr. Smith did not mention anything about mottle in his report. (RX1).

On cross examination, Dr. Meyer testified that he performed roughly 30-40 B-readings per week. He agreed that a B-reader was a preferred person to read a chest x-ray for the presence or absence of an occupational disease rather than just a radiologist who was not a B-reader. He agreed that when someone had coal worker's pneumoconiosis, when they had abnormalities on their film consistent with coal worker's pneumoconiosis those abnormalities were usually called opacities. When asked whether coal worker's pneumoconiosis also caused a scarring process, Dr. Meyer responded that in the general term coal worker's pneumoconiosis could result in some lung fibrosis, most commonly in the upper zones. (RX1).

On cross examination, Dr. Meyer agreed that coal worker's pneumoconiosis primarily occurred in the upper lobes. He agreed that he was not saying that coal worker's pneumoconiosis did not happen or begin in the lower lobes, and further testified that coal worker's pneumoconiosis when it was extensive could extend down to the bases. He testified that the typical description of coal worker's pneumoconiosis was that it began in the upper zones, most commonly in the apical and posterior segment of the right upper lob greater than the left upper lobe, and that it did not begin generally as a basilar process. (RX1).

On cross examination, Dr. Meyer agreed that there was no treatment for coal worker's pneumoconiosis. When asked whether it was true that a person could have coal worker's pneumoconiosis by x-ray and still have a normal physical examination of the chest, Dr. Meyer responded that this was outside his area of expertise and would be better answered by a pulmonary medicine physician. When asked whether he had an opinion as to whether someone with coal worker's pneumoconiosis by x-ray could have normal pulmonary function studies, Dr. Meyer responded that he did not know and that mild simple coal worker's pneumoconiosis was generally asymptomatic. He testified that if Petitioner's film was to come through on a regular clinical workday, it would be read as no acute cardiopulmonary disease and there would be no additional findings. (RX1).

On cross examination, Dr. Meyer agreed that a negative film for coal worker's pneumoconiosis did not necessarily rule out the disease. He agreed that it was true that, on autopsy or biopsy, many coal miners that had had negative chest x-rays for coal worker's pneumoconiosis that was not appreciated on a chest x-ray actually had it pathologically. (RX1).

On cross examination, Dr. Meyer testified that he did not know why the x-rays that he reviewed were taken. He agreed that in the films that he reviewed he did not know which settings were used. When asked whether he knew of any recent studies that disagreed with the finding that it started in the upper lung

zones, Dr. Meyer responded that he was aware of a study that was recently published by Laney and Petsonk that looked at distribution of small pneumoconiotic opacities, but that there were some significant problems with that study. He testified that he did not dispute the fact that when coal worker's pneumoconiosis became more severe it was diffuse and involved all lung zones, and that the real question had to do with when coal worker's pneumoconiosis started as an early disease. (RX1).

On cross examination, Dr. Meyer agreed that he did not find anything related to coal worker's pneumoconiosis on the films. He testified that he did not find any nodules or small or large opacities. He agreed that it was a 0/0 and not a 0/1. (RX1).

On cross examination, Dr. Meyer agreed with the statement in the Laney and Petsonk study that individual coal macules were generally too small to be appreciated on chest x-rays. He testified that most of the nodules that he saw on chest x-rays were actually what were known as summation shadows, which meant that multiple coal macules superimposed on one another to form a shadow that was big enough for them to see. He agreed that even though he read Petitioner's chest x-ray as negative, he still could have coal worker's pneumoconiosis on a pathological level. (RX1).

On cross examination, Dr. Meyer disagreed with the statement in the Laney and Petsonk study that overall the findings demonstrated that small opacities on chest x-rays of coal miners were not predominantly in upper lung zones and suggested that the distribution of small radiographic opacities among coal miners was more diverse than suggested in some textbooks and expert opinions. He testified that it depended on the extent of the disease, and that he believed that in early coal worker's pneumoconiosis the small opacities were upper-zone predominant and that as the disease became more extensive or more diffuse, then all six zones could be involved. He testified that he did not think that this study was designed in a fashion to demonstrate the evolution of small opacities over time. (RX1).

On cross examination, Dr. Meyer agreed that it was a fair statement that an intelligent physician with extensive knowledge and training in occupational diseases could fail the B-reading test easily. He testified that the B-reading test was quite challenging. He agreed that it was a fair statement that similar experts with similar credentials may disagree on the reading of chest films, especially in Category 1. (RX1).

On redirect, Dr. Meyer testified that simple pneumoconiosis typically would not progress once exposure ceased. He testified that Petitioner did not have either progressive massive fibrosis or *cor pulmonale*. He testified that in looking at Petitioner's films, there was no evidence of bulla or hyperinflation. (RX1).

On redirect, Dr. Meyer testified that the American Journal of Industrial Medicine in which the study appeared had a low impact factor and was not considered a front-line journal for either radiology or pulmonology. (RX1).

On redirect when asked for a physician who was not a B-reader or an A-reader or a radiologist to make a diagnosis of pneumoconiosis whether we knew if it technically met the criteria that the ILO had established for that diagnosis, Dr. Meyer testified that they absolutely did not. (RX1).

The transcript of the deposition of Dr. James Castle dated June 21, 2018 was entered into evidence at the time of arbitration as Respondent's Exhibit 2. Dr. Castle testified that he is a pulmonologist and is board-certified in internal medicine and the subspecialty of pulmonary disease. He testified that he was a B-reader and that he first became a B-reader in 1985 and that he was certified as a B-reader continuously since 1985 with his certification good through June 30, 2017. (RX2).

Dr. Castle testified that according to the American Thoracic Society, an obstruction was defined by a reduction in the FEV1/FVC ratio. He testified that for there to be an obstruction, it needed to be below the lower limit of normal. He testified that Petitioner's testing did not reveal an obstruction. He testified

that he agreed with Dr. Istanbouly's testimony that the testing did not reveal a disabling impairment. He testified that as to the spirometry performed at Methodist Hospital, it was "entirely normal" and there was no evidence of restriction. He testified that diffusion capacity was also performed and that it was "entirely normal" as well. He testified that this would suggest that the alveolar capillary membrane was "entirely normal." He testified that there was no indication from the objective testing performed of COPD. (RX2).

Dr. Castle testified that he was familiar with the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition,* and that if one applied the most recent pulmonary function testing on Petitioner to Table 5-4, he would be in Class Zero. He testified that based upon the objective testing performed on Petitioner, he was capable of heavy manual labor from a pulmonary standpoint. (RX2).

Dr. Castle testified that the diagnosis of chronic bronchitis required an individual to have a chronic productive cough for at least three months out of the year for two successive years not caused by any other specific problem such as bronchiectasis. He testified that from his review of the medical records, Petitioner did not meet the requirement for that diagnosis. He testified that that diagnosis did not appear anywhere in the medical records that he reviewed. When asked whether cough was considered an objective determinant of pulmonary impairment, Dr. Castle responded that it was not and that it was a symptom, not an objective finding. (RX2).

Dr. Castle testified that he reviewed a chest x-ray dated November 4, 2015 from Ferrell Hospital and that he also prepared an ILO classification sheet for same. He testified that it was his opinion that there were no parenchymal abnormalities consistent with pneumoconiosis, and that it was therefore his opinion that the chest x-ray did not show radiographic evidence indicating the presence of coal worker's pneumoconiosis. (RX2).

Dr. Castle testified that it was extremely unlikely for simple pneumoconiosis to progress once the exposure ceased. He testified that he agreed with the position of the American Thoracic Society that an older worker with a mild pneumoconiosis may be at low risk for working in currently-permissible dust exposure levels until he reached retirement age. He testified that the Mine Safety Health Administration did not require a miner diagnosed with pneumoconiosis to cease all exposure to coal dust, and that they indicted to the miner that he should be moved to an area of lower dust concentration. (RX2).

Dr. Castle testified that it was his opinion that Petitioner did not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to coal mine dust, that he worked in or around the underground mining industry for a sufficient enough time to have developed coal worker's pneumoconiosis if he were a susceptible host, that he worked for 39 years in the mining industry and last worked in 2015 as a supervisor, that he was a lifelong non-smoker, that he did not demonstrate any consistent physical findings indicating the presence of an interstitial pulmonary process, and that he did not have the consistent finding of rales, crackles, or crepitations. He testified that the majority of the radiographic reports indicated that there were no findings whatsoever of coal worker's pneumoconiosis and that the majority of x-rays indicated that the ILO classification was 0/0, that he shared the same opinions as Dr. Meyer, and that only Dr. Smith felt that there were minimal findings indicating the presence of pneumoconiosis. He testified that there were two valid pulmonary function studies in the data set which he reviewed, that they were both normal, that Petitioner did not demonstrate any evidence of obstruction or restriction, and that the diffusing capacity was normal. He testified that it was his opinion that Petitioner had normal physiologic function and had no evidence of any respiratory impairment or disability from any cause, and that it was also his opinion that he did not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to coal mine dust. (RX2).

On cross examination, Dr. Castle testified that he was "semi-retired" and that he did not see any active patients but had done examinations for coal worker's pneumoconiosis since he left his practice. He testified that he still did reviews, but was retired from an active practice. (RX2).

On cross examination, Dr. Castle testified that coal worker's pneumoconiosis was a type of interstitial lung disease. When asked whether along with that disease process there was scarring and fibrosis that occurred in the lungs, Dr. Castle responded that it could occur in that way as well. He testified that there was not a cure, to his knowledge, for coal worker's pneumoconiosis. He testified that the scarring and fibrosis that occurred with pneumoconiosis was irreversible. He testified that, in general, the scarring and fibrosis represented an alteration in the structure of the involved lung tissue. He agreed that the scarring and fibrosis also represented an alteration in the function of the involved lung tissue. (RX2).

On cross examination, Dr. Castle testified that simple coal worker's pneumoconiosis could progress in the absence of further dust exposure, and that it was very unusual and would depend on the extent of the disease process. He testified that if there was an individual that had a very high degree of profusion of simple and they had no further exposure then there could be some coalescence and progression in that sense, but that it would be extraordinarily unlikely for someone with no or minimal disease to progress to any great idea after cessation of exposure. (RX2).

On cross examination when asked whether the best treatment for someone with coal worker's pneumoconiosis was to remove them from the dust exposure, Dr. Castle responded that he could say that that would be considered to be a treatment but that might be a further preventive for someone that did not have it, but that it was important to recognize that people even with minimal degrees of abnormality could continue to work without any significant risk of further significant progression. He agreed that the American Thoracic Society indicated that individuals were at a low risk of progression, but that they did not say that there was no risk of progression. (RX2).

On cross examination when asked if there was any safe level of dust exposure to coal dust with someone with coal worker's pneumoconiosis, Dr. Castle responded that it was a very difficult question and that there were contradictory opinions about that throughout the occupational realm. He agreed that even at the "safe" dust levels that were present today, there were still people that were getting coal worker's pneumoconiosis. (RX2).

On cross examination, Dr. Castle agreed that a person could have coal worker's pneumoconiosis and not know that they had it, and further testified that most people that had it were asymptomatic. He agreed that a spirometry test would tell the type of the abnormality and its severity, but would not indicate the etiology. He agreed that one could have shortness of breath despite having normal PFTs. He agreed that a person could have normal PFTs and still have coal worker's pneumoconiosis, and that it was not unusual. When asked whether having PFTs within the range of normal meant that the lungs had not been damaged Dr. Castle responded in the negative, and further testified that it meant that the lung function was normal. (RX2).

On cross examination, Dr. Castle agreed that it was possible that a person could have a portion or a lobe of their lung removed and still have PFTs that were within the range of normal, but further testified that it was not very common and would depend on what underlying disease process the individual may have and how much lung was removed. He testified that spirometry was a total reflection of the ability or function of the entire pulmonary system. He agreed that a person could have certain amounts of their lungs that did have focal areas of pulmonary impairment, yet their overall global function was normal. (RX2).

On cross examination, Dr. Castle agreed that he did not take a patient history from Petitioner, nor did he speak to him. He further testified that he did not speak to Petitioner's examining or treating physician, and that he did not perform a physical examination. (RX2).

On cross examination when asked whether the reading of x-rays was very subjective, Dr. Castle responded that it was a subjective means of making an objective evaluation. When asked if it was fair to say that similarly qualified, educated physicians could and did disagree as to the findings on the x-rays, Dr.

Castle responded that there was a possibility of both intraobserver and interobserver variation. When asked if there were other exposures in a coal mine environment that could damage the lungs other than just coal dust, Dr. Castle responded that there was a possibility of silica and that there were probably other things that were not commonly discussed. (RX2).

On cross examination, Dr. Castle agreed that he was no longer seeing patients or doing federal Black Lung exams. He agreed that what he was currently doing was that of medical-legal reviews for attorneys. He agreed that he previously was a B-reader for approximately 32 years, and that he voluntarily let his B-reading certificate lapse on June 30, 2017. (RX2).

On cross examination, Dr. Castle agreed that the ILO system was not brought about for legal purposes and further agreed that it was done for epidemiological study purposes. He testified that he believed that the predicteds of normal in pulmonary function testing recommended to be used by the American Thoracic Society was that of NHANES III. He testified that he thought that Dr. Istanbouly used NHANES III on his pulmonary function testing. He testified that he did not know what set of predicteds Dr. Selby used when he did the pulmonary function testing at Methodist Hospital. (RX2).

On cross examination, Dr. Castle testified that one did not have to be a B-reader to diagnose someone with pneumoconiosis. He agreed that there were doctors diagnosing coal miners with Black Lung prior to the B-reading program. He agreed that the B-reading program and the ILO categorization was for basically quantifying the number and size of the nodules and their location. (RX2).

On cross examination, Dr. Castle testified that in the medical records Petitioner was diagnosed with episodes of acute bronchitis but were usually associated with an upper respiratory infection starting at 2-5 days ahead of time. He testified that Petitioner was never diagnosed, based on the records that he reviewed, with chronic bronchitis. He agreed that the x-ray that he reviewed dated November 4, 2015 he found to be Quality 2 because of poor contrast and underinflation. He testified that underinflation would cause crowding of structures in the lung and made certain structures look more prominent and may, in fact, make it a lighter film, and that contrast could be the same way such as either too light or too dark. He testified that he was sure in this case that the underinflation would have caused it to be a bit lighter and also caused crowding of lower zone structures which could have, although it did not in this case, the appearance of linear, irregular-type opacities, particularly if there was any cardiac abnormality. He agreed that he did not mark the box for "mottle" when he reviewed the film. (RX2).

On cross examination, Dr. Castle agreed that one did not have to have findings of rales, crackles or crepitations in order to have simple coal worker's pneumoconiosis. He agreed that one could have a normal physical examination of the chest and still have coal worker's pneumoconiosis. He testified that one could still have simple coal worker's pneumoconiosis and have a normal diffusing capacity. He agreed that a normal diffusing capacity did not, in and of itself, rule out coal worker's pneumoconiosis. (RX2).

On redirect, Dr. Castle agreed that impairment in pulmonary function due to scarring of the lung from dust exposure was a permanent condition. He agreed that in the testing that was performed June 21, 2016, there was no abnormality in Petitioner's pulmonary function. When asked whether the fact that on an earlier date Dr. Istanbouly obtained slightly lower numbers for forced vital capacity and forced expiratory volume in one second he would attribute that to a permanent condition, Dr. Castle responded in the negative and testified that if it were a permanent condition it would have not have improved it by testing at a later date. He testified that Petitioner had several episodes of acute illness that could have been causing it at the time. (RX2).

On redirect when asked if there was a physiologic ability to have higher numbers in spirometry than one was actually capable of producing, Dr. Castle responded that it was absolutely impossible. He testified that if one did their maximum then that was their maximum, and that it was repeatable on any

given day. He testified that it may not be the same every day because of variations or acute illness, but one could only achieve one's best. (RX2).

On redirect, Dr. Castle testified that the Department of Labor in the federal claims still went by Knudsen predictions. When asked if he converted the results from the testing that was obtained by Dr. Selby in a spirometry from June 21, 2016 to NHANES III and whether Petitioner would still fall in Class 0, Dr. Castle responded in the affirmative. He testified that everything was well above normal and would be Class 0 regardless of the predicteds used. (RX2).

The medical records of Methodist Hospital in Henderson, Kentucky were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The records reflect that Petitioner underwent pulmonary function testing on June 21, 2016. The Interpretation was noted to be that of normal spirometry without change post-bronchodilator and normal diffusion capacity. It was noted that Petitioner showed a very good effort. (RX3).

The medical records of Harrisburg Medical Center were entered into evidence at the time of arbitration as Respondent's Exhibit 4. The records reflect that Petitioner was seen on April 2, 2009 at which time he underwent chest x-rays, which were interpreted as revealing (1) negative chest; (2) category classification 0/0. It was noted that the reason for the testing was that of "coal miner." Petitioner was also seen on December 20, 2006 at which time he underwent chest x-rays, which were interpreted as revealing (1) negative chest; (2) category classification 0/0. It was noted that the reason for the procedure was that of "AM COAL VOL." Petitioner was also seen on April 2, 2002 at which time he underwent chest x-rays, which were interpreted as revealing (1) negative chest; (2) category classification 0/0. (RX4).

The medical records of Alexander Primary Care were entered into evidence at the time of arbitration as Respondent's Exhibit 5. The records reflect that Petitioner was seen on April 3, 2013 for a check-up. It was noted that Petitioner's "Active Problems" were that of esophageal reflux. It was noted that Petitioner was having no symptoms and that he had a normal appetite. It was also noted that Petitioner had no tobacco use and was not a former smoker and that he had no pulmonary symptoms. As to the physical examination, it was noted that Petitioner's respiratory excursion was not diminished, that his lungs were clear to auscultation, that he had normal breath sounds/voice sounds, that no wheezing was heard, that no rhonchi were heard, and that no rales/crackles were heard. The assessment was noted to be that of a normal routine history and physical. (RX5).

The medical records of SIH Medical Group Internal Medicine were entered into evidence at the time of arbitration as Respondent's Exhibit 6. The records reflect that Petitioner was seen on May 21, 2015 for a cough. It was noted that for the last 2-3 weeks Petitioner had had severe, sometimes productive cough. It was noted that Petitioner stated that his head cold cleared up after the last office visit with antibiotic treatment, but that this came around shortly thereafter and had persisted. It was noted that Petitioner had had mild seasonal allergies in the past but nothing like this. It was noted that Petitioner denied any particular timing of the cough, that he had a history of GERD but was well-controlled on Prilosec, and that his coughing was not any worse in the evening or morning. The assessment was noted to be that of bronchitis. Petitioner was given a prescription for Levaquin and was advised to take over-the-counter Claritin daily. At the time of the April 29, 2015 visit, it was noted that Petitioner had had head congestion that had recently moved into his chest, that he had subjective fevers with chills, and that his cough was productive of yellow/bloody sputum. It was noted that several guys at Petitioner's work had had this recently and that one ended up in the hospital with "PNA." The assessment was noted to be that of bronchitis and sinus infection, among other issues. Petitioner was given a prescription for Augmentin. (RX6).

The medical records of SIH Logan Primary Care were entered into evidence at the time of arbitration as Respondent's Exhibit 7. The records reflect that Petitioner was seen on October 24, 2018, at which time it was noted that he was seen for a regular check-up. It was noted that Petitioner reported having

a scratching feeling in his left eye for the last two weeks, that it did not bother him if he was lying down but felt like there may be a foreign body in the eye otherwise, and that there was minimal redness but no vision change or other drainage. It was noted that Petitioner reported mowing the lawn frequently and felt that this may have something to do with it, and that he did not recall specific incident/injury to the eye. It was noted that Petitioner's review of systems was negative for cough, shortness of breath and wheezing, that his effort and breath sounds were normal, that he had no wheezes, and that he had no rales. The assessment was noted to be that of irritation of left eye, among other issues. (RX7).

The records of SIH Logan Primary Care reflect that Petitioner was seen on June 9, 2017, at which time it was noted that he stated that he was feeling very good and that he had no complaints. It was noted that Petitioner's review of systems was negative for cough, shortness of breath, and wheezing. It was noted that Petitioner's effort was normal as to the pulmonary/chest physical examination. The assessment was noted to be that of hyperlipidemia. At the time of the March 10, 2017 visit, it was noted that Petitioner was seen in follow-up and was interested in stopping Atorvastatin. It was noted that Petitioner reported feeling well and that he had been exercising more and had lost some weight on purpose. It was noted that Petitioner's review of systems was negative for dyspnea. It was also noted that Petitioner's respiratory physical examination was normal to inspection, that auscultation was normal, and that his effort was normal. The assessment was noted to be that of hyperlipidemia. (RX7).

The records of SIH Logan Primary Care reflect that Petitioner was seen on October 19, 2016, at which time it was noted that he was there for a general check-up and was requesting a colonoscopy. It was noted that Petitioner had no complaints. It was noted that Petitioner's review of systems was negative for cough and dyspnea. It was also noted that Petitioner's respiratory physical examination was normal to inspection, normal to auscultation and normal for effort. Petitioner was given a referral to Gastroenterology. The records further reflect that Petitioner was also given a referral to Dermatology on October 24, 2018. (RX7).

The medical records of Logan Primary Care Services were entered into evidence at the time of arbitration as Respondent's Exhibit 8. The records reflect that Petitioner was seen on January 16, 2014, at which time it was noted that he presented with upper respiratory infection symptoms including runny nose, congestion, mucopurulent nasal discharge, and cough. It was noted that Petitioner's lungs were clear to auscultation and percussion. The assessment was noted to be that of upper respiratory infection and that Petitioner was advised to use Acetaminophen for fever, increase fluids and follow-up for worsening symptoms, development of productive cough or ear pain, or persistence of symptoms for more than one week. At the time of the May 7, 2010 visit, it was noted that Petitioner was seen for follow-up of a sebaceous cyst. (RX8).

The records of Logan Primary Care Services reflect that Petitioner was seen on May 5, 2010, at which time it was noted that he was seen for a sebaceous cyst on the left shoulder which was swollen, tender, and inflamed. It was noted that Petitioner's lungs were clear to auscultation bilaterally with no wheezes, rhonchi or rales on physical examination. The assessment was noted to be that of a sebaceous cyst. At the time of the September 29, 2008 visit, it was noted that Petitioner was seen for a lesion on the right leg. It was noted that on physical examination Petitioner's lungs were clear to auscultation bilaterally with no wheezes, rhonchi or rales, that there was no dullness to percussion, and that there were normal inspiratory and expiratory phases. Petitioner underwent a punch biopsy on that date. At the time of the April 24, 2008 visit, it was noted that Petitioner was seen with upper respiratory infection symptoms and that his current symptoms included dry cough with congestion. It was noted that Petitioner's lungs were clear to auscultation and percussion bilaterally. The assessment was noted to be that of upper respiratory infection. Petitioner was advised to use Acetaminophen for fever, increase fluids and follow-up for worsening symptoms, development of productive cough or ear pain, or persistence of symptoms for more than one week. (RX8).

The records of Logan Primary Care Services reflect that Petitioner was seen on June 15, 2007, at which time it was noted that he was seen for purulent nasal discharge. It was noted that Petitioner's lungs were clear to auscultation and percussion bilaterally. The assessment was noted to be that of sinusitis. At the time of the November 2, 2006 visit, it was noted that Petitioner "messed up" his back again packing deer and that it always hurt, but that it on that date it hurt more. The assessment was noted to be that of low back pain. At the time of the April 5, 2006 visit, it was noted that Petitioner was seen for a re-check of a sebaceous cyst. It was noted that the packing was removed and that the cyst was healing. At the time of the April 3, 2006 visit, it was noted that Petitioner was seen for a large infected sebaceous cyst on the shoulder. Petitioner underwent irrigation and debridement of the cyst on that date. At the time of the February 27, 2006 visit, it was noted that Petitioner presented with upper respiratory infection symptoms including runny nose, congestion, mucopurulent nasal discharge, observed low grade temperature, cough, and sneezing. It was noted that Petitioner's lungs were clear to auscultation and percussion bilaterally. The assessment was noted to be that of upper respiratory infection. Petitioner was advised to use Acetaminophen for fever, increase fluids, and follow-up for worsening of symptoms, development of productive cough or ear pain, or persistence of symptoms for more than one week. (RX8).

The records of Logan Primary Care Services reflect that Petitioner was seen on April 5, 2005, at which time it was noted that he was seen for cardiomegaly. It was noted that Petitioner denied shortness of breath and atypical chest pain, and that during a physical a chest x-ray showed cardiomegaly. Petitioner was recommended to undergo an echocardiogram, stress test, and labs. At the time of the December 27, 2004 visit, it was noted that Petitioner was seen for fasciitis. It was noted that Petitioner had had a flare-up of fasciitis in his foot, that he was limping, that it was hard to walk on it, and that his low back was in dull, constant pain. The assessment was noted to be that of lumbar strain and fasciitis. At the time of the March 5, 2004 visit, it was noted that Petitioner was seen for sinus congestion. It was noted that Petitioner complained of sinus symptoms for four days including congestion, headache, facial pressure, and post-nasal drainage. It was noted that Petitioner had a low-grade fever and cough, and that his lungs were clear. The diagnosis was noted to be that of acute sinusitis and upper respiratory infection. Petitioner was recommended to increase fluids, to use over-the-counter nasal sprays for five days, and to follow-up in two weeks or sooner for new or worse problems. (RX8).

The records of Logan Primary Care Services reflect that Petitioner was seen on April 10, 2003, at which time he was seen for a cough. It was noted that Petitioner had had a cough for the last two weeks, that it came and went, and that the cough got severe and non-productive at times. It was noted that Petitioner's lungs were clear to auscultation and percussion, that there was no decreased fremitus, no egophony, no chest wall tenderness or mass, and that there was no crepitation. It was also noted that Petitioner had good chest wall expansion and effort. The assessment was noted to be that of allergy and mild asthma. Petitioner was given a prescription for Proventil, Allegra and Protonix. At the time of the May 2, 2002 visit, it was noted that Petitioner complained of sinus congestion. It was noted that Petitioner was complaining of sinus symptoms for four days, including congestion, headache, facial pressure, and post-nasal drainage. It was also noted that Petitioner's lungs were clear. The diagnosis was noted to be that of acute sinusitis. Petitioner was recommended to increase fluids, to limit over-the-counter nasal sprays to three days, and to follow-up in two weeks or sooner for new or worse problems. (RX8).

The records of Logan Primary Care Services reflect that Petitioner was seen on January 28, 2002, at which time it was noted that he was seen for sinusitis. It was noted that Petitioner's symptoms included purulent nasal discharge, cough, face pain, fever, and maxillary toothache. It was also noted that Petitioner's lungs were clear to auscultation and percussion bilaterally. The assessment was noted to be that of sinusitis. At the time of the April 9, 2001 visit, it was noted that Petitioner was seen for leg pain. It was noted that in 1997 Petitioner had a rock fall on him in the mines and that the leg was never x-rayed, but that for the last few months he had pain down the back of his leg. It was noted that Petitioner also had GERD and was taking nothing for it. It was noted that Petitioner wished to wait on further testing on his

leg and that he was recommended Protonix for GERD. At the time of the August 30, 1999 visit, it was noted that Petitioner complained of right hip pain for 4-6 months that was unchanged, and that he recently was getting a burning sensation in his right groin. It was noted that Petitioner wore a self-rescuer which weighed 5-6 pounds in the mine and that it put pressure on his anterior groin. It was noted that it seemed to get better when Petitioner was off work on the weekend, that he worked as a mine operator, and that he used his right foot to pull cable over. The assessment was noted to be that of right hip pain. It was noted that Petitioner needed to rest his leg and take over-the-counter pain medications, and that Dr. Smith did not think that physical therapy would help that much. (RX8).

The Layoff Notice was entered into evidence at the time of arbitration as Respondent's Exhibit 9.

CONCLUSIONS OF LAW

With respect to disputed issue (c), pursuant to Section 1(d) of the Workers' Occupational Diseases Act, "the term 'Occupational Disease' means a disease arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment. Such aggravation shall arise out of a risk peculiar to or increased by the employment and not common to the general public." 820 ILCS 310/1(d). To recover compensation under the Workers' Occupational Diseases Act, a claimant must prove that he suffers from an occupational disease and that a causal connection exists between the disease and his employment. An occupational exposure need not be the sole or principal causative factor, as long as it was a causative factor in the condition of ill-being. *Bernardoni v. Industrial Comm'n*, 362 Ill. App. 3d 582, 596 (3rd Dist. 2005).

In the case at hand, the Arbitrator finds that Petitioner failed to prove that he suffered from any occupational lung disease, including coal workers' pneumoconiosis or chronic obstructive pulmonary disease, that arose out of and in the course of the exposures of his coal mine employment, and that his condition of ill-being was causally related to his employment. In so concluding, the Arbitrator finds the chest x-ray interpretations by Drs. Meyer and Castle to be more credible than the interpretations by Drs. Istanbouly and Smith in this matter. Of significance to the Arbitrator is the fact that Dr. Istanbouly is not a B-reader and has never taken the NIOSH B-reading course. (PX1).

The Arbitrator finds to be significant in this case that Dr. Meyer found the chest x-ray of November 4, 2015 to be Quality 3 due to poor contrast and mottle. (RX1). Dr. Meyer testified that mottle can make the film look grainy and simulate small opacities. (*Id.*). In addition, Dr. Castle noted that the film was Quality 2 because of poor contrast and underinflation. (RX2). To the contrary, Dr. Smith found the film to be Quality 1 and did not record any mottle, poor contrast, or underinflation. (PX2). Similarly, Dr. Istanbouly testified that the film was of diagnostic quality and did not indicate any deficiencies in film quality in his interpretation. (PX1). The Arbitrator finds to be significant Dr. Meyer's testimony that it is important for the reviewer of the chest x-ray to note the film quality and the deficiencies to know that he or she took same into account in interpreting the film. (RX1). Similarly, the Arbitrator also finds to be significant that even Dr. Istanbouly noted that the quality of the film was important because the position of the patient or the level of penetration could cause a film to be misleading. (PX1).

The Arbitrator notes that Dr. Istanbouly also diagnosed Petitioner with chronic obstructive pulmonary disease and, per his testimony, he used the GOLD Standard for determining that he suffered from COPD. (PX1). Dr. Istanbouly testified that Petitioner met the standard because of a reduced FEV1 and reduced FEV1/FVC ratio. (*Id.*). Per his own testimony Dr. Istanbouly did not know the specific number for the lower limit of normal for Petitioner's FEV1/FVC, but he was quite positive that Petitioner had an abnormal ratio for his age. (*Id.*). Dr. Castle, on the other hand, testified that in regard to the spirometry performed by Dr. Istanbouly, the lower limit of normal for Petitioner's FEV1/FVC ratio was 65.58% and

that, on Dr. Istanbouly's testing, his FEV1/FVC ratio was 68%. (RX2). Dr. Castle further testified that the studies both by Dr. Istanbouly and by Methodist Hospital were normal, and there was no evidence of obstruction or restriction. (*Id.*).

The Arbitrator also finds to be significant Dr. Castle's testimony that, based on the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition*, Petitioner would be in Class 0 impairment based on his most recent pulmonary function testing and that, based on the objective testing performed on him, he was capable of heavy manual labor. (RX2). As such, the Arbitrator finds that no evidence was provided establishing that any doctor restricted Petitioner from working in the coal mines as a result of any occupational disease. Furthermore, there was no evidence in this case that Petitioner left his coal mine employment due to any breathing problems or pulmonary complaints. Petitioner's testimony at the time of arbitration - as well as the layoff notice as contained in Respondent's Exhibit 9 - indicated that he was part of a mass layoff which occurred in August 2015. (RX9). In fact, on cross examination Petitioner agreed that, but for the layoff, he would have reported for his next shift at the coal mine.

Based upon the foregoing and the record in its entirety, the Arbitrator concludes that Petitioner failed to prove that he suffered from any occupational lung disease, including coal workers' pneumoconiosis, that his condition of ill-being was causally related to his employment or that he suffered a timely disablement as defined in Section 1(e) of the Occupational Diseases Act. All benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TROY HOLLINGSWORTH,

Petitioner,

vs. NO: 14 WC 8471

QUAKER OATS,

Respondent.

20IWCC0178

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, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator ruled that Petitioner was entitled to 170 weeks of temporary total disability benefits. Respondent argues that Petitioner claimed and is entitled to 142 and 6/7 weeks of benefits, from March 25, 2014 through February 4, 2015, from May 5, 2015 through March 14, 2016, and May 17, 2016 through May 15, 2017. Petitioner agrees that he is entitled to only 142 and 6/7 weeks of benefits.

Accordingly, the Commission modifies the award of temporary total disability benefits downward to reflect payments for 142 and 6/7 weeks. The Commission affirms the Arbitrator's award of credits to Respondent of $30,524.40 for temporary total disability benefits already paid and $20,577.80 in in short- and long-term disability benefits paid, for a total of $50,802.20, as stipulated by the parties in the Request for Hearing.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner's current condition of ill-being is causally connected to the accidental injury at work on November 6, 2013.

20IWCC0178

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay Petitioner's medical expenses in the amount of $1,964.00 pursuant to the fee schedule and §§8(a) and 8.2 of the Act, as set forth in Petitioner's Exhibit 17. Respondent is entitled to a credit for any amounts already paid by Respondent on the awarded bills. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent receives a credit, pursuant to §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $678.32/week for 142 and 6/7 weeks, commencing from March 25, 2014 through February 4, 2015, from May 5, 2015 through March 14, 2016, and from May 17, 2016 through May 15, 2017, as provided in §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability benefits of $610.49/week for 94 weeks, because the injuries sustained caused the 25% loss of use of the right arm and 15% loss of use of the right hand, as provided in Section 8(e) of the Act. Respondent shall be given a credit of $17,636.32 for permanent partial disability benefits already paid.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000. The party commencing 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 2020
d: 2/6/20
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOLLINGSWORTH, TROY
Employee/Petitioner

Case# **14WC008471**

QUAKER OATS
Employer/Respondent

20IWCC0178

On 7/8/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0157 ASHER & SMITH
CRIAG SMITH
1119 N MAIN ST PO BOX 340
PARIS, IL 61944

0522 THOMAS MAMER & HAUGHEY LLP
ERIC S CHOVANEC
PO BOX 560
CHAMPAIGN, IL 61824-0560

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

Troy Hollingsworth
Employee/Petitioner

v.

Quaker Oats
Employer/Respondent

Case # 14 WC 8471

Consolidated cases: N/A

20IWCC0178

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Urbana**, on **6/26/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0178

FINDINGS

On **11/06/13**, 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 **$52,908.96**; the average weekly wage was **$1,017.48**.

On the date of accident, Petitioner was **45** 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 **$30,524.40** for TTD, **$0** for TPD, **$0** for maintenance, and **$20,577.80** for other benefits, for a total credit of **$50,802.20**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $1,964.00, as set forth in PX 17, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $Any 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 $678.32/week for 170 weeks, commencing 2/4/13 through 3/11/16 (118 weeks), and 5/17/16 through 5/15/17 (52 weeks) ,as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $50,802.20 for temporary total disability and non-occupational indemnity benefits that have been paid.

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 25% loss of use of the right arm and 15% loss of use of the right hand pursuant to §8 (e) of the Act.

Respondent shall be given a credit of $17,636.32 for permanent partial disability benefits that have been paid.

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

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

Michael K. Nowak, Arbitrator — 7/2/19 Date

ICArbDec p. 2

JUL 8 - 2019

FINDINGS OF FACT

At the time of his accident Petitioner was employed by Respondent as a Process Forming Operator.

The Petitioner testified that he was injured on November 6, 2013, while he was hosing down a conveyor and stepped backward, stepping on the hose, and fell to the ground, hitting his right hand, wrist, and arm. (See Employer's First Report of Injury (RX 4).) He noticed immediate pain in his right hand, wrist, and elbow. Following the injury, the Respondent referred the Petitioner to Dr. Philbert Chen at the Department of Occupational Medicine for Carle Clinic on November 14, 2013. (PX 3) Dr. Chen then referred the Petitioner to Outpatient Occupational Therapy for an evaluation, and recommended injections on Petitioner's right elbow. (PX 4) At Occupational Therapy, Petitioner was treated by Dr. Anne Li, and her treatment consisted of physical therapy and two injections to his elbow. His last treatment for occupational therapy was on February 6, 2014.

Petitioner stated that he continued to have pain symptoms to his wrist, elbow, and right arm, and at that time, was seen by his family physician, Dr. Guinto at Family Medical Center in Paris, Illinois, on February 17, 2014. Dr. Guinto noted that he was having pain in his right shoulder, wrist, and elbow. At that time, Dr. Guinto referred him to neurology for an EMG. (PX1)

An EMG was performed on March 31, 2014. Dr. Guinto then set up an MRI on April 16, 2014. Following the MRI, Dr. Guinto referred the Petitioner to Dr. Steven H. Packard, an orthopedic surgeon, with Orthopedic Partners. (PX 5)

The Petitioner saw Dr. Packard on June 18, 2014. At that time, it was Dr. Packard's recommendation that the Petitioner proceed with a decompressive surgery for his cubital tunnel and carpal tunnel. At that time, Dr. Packard released him to perform modified work in the form of somewhat limited grasp and release, and the ability to change tasks on a frequent basis. He further indicated that if Petitioner cannot be given modified work, his best chance of returning to gainful employment may be to pursue surgical intervention, which he had recommended. (PX 5)

Dr. Packard did perform surgery on October 14, 2014, which consisted of cubital tunnel decompression with anterior transfer of ulnar nerve and right carpal tunnel release. (PX 6) The Petitioner followed up with Dr. Packard two days following surgery. At that time, Dr. Packard recommended home exercises. Then, on November 6, 2014, Dr. Packard noted at an office visit that Petitioner still had 4 plus pain and tenderness over insertion of ECRB on the lateral epicondyle right elbow. Dr. Packard injected Petitioner's right elbow, and he made a referral to Occupational Therapy.

Respondent set up an IME with Dr. Robert Baltera with the Indiana Hand to Shoulder Clinic. Petitioner was seen by Dr. Baltera on December 2, 2014. (PX 14) During that visit, Dr. Baltera performed a physical examination, and his impression was that Petitioner appeared to have done well status post carpal tunnel release, as well as ulnar nerve transposition, however, he still has persistent lateral elbow pain, most likely consistent with lateral epicondylitis. It was Dr. Baltera's opinion that it is more likely than not that Petitioner's carpal tunnel syndrome, cubital tunnel syndrome, and lateral epicondylitis is posttraumatic in nature, directly due to the fall he sustained at work. (PX 14) At that time, he noted that Petitioner may be a candidate for lateral epicondylectomy due to his residual symptoms at the lateral aspect of his elbow. However, he first recommended Xylocaine injection prior to recommending proceeding with lateral epicondylar debridement.

Petitioner continued to treat with Dr. Packard, seeing him on follow-up on February 11, 2015. At that visit, Dr. Packard noted that Petitioner had been waiting to get a determination that his problem was work related, and that he had not received any physical therapy post op. At that visit, Dr. Packard injected Petitioner's elbow, made a physical therapy referral, ordered a tennis elbow air pad, and indicated that Petitioner was fit for work with a 5-pound lifting restriction.

The next visit with Dr. Packard was on March 26, 2015. It was noted at this appointment that Petitioner continued to have proximal right forearm pain, elbow joint pain when actively moved, and is exacerbated by wrist extension and by lifting an object. It was Dr. Packard's plan that outpatient lateral elbow tennis elbow reconstruction be offered. He indicated that due to the poor result from injections, Petitioner's outcome on surgery expectations would be lower, with a 50-60% chance of good to excellent outcome with surgery, *i.e.*, a failure rate of 40-50%.

Petitioner testified that was the last visit he had with Dr. Packard due to Dr. Packard's retirement.

Prior to Dr. Packard's retirement, he did refer the Petitioner to Accelerated Rehabilitation Center for hand therapy, consisting of pain control, edema control Iontophoresis. (PX 7) Petitioner received an initial evaluation on February 13, 2015, at Accelerated Rehabilitation, and had followup treatments through May 8, 2015.

Petitioner testified that on May 5, 2015, he was laid off from work, and received TTD payments until March 14, 2016.

On August 13, 2015, Dr. Baltera wrote a letter to Respondent's Attorney advising him that his recommendation remained unchanged as far as recommending that Dr. Packard perform a 2 ml Xylocaine injection into the lateral epicondyle. Then, Dr. Baltera saw Petitioner on December 29, 2015. At that time, it was his opinion that further surgery would not be of any benefit. He felt that the Petitioner had reached maximum medical improvement and would recommend a Functional Capacity Evaluation to determine permanent work restrictions.

An FCE was performed on February 18, 2016. The results of the FCE indicated that Petitioner demonstrated a physical capability and tolerances to function at a medium physical demand level, as delineated by a 2-hand occasional floor to waist lift of 30 pounds. Following the FCE, Respondent brought Petitioner back to work on March 11, 2016, where he worked until May 16, 2016. Petitioner testified that during that time, he

noted that his arm and hand were swelling due to the work he was performing. At that time, Respondent requested that the Petitioner obtain a separate Disability Examination, which was performed by SafeWorks Illinois by Dr. David Fletcher on April 25, 2016. The Petitioner's complaints were numbness in fingers of right hand, moderate pain behind his right elbow, constant pain on ulnar side right elbow, increased right elbow pain with activity, varying sharp pain and swelling, and constant pain in lateral and medial wrist and lack of flexibility.

Dr. Fletcher completed the ADA Accommodation Forms from the Respondent, and his responses were: (1) Petitioner has a physical impairment which substantially impacts his ability to perform manual tasks; (2) He has permanent work restrictions; (3) He does not have any temporary restrictions; and (4) He is not able to perform the essential functions of the Process Forming Operator position with or without an accommodation. He indicated that Petitioner's permanent work restrictions were no lifting more than 30 pounds, that he be restricted to limited use of right upper extremity to avoid high force/high frequency repetitive tasks, vibration, avoid frequent pressure on the volar surface of his wrist, and only occasional high torque tasks. Frequent means more than 2/3rds of the workday and occasional is less than 1/3rd of the work day. Dr. Fletcher also recommended impact-resistant work gloves.

Following the Disability Examination and Report, the Respondent sent the Petitioner a letter on May 16, 2016, indicating that they were unable to accommodate the Petitioner with his current restrictions. (PX 16)

Following Petitioner's layoff on May 16, 2016, he was referred by Dr. Guitos former practice, to UAP Clinic Bone & Joint Center in Terre Haute, Indiana, as Dr. Packard has also retired. (PX 8) Petitioner had testified earlier Dr. Packard had retired, and he had no orthopedic specialist assigned to his case and giving him treatment. On June 28, 2016, he saw Dr. Jaafar, who recommended an EMG. Following the EMG, Dr. Jaafar referred Petitioner to UAP Hand Surgeon, Dr. Douglas McGuirk. Petitioner saw Dr. McGuirk on November 29, 2016. Following the exam and review of test results, Dr. McGuirk's impression was: (1) right limb pain; (2) osteoarthritis right elbow; (3) right lateral epicondylitis; (4) right cubital tunnel syndrome; (5) right carpal tunnel syndrome; and (6) diabetes mellitus. Dr. McGuirk opined that he felt Petitioner's symptoms in his right arm are directly secondary to his work injury on November 6, 2013. He further indicated that Petitioner's current symptoms in his right arm including his right elbow pain, numbness and tingling as well as right hand pain are secondary to his initial work injury as well as subsequent surgery he has had on his right arm. At that time, Dr. McGuirk recommended another MRI of his right elbow. Following the MRI, Dr. McGuirk performed surgery on February 21, 2017, which consisted of right extensor carpi radialis brevis tenotomy at the elbow, right ulnar nerve subcutaneous transposition at the elbow, right carpal tunnel release, and right long arm plaster splint application.

On March 22, 2017, Dr. McGuirk noted that the Petitioner could return to work on March 23, 2017, with the following restrictions: no lifting/gripping/grasping/pushing/pulling greater than 2 pounds for one week with right hand; then, on March 29, 2017, no lifting/gripping/grasping/pushing/pulling greater than 5 pounds with the right hand for one week; then on April 5, 2017, no lifting/gripping/grasping/pushing/pulling greater than 10 pounds with the right hand. Petitioner then saw Dr. McGuirk on April 17, 2017, wherein the Doctor indicated his restrictions at that time would be 15-pound weight restriction for two weeks, then 25 pounds for two weeks, then no restrictions as of May 15, 2017. (PX 13)

On December 3, 2013, Dr. Li placed the Petitioner on work restrictions consisting of left, pull, push 15 pounds. (PX4) Then, on December 23, 2013, Carle Outpatient Occupational Therapy records modified the restrictions to 10 pounds lifting and light duty. Petitioner continued to work during this period of time with modified light-duty/transitional work. As March 25, 2014, the Respondent did not offer any accommodated transitional work for the Petitioner, and he was off work from March 25, 2014, through February 4, 2015. (PX 18) During that period of time, Petitioner was on specific work restrictions from his family physician, Dr. Guinto, and his orthopedic surgeon, Dr. Packard. (PX 13)

On February 5, 2015, Respondent offered Petitioner transitional/light-duty work until May 4, 2015. On May 5, 2015, Petitioner was not offered any transitional work, but was paid TTD until March 14, 2016. (PX 18)

On February 18, 2016, Petitioner underwent a Functional Capacity Evaluation, which stated that he could perform medium duty with lifting up to 30 pounds. The report also stated that he was employable if a position was available within the capabilities and the tolerances shown in the FCE Report. (PX 11) The Petitioner returned to work under those modifications/restrictions from March 11, 2016, through May 16, 2016.

Petitioner testified that the Respondent wanted him to obtain a work evaluation, which he set up and paid for on his own from Dr. David Fletcher. On April 25, 2016, Dr. Fletcher's Report stated that he had permanent work restrictions, consisting of no lifting more than 30 pounds, limited use of right upper extremity to avoid high force/high frequency repetitive tasks, vibration, avoid frequent pressure on the volar surfaces of his wrist, and only occasionally high torque tasks. He indicated frequent means more than 2/3rds of the workday and occasional is less than 1/3rd of the workday. Impact/resistant work gloves were also recommended.

Following Dr. Fletcher's Disability Examination Report, the Respondent sent a letter to Petitioner on May 16, 2016. (PX 16) The letter contained the permanent medical restrictions outlined by Dr. Fletcher, and advised the Petitioner that the Respondent was unable to accommodate those restrictions as of May 16, 2016. Petitioner was then off work from May 17, 2016, until May 15, 2017, when he was released to return to work by orthopedic surgeon, Dr. McGuirk.

From August 25, 2016, through May 15, 2017, the Petitioner also was placed on restrictions by UAP Bone and Joint Center until May 15, 2017, when Dr. McGuirk released the Petitioner to return to work. (PX's 8, 9 and 13)

CONCLUSIONS

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

The Respondent set up an IME with Dr. Robert Baltera with Indiana Hand to Shoulder Clinic. Following Dr. Baltera's physical examination and review of medical records, it was Dr. Baltera's opinion that it is more likely than not that Petitioner's carpal tunnel syndrome, cubital tunnel syndrome, and lateral epicondylitis is post-traumatic in nature, directly due to the fall he sustained at work on November 6, 2013. (PX 14) Furthermore, following Dr. Packard's retirement, the Petitioner was treated by Dr. Douglas McGuirk, an orthopedic surgeon, at UAP Bone & Joint Center in Terre Haute, Indiana. Dr. McGuirk opined that he felt Petitioner's symptoms in his right arm are directly secondary to his work injury on November 6, 2013. Dr. McGuirk stated: I do feel his

current symptoms in his right arm including his right elbow pain, numbness and tingling as well as right hand pain are secondary to his initial work injury, as well as subsequent surgery he has had on his right arm. (PX 9)

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that the Petitioner has sustained his burden of proof on the issue of causal connection. The opinions of Respondent's IME, as well as Petitioner's treating physician, Dr. Douglas McGuirk, both established that Petitioner's current condition of ill-being was causally related to the work injury on November 6, 2013.

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?

Based upon the record taken as a whole, the Arbitrator finds the care and treatment Petitioner received from Drs. David Packard and Douglas McGuirk represent reasonable and necessary treatments for his work injury on November 6, 2013. Medical bills related to said treatment from Drs. Packard and McGuirk were reasonable and necessary. The Arbitrator notes that prior medical bills were paid by respondent.

Respondent shall pay reasonable and necessary medical expenses of $1,964.00 as provided in Sections 8(a) and 8.2 of the Act, reflected in Petitioner's Exhibit 17. Respondent is entitled to credit for any amounts paid on the awarded bills by Respondent and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Issue (L): What temporary benefits are in dispute? TTD.

Petitioner's testimony and the medical records of Drs. Li, Guinto, Packard, Fletcher, and McGurik and the FCE indicate Petitioner was temporarily totally disabled from December 11, 2013, through March 11, 2016 (118 weeks); and May 17, 2016, through May 15, 2017 (52 weeks), representing a total of 170 weeks.

Petitioner is entitled to receive 170 weeks of TTD for the aforementioned weeks.

Respondent is entitled to credit for $30,524.40 paid in TTD, and $20,577.80 paid in STD and LTD, for a total credit of $50,802.20.

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 the Respondent introduced an impairment rating from its IME indicating a 10% impairment of the right arm below the elbow, which is equal to 6% of the whole person. 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 Process Forming Operator. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 45 years old at the time of his injuries. 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. The Petitioner has returned to his job with the Respondent as of May 15, 2017. He was 49 years old when he returned to work following his surgeries, and was released with no restrictions.

The Petitioner missed more than 2 2 years from work while he was receiving treatment, consisting of two surgeries to his right wrist and two surgeries to his left elbow. Petitioner testified that he has been trying to get strength back in his arm, but he can't seem to get a lot of strengthen, indicating that he has lost a lot of strength. He noted that his grip strength is not what it used to be.

The Arbitrator notes that while Dr. McGuirk released the Petitioner to return to work with no restrictions following his second surgery on May 15, 2017, however, both the FCE and Dr. Fletcher's Disability Examination performed in 2016 state that Petitioner does have permanent restrictions, the Arbitrator therefore gives *greater* weight to this factor.

Based upon the foregoing factors, the Arbitrator awards the Petitioner 15% loss of use of right hand as Petitioner underwent two carpal tunnel releases, and 25% of right arm in that Petitioner had cubital tunnel syndrome and right lateral epicondylitis, which also resulted in two operative procedures.

Respondent shall be given a credit of $17,636.32 for permanent partial disability benefits that have been paid.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jesse L. Caver,

Petitioner,

vs. NO: 18 WC 5916

City of Chicago, Dept. of Streets & Sanitation, **20IWCC0179**

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission corrects the decision of the Arbitrator at page 2 of the Form decision and page 7 of the Addendum to show that Petitioner was entitled to TTD from 2/21/18 through 8/27/18, for a period of 26-6/7 weeks.

The Commission also modifies the decision of the Arbitrator at page 2 of the Form decision as well as at pages 9-11 of the Addendum to show that Petitioner is entitled to additional compensation pursuant to §19(l) in the amount of $5,640.00 ($30.00/day x 188 days) and §19(k) in the amount of $17,351.31 (50% of outstanding medical expenses and TTD, or .5 [$18,832.20 + $15,870.42]) as well as attorneys' fees pursuant to §16 in the amount of $3,470.26 (20% of §19[k] award, or .2 [$17,351.31]).

20IWCC0179

Finally, the Commission corrects and clarifies the Arbitrator's "Findings" at page 2 of the Form decision to show that Respondent is entitled to a credit pursuant to §8(j) of the Act in the amount of $425.42 (not $425.52 per RX4) for medical benefits paid. The Commission notes that the Arbitrator ultimately took this credit into account at page 11 of the Addendum of his decision by deducting the credit from the total amount of medical bills and awarding medical expenses in the amount of $18,832.20 ($19,257.62 - $425.42). However, the Arbitrator also mistakenly referred to this credit as equaling "$425.52" and "$424.52" in the final paragraph of his Addendum. All references in the decision to said credit are hereby corrected to show $425.42.

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 10/18/18 is affirmed and adopted with changes as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $590.92 per week for a period of 26-6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses in the amount of $18,832.20, pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to the Petitioner additional compensation in the amount of $17,351.31, as provided in §19(k) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to the Petitioner additional compensation in the amount of $5,640.00, as provided in §19(l) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to attorney for the Petitioner legal fees in the amount of $3,470.26 as provided by §16 of the Act; the balance of attorney fees to be paid by Petitioner to his attorney.

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

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

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

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

DATED:
o:1/21/20 MAR 16 2020
MP/pmo
68

Marc Parker

Barbara N. Flores

DISSENT

I disagree with the award of penalties and attorneys' fees under Sections 19(k), 19(l) and 16.

Respondent from the outset had denied the compensability of the claim. The undisputed facts show Petitioner sustained an unwitnessed accident when descending stairs at work. The Supervisor's Statement, prepared by Acting Chief Dennis White on information from Petitioner at the hospital, states: "Jesse Caver told me he was walking down the stairs to use the restroom, then slipped and fell down the stairs and hurt his ankle." (RX1) The report does not indicate the stairs were wet, defective or of unusual configuration. Based on the Supervisor's Statement, Respondent had a reasonable basis to dispute the compensability of the claim.

Section 9110.70 of the Rules Governing Practice Before the Illinois Workers' Compensation Commission, states, in pertinent part: "...if the employer denies liability for payment of temporary total compensation for whatever reason, provide the employee with a written explanation for the denial;"

Respondent responded to Petitioner's demand for payment and communicated to Petitioner the reason for the denial as required by the Illinois Workers' Compensation Act and the Rules Governing Practice Before the Illinois Workers' Compensation Commission. Respondent advised Petitioner the claim was denied because it was found not compensable. The notice to Petitioner as to the basis for the denial complies with section 19(l) and Section 9110.70 of the Rules Governing Practice Before the Illinois Workers' Compensation Commission.

Respondent did not refuse to pay without good and just cause under Section 19(l) and did not unreasonably or vexatiously delay benefits under Section 19(k). Respondent's refusal to pay was based on a reasonable defense. As an award of penalties is not appropriate, attorney fees under Section 16 are inapplicable. Thus, I dissent.

Kathryn A. Doerries

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

CAVER, JESSE L
Employee/Petitioner

Case# **18WC005916**

CITY OF CHICAGO DEPT OF STREETS AND S
Employer/Respondent

20IWCC0179

On 10/18/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1293 VITELL & SPITZ LTD
EDWARD SPITZ
155 N MICHIGAN AVE SUITE 600
CHICAGO, IL 60601

0010 CITY OF CHICAGO/LAW DEPT
DANIEL KALLIO
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)
COUNTY OF COOK)

20IWCC0179

☐ Injured 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

Jesse L. Caver,
Employee / Petitioner

Case # 18 WC 05916

v.

City Of Chicago, Dept. Of Streets & S,
Employer / Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party.

The matter was heard by the Honorable **Robert M. Harris** , arbitrator of the Commission, in the city of **Chicago** , on **August 27, 2018** . After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues circled below and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was the respondent operating under and subject to the Illinois Worker's Compensation or 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 the 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 _____

FINDINGS 20IWCC0179

- On **02/20/2018** , the respondent **City Of Chicago, Dept. Of Streets & S** 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 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 $ **31,023.45** ; the average weekly wage was $ **886.38** .

- At the time of the injury the petitioner was **50**, years of age, married with **2** children under 18.

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

- To date, **$425.52** has been paid by the respondent on account of this injury. Respondent shall receive credit in this amount.

******* SEE ATTACHED RIDER *******

ORDER

- Respondent shall pay Petitioner Temporary Total Disability benefits of $ **590.92** /week for a period of **26-5/7** weeks, from **February 21, 2018** through **August 28, 2018**, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of Petitioner, the disabling condition is temporary and has not yet reached a permanent condition, pursuant to Section 19(b) of the Act.

- Respondent shall pay Petitioner $**18,832.20** for reasonable and necessary medical services, as provided in Section 8(a) and **after** all applicable adjustments are made to this amount pursuant to the fee schedule in Section 8.2 of the Act, as found in Petitioner's Exhibits 1-8 admitted into evidence.

- Respondent shall pay $**7,935.16** in penalties, as provided in Section **19(k)** of the Act.

- Respondent shall pay $**5,640.00** in penalties, as provided in Section **19(l)** of the Act.

- Respondent shall pay $**5,889.09** 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.

Robert M. Harris

20IWCC0179

Robert M. Harris, Arbitrator

Dated: October 18, 2018

OCT 18 2018

STATE OF ILLINOIS)
)
COUNTY OF COOK)

20IWCC0179

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jesse L. Caver,
Employee / Petitioner
v.
City Of Chicago, Dept. Of Streets & S
Employer / Respondent

Case # **18 WC 05916**

STATEMENT OF FACTS

On February 20, 2018, Petitioner Jesse Caver was employed by Respondent City of Chicago. On February 20, 2018, Petitioner was working at a bridge located at 3331 E. 92nd St., Chicago, Illinois at the river (Res. Ex. #1) Petitioner testified he was working in the bridge house which is located at one end of the bridge and sits on top of the bridge. Petitioner at that time was being trained how to operate the bridge. Petitioner testified that he would lower and raise to bridge according to the boat traffic in the river. Petitioner testified that on February 20, 2018 it was snowing and raining outside. Petitioner further testified the condition of the stairs were wet. While at work that day he had to go use the bathroom. The bathroom is located outside the bridge house and beneath the bridge. Petitioner had to go outside the bridge house and down some stairs leading to the bathroom. While walking down the stairs, Petitioner slipped and fell and twisted his right ankle. (Res. Ex.#1) Petitioner testified he gave notice of the incident to his trainer, a Ms. Chiquila Brown and Petitioner then called the employer's emergency desk. (Res. Ex.#1) Petitioner then drove himself to Advocate Trinity Hospital. (Pet. Ex.#1) At the hospital it was noted the incident occurred just prior to arrival. (Pet. Ex.#1) Petitioner's acting chief Dennis White was notified of this incident by their supervisor, Darryl Rouse. (Res. Ex.#1) Dennis White then met Petitioner at Advocate Trinity Hospital. (Res. Ex.#1) At the hospital, Dennis White took a statement from Petitioner regarding the accident. The "Supervisor Statement" notes as follows:

"Jesse Caver told me he was walking down the stairs to use the restroom, then slipped and fell down the stairs and hurt his ankle". (Res. Ex.#1) This "Supervisor Statement" was signed by Dennis White on April 11, 2018 and by his own statement, he states there was a delay in completing the Injury on Duty Report because "it was done at the hospital." (Res. Ex.#1)

The official "City of Chicago Injury on Duty Report" was entered on February 26, 2018. (Res. Ex.#1) This Report indicates the "Reported Incident Description" as follows: "Jess caver was walking down the stairs to use the restroom and slipped down the wet stairs and twisted his right ankle."

While at the hospital in the ED, Petitioner gave an injury history as follows: "The location where the incident occurred was at work. Well appearing pt presents to ed with right ankle pain s/p incident at work pta. pt states he slipped and twisted and fell onto his right ankle. no other injuries noted." Petitioner was examined and x-rays were taken of his right ankle, which was wrapped in an ace wrap and crutches were provided. Petitioner was advised to follow up with a primary care provider or a specialist as necessary and was given a prescription for Motrin/Advil 600 mg tablets and discharged. (Pet. Ex.#1)

On February 27, 2018, Petitioner followed up with an orthopedic surgeon, David N Garras, M.D. at Midwest Orthopedics Consultants. Dr. Garras recorded a history from Petitioner as follows: "Patient is a bridge operator. The problem started February 20, 2018 after an injury at work. He was going to the bathroom, slipped on metal stairs in a cork staircase outside as it was snowing and raining and slippery as there is no bathroom inside, and he twisted his ankle inward." Respondent introduced photographs of the stairs which by Respondent's own admission were taken after the accident but clearly show the stairs were made of metal and cement. (Res. Ex. #4) Petitioner also advised Dr. Garras that that he went to the emergency room, where he was told he has no ankle fractures and the ankle was wrapped in an ace bandage and he was given crutches. Petitioner described his pain as throbbing, aching. The symptoms are constant and are unchanged since the injury. The symptoms are made worse with moving and often cause the patient to wake up from sleep. His pain is localized to the medial aspect of the ankle and foot and his swelling has gotten a little better since the accident. (Pet. Ex.#2) Dr. Garras examined Petitioner's right ankle and found moderate medial swelling tenderness at the deltoid ligament attachment in the posterior tibial tendon and medial gutter and the ankle joint by palpitation. Petitioner's antalgic gate favored the injured side. Dr. Garras had right ankle x-rays taken ordered an MRI to rule out possible fractures or possible posterior tibial tendon tear. Dr. Garras prescribed a "tall Cam walking boot" and told him he may begin weight bearing as tolerated. Petitioner was instructed in a home exercise program and to use ice rest and elevate this for. Petitioner was also advised to take 325 mg of aspirin daily while immobilized in order to decrease the risk of clot. Petitioner was taken off work at this time (Pet. Ex.#2)

On March 21, 2018, Petitioner had a follow-up appointment with Dr. Garras to discuss the results of his MRI performed on March 19, 2018. The MRI indicated a mild sprain medial deltoid ligament complex and minimal bone contusion. Dr. Garras prescribed physical therapy continued use for protective brace to support the ankle and weight-bearing as tolerated. Petitioner was taken off work at this time and advised to follow up with Dr. Garras in four weeks. (Pet. Ex.#2) Petitioner followed up with Dr. Garras on April 17, 2018 and Dr. Garris advised Petitioner to continue taking aspirin to reduce the risk of blood clots while immobilized, continue therapy, continue wearing the brace and follow-up on May 30, 2018. Petitioner was returned to work on April 23, 2018 with the following modifications to his duties of "sit down only, race/crutches or cane." (Pet. Ex.#2) Petitioner testified that he took the return to work slip with

the restriction to his supervisor Darryl Rouse and that Rouse advised him that Respondent could not accommodate these restrictions. Petitioner followed up with Dr. Garras on May 30, 2018 and was again returned to work with the same restrictions as before, (Pet. Ex.#2) Petitioner took this return to work slip with the restrictions to his supervisor and was advised that Respondent could not accommodate these restrictions. Petitioner was given a follow-up date of July 11, 2018 to see Dr. Garras and on that date he was again returned to work modified duty with restrictions of no climbing, no use of ladders and sitting work only. Petitioner took this return to work slip with the restrictions to his supervisor and was advised again Respondent could not accommodate these restrictions (Pet. Ex.#3) Petitioner was given a follow-up date of August 8, 2018 to see Dr. Garras and on that date Petitioner was again returned to work modified duty with same restrictions as before of no climbing, no use of ladders, continuous sitting only. Petitioner again took this return to work slip with the restrictions to his supervisor and was again advised Respondent could not accommodate these restrictions. Petitioner was given a follow-up date with Dr. Garras on September 19, 2018. (Pet. Ex.#3)

During his treatment by Dr. Garras, Petitioner attended physical therapy at ATI Physical Therapy for treatment to his right ankle (Pet. Ex.#4)

Petitioner testified Respondent had not paid any of his medical bills. Respondent introduced into evidence a "Payment Listing" printout of medical bills received by the City of Chicago regarding the claim of Jesse Caver. (Res. Ex. #4) This listing indicates a total amount for medical services rendered to the Petitioner $19,257.62. It also indicates payments made by City of Chicago in the amount of $425.42. At trial, Petitioner stipulated that the Respondent should receive a credit for any payments made by the City of Chicago. (Res. Ex. #4)

CONCLUSIONS OF LAW

Regarding disputed Issue (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:

Petitioner's unrebutted testimony was that he was at work in the morning of February 20, 2018 as a bridge tender in training at the bridge located at 3331 E. 92nd St., Chicago, Illinois at the river. Petitioner was working in the bridge house which is located on top of the bridge. While at work in the bridge house that morning, Petitioner had to use the bathroom. The bathroom was located outside of the bridge house and below the bridge. Petitioner had to traverse steel and concrete stairs to get to the restroom. Petitioner testified that it was raining and snowing the day of the accident. **Petitioner further testified the condition of the stairs were wet**. While going down the stairs, Petitioner twisted his right ankle.

"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." *Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill. 2d 52 (1989) "An injury is received in the course of employment where it occurs within a period of employment and at a place where the worker may reasonably be in the performance of his duties, and while he is fulfilling those duties were engaged in something incidental thereto." *Scheffler Greenhouses, Inc. v. Industrial Comm'n*, 66, Ill. 2d 361, (1977) "...injuries sustained by an employee while in the performance of reasonable, necessary acts of personal comfort may be found to have occurred in the course of his employment, since they are incidental to the employment." *Eagle Discount Supermarket v. Industrial Comm'n,* 82 Ill. 2d331(1980).

Petitioner was at work in a place, the bridge house, where it is apparent that climbing and traversing **wet** stairs made out of steel and cement which are outside the bridge house, especially during a day that is raining and snowing outside, is both connected with and incidental to his employment and presented an increased risk of injury to such employees under such circumstances. Petitioner faced an increased risk of employment and as a result, sustained a compensable injury. Traversing this type of wet stairs under such weather conditions clearly increased Petitioner's risk of injury during the course of his employment. The use of the bathroom, which is outside the bridge house and below the bridge, is necessary to Petitioner's health and comfort, and such sue is expected and normal use and is incidental to his employment. *Hunter Packing Co. v. Industrial Comm'n*, 1 Ill. 2d. 99 (1953). Traversing wet steel and concrete stairs to take a restroom break presented an increased risk of injury not confronted by the general public. The Arbitrator draws the inference that these steel and concrete stairs positioned outside of an attached to the bridge house were not accessible by the general public. Further, the Arbitrator examined the photos of the accident scene (RX 3 A,B,C) and finds they depict the condition of the concrete and steel stairs as hazardous and unlike typical stairs or steps commonly used by the general public. It is clear that traversing such stairs, as positioned, and when wet, presents a clear increased risk and hazard to employees so exposed during the course of employment. This should have been obvious to Respondent.

Furthermore, the Arbitrator emphasizes that Respondent offered no testimony or record evidence contrary to Petitioner's testimony which remained unrebutted.

Furthermore, the Arbitrator emphasizes the official "City of Chicago Injury on Duty Report" (Res. Ex.#1) unequivocally - and without indicating any challenge to Petitioner's reported history by the supervisor - indicates the "Reported Incident Description" as follows: "Jess caver was walking down the stairs to use the restroom and slipped down the wet stairs and twisted his right ankle."

The Arbitrator finds and concludes this "City of Chicago Injury on Duty Report" supports a finding of a compensable injury and offered Respondent no evidence or reasonable basis to disputed and deny this claim.

Based on the foregoing, the Arbitrator finds and concludes Petitioner sustained an accidental injury arising out of and in the course of his employment with Respondent on February 20, 2018.

Regarding Disputed Issue (F): Is Petitioner's present condition of ill-being causally related to the injury? The Arbitrator finds and concludes as follows:

Petitioner has proven causation, both by his unrebutted testimony and after a thorough review of the records. No evidence was offered to dispute, let alone rebut, causation.

On February 20, 2018, Petitioner suffered an injury to his right ankle resulting from an accident that arose out of and in the course of his employment with Respondent. Petitioner sought medical care the same morning of the accident at Advocate Trinity Hospital. Petitioner was diagnosed with an ankle sprain which caused pain and swelling and was discharged the same day. Petitioner was advised to follow up with his primary care physician or a specialist. (Pet. Ex. #1) Petitioner followed up with Dr. David Garras, an orthopedic surgeon on February 27, 2018. Dr. Garras noted a history that Petitioner while at work slipped on some metal stairs and injured his right ankle. Dr. Garras treated Petitioner from February 27, 2018 until August 27, 2018, the date of trial. Petitioner testified he has a follow-up visit with Dr. Garras on September 19, 2018. All the treatment rendered by Dr. Garras involved Petitioner's right ankle. (Pet. Ex.#2) Petitioner sought treatment shortly after the accident and has continued to be treated for his injury until the date of trial.

Based on the foregoing, the Arbitrator finds that Petitioner proved a causal connection exists between his current condition of ill-being and the accident of February 20, 2018.

Regarding disputed Issue (J): Were the medical services that were provided to the petitioner reasonable and necessary? The Arbitrator finds and concludes as follows:

On February 20, 2018, Petitioner suffered an injury to his right ankle resulting from an accident that arose out of and in the course of his employment by Respondent. Petitioner sought medical care the same morning of the accident at Advocate Trinity Hospital. Petitioner was diagnosed with an ankle sprain which caused pain and swelling and was discharged the same day. Petitioner was advised to follow up with his primary care physician or a specialist. (Pet. Ex. #1) Petitioner followed up with Dr. David Garras

on February 27, 2018. Dr. Garras ordered appropriate diagnostic tests, prescribed braces and crutches, prescribed physical therapy and had Petitioner follow-up on a regular basis for treatment. (Pet. Ex.#2 & 3) **The medical services provided to Petitioner were clearly shown to be reasonable and necessary. Further, the Arbitrator emphasizes no evidence, medical or otherwise, was offered to challenge or dispute this conclusion.**

Petitioner at trial introduced into evidence certain medical bills for services rendered on his behalf as follows:

ATI – $1776.81 (Pet. Ex. 4)

Premier River North (MRI) – $4740.00 (Pet. Ex. #5)

Advocate Medical Group – $360.00 (Pet. Ex. #6)

Advocate Trinity Hospital - $1,540.00 (Pet. Ex. #7)

Integrated Imaging Consultants – $40.00 (Pet. Ex. #8)

The bills for Advocate Trinity Hospital and Midwest Orthopedic Consultants are included in their medical records. (Pet. Ex. #1 & #2)

Respondent introduced into evidence as exhibit number four a Payment Listing for the Petitioner. This Payment Listing indicates that Respondent received medical bills for the Petitioner in excess of $19,257.62 and has made payments $425.42. This leaves a balance of $18,832.20. This exhibit introduced by Respondent into evidence with no objection by Petitioner is an admission against interest by the Respondent and the medical bills found therein are awarded to Petitioner, subject to the provisions of the Commission fee schedule. Furthermore, Petitioner stipulated at trial that Respondent shall be given a credit for any medical bills that Respondent has already paid.

Regarding disputed Issue (K): What amount of compensation is to for temporary total disability? The Arbitrator finds and concludes as follows:

Petitioner sought medical treatment for this injury at Advocate Trinity Hospital on the accident date. Petitioner was discharged from the hospital on that same day and was told to follow up with his primary care physician or a specialist. Petitioner was discharged with his right ankle wrapped Ace bandage and was provided crutches. (Pet. Ex. #1) Petitioner followed up with Dr. David Garras and the earliest he could get in to see Dr. Garras was February 27, 2018. On that date, Dr. Garras took Petitioner off work, ordered an MRI and made a follow-up appointment March 21, 2018. The MRI was performed on March 19, 2018. Petitioner followed up with Dr. Garris on March 21, 2018 when they discussed the results of the MRI. Petitioner saw Dr. Garras again on April 17, 2018. On that date, Dr. Garras returned the Petitioner to work with the following restrictions: Petitioner was to sit, use a brace, a cane and crutches. (Pet. Ex. #2) Petitioner testified that he attempted to return to work with these restrictions and

his supervisor, Darrell Rouse, advised him that **his employer would not allow Petitioner to return to work with these restrictions.**

These restrictions were similar to the ones that Petitioner was given by Advocate Trinity Hospital, especially the use of crutches. Petitioner had follow-up appointments with Dr. Garris on May 30, 2018, July 11, 2018 and August 8, 2018. At all of these follow-up appointments, Dr. Garras placed restrictions on Petitioner's return to work. On May 30, 2018, the restrictions were the same as on April 17, 2018. On July 11, 2018 Petitioner was returned to work with the restrictions of no climbing or use of ladders. On August 8, 2018 Petitioner was returned to work with the restrictions of no climbing or use of ladders. (Pet. Ex. #2 & 3) **Petitioner testified that during this time, he was not allowed to return to work for Respondent with these restrictions**. As a result, Petitioner has been off work since February 21, 2018 through the date of trial August 27, 2018 a period of 26 6/7 weeks.

The Arbitrator emphasizes Respondent offered no evidence contrary to Petitioner's testimony.

Based on the foregoing, the Arbitrator finds and concludes Respondent shall pay Petitioner Temporary Total Disability benefits of a $590.92 per week for a period of 26-6/7 from February 21, 2018 through August 28, 2018. Petitioner was not at MMI and Respondent did not accommodate his work restrictions.

Regarding disputed Issue (L): Should penalties or fees be imposed upon the Respondent? The Arbitrator finds and concludes as follows:

Petitioner suffered an injury which arose out of an accident that occurred in the course of Petitioner's employment. Petitioner provided Respondent timely notice. The Arbitrator finds and concludes Respondent had no objective, good faith basis or reason to dispute and deny this claim. To the contrary, **the Arbitrator emphasizes that Respondent offered no testimony or record evidence contrary to Petitioner's testimony, which remained unrebutted. Further, the Arbitrator emphasizes that just days after the accident, the official "City of Chicago Injury on Duty Report" (Res. Ex.#1) unequivocally - and without indicating any challenge to Petitioner's reported history by the supervisor - indicates the "Reported Incident Description" as follows: "Jesse Caver was walking down the stairs to use the restroom and slipped down the wet stairs and twisted his right ankle." This report fully supported Petitioner's claim of an accident, which was never rebutted. Further, the very late letter (RX 2, dated May 15, 2018, nearly three months after the accident date) sent to Petitioner notifying him that his claim has been "denied" failed to provide any reason as to why his**

benefits had been/were being denied, other than stating "Claim is not compensable", which is not an explanation, but merely a conclusion."

Commission Rule Section 91170.70 is applicable here. This Rule states, 91170.70 a) 2) in pertinent part: "if the employer denies liability for payment of temporary total compensation for whatever reason, provide the employee with a written explanation of the basis for denial..." Merely stating "Claim is not compensable" is not an "explanation" of the denial, but only restating the obvious with boilerplate language. Further, Section 91170.70 e) indicates that " Failure by either party to comply with the provisions of subsection (a), (b), (c) or (d) of this Section, without good and just cause, shall be considered by the Commission or an Arbitrator when adjudicating a petition for additional compensation pursuant to Section 19(l) of the Act, or a petition for assessment of attorneys' fees and costs pursuant to Section 16 of the Act." The Arbitrator finds no "good and just cause" here, and accordingly considers Respondent's failure to comply with this Section when adjudicating penalties.

Furthermore, Petitioner testified that after every doctor's visit, Petitioner received a work status slips either keeping him off work or returning him to work with restrictions. Respondent would not accommodate Petitioner with work that included the restrictions placed on petitioner by his treating physician. Petitioner testified that he delivered these work status slips to his supervisor, Darrell Rouse. Respondent was aware that Petitioner was off work from the date of the accident of February 20, 2018 until the date of trial of August 27, 2018. During that entire period, Petitioner did not receive nor did Respondent pay Petitioner any Temporary Total Disability benefits. Respondent also did not pay any medical bills except for $425.42, out of a total amount of medical bills of $19,257.62 (Res. Ex. #4) leaving a balance of $18,832.20.

Section 19(k) states as follows: " 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 provisions of Section 8, paragraph (b) of this act, shall be considered unreasonable delay."

Respondent has always been aware that Petitioner has not received any compensation pursuant to Section 8 (b) of the Act. During the trial, Respondent offered no proof or evidence as to why Petitioner did not receive any compensation pursuant to Section 8(b) of the Act. Petitioner at trial testified as well as produced work status slips that indicated he was either unable to work or was returned to work with restrictions. There is no dispute Petitioner turned these work status slips to his supervisor, Darrell Rouse.

When Petitioner was returned to work with restrictions, Respondent would not allow Petitioner to return to work with those restrictions and Respondent did not pay Petitioner any compensation pursuant to Section 8(b). Respondent has engaged in clear, unreasonable and vexatious conduct in denying payment of compensation. Respondent clearly did not carry its burden of proof before the Commission demonstrating the reasonableness of its conduct. It made little effort to do so. Respondent did not offer any reasonable proof as to why there was any delay or no payment of any compensation at trial. Respondent, in fact, did not present any defenses of real controversy within the purview of the provisions of paragraph (k) of section 19 of this Act. Respondent introduced no medical evidence to refute the evidence produced by Petitioner that he was taken off work by his treating physician or was released to work with such restrictions that Respondent would not allow Petitioner to return to work with those restrictions. Respondent offered no evidence to the contrary. (*Miller v. The Industrial Commission*, et al. (1993), 255 Ill. App. 3d 974 ,627 N.E.2d 676, 193 Ill. App. Lexis 2035, 194 Ill. Dec. 339. As such, the Arbitrator awards penalties pursuant to Section 19(k) of the Act.

Petitioner has proven that he has been off work from the date of accident February 20, 2018 to the date of trial of August 27, 2018, a period of 26-6/7 weeks at a TTD rate of $590.92. This equals a total of $15,870.33. The Arbitrator awards Petitioner an amount equal to 50% of $15,870.33 which equals $7,935.16 for a total of $23,805.49. **Based on the foregoing, the Respondent shall pay $7935.16 as penalties, as provided in Section 19(k).**

Section 19(L) states as follows: "If the employee has made written demand for payments of benefits under Section 8 (a) or Section 8 (b), the employer shall have 14 days after receipt of the demand to set forth in writing with the reason for the delay. In the case of the demand for payment of medical benefits under Section 8 (a), the time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under section 8.2 (d). In case employer or his or her insurance carrier show without good and just cause, fail, neglect, refuse, or unreasonably delayed the payments of benefits under Section 8(a) or Section 8(b), the Arbitrator or the commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more, shall create a rebuttable presumption of unreasonable delay."

Petitioner testified that to the best of his knowledge, none of his medical bills were paid. Furthermore, Respondent introduced into evidence a "Payment Listing" printout of medical bills Respondent received regarding this claim. (Res. Ex. #4) These were admitted without objection by Petitioner. This Payment Listing indicates the date of receipt of the last medical bill was on or about May 4, 2018. Section 19 (l) states "... The time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under section 8.2 (d)". The date of trial, August 27, 2018,

exceeded the 30 days allotted under section 8.2 (d). The Respondent offered no proof as to why Respondent had not made any payments since March 21, 2018 other than $425.42. (Res. Ex. #4) The remainder of the bills listed on the Payment Listing are still unpaid and exceed 30 days allotted under Section 8.2 (d) of the Act.

"Penalties under section 19 (l) are in the nature of a late fee" and are "mandatory if the payment is late for whatever reason, and the and the employer or its carrier cannot show adequate justification for the delay. *McMahan v. Industrial Commission*, 183 Ill.2d 499, 702 N.E.2d 545, 552 (1998).

Petitioner having proved that the bills he incurred were not paid in a timely manner, the Arbitrator hereby awards Petitioner penalties pursuant to Section 19 (l) of the Act. Petitioner has proven that he was off work and paid no benefits from February 20, 2018 up and through August 27, 2018 pursuant to Section 8(b), a period of 26-6/7 weeks or 188 days. Section (l) provides for penalties of "$30 a day, not to exceed $10,000. A delay in payment of 14 days or more, shall create a rebuttable presumption of unreasonable delay." Furthermore, there's been a delay in payments for more than 14 days, and this rebuttable presumption is not overcome by Respondent.

The Arbitrator finds Petitioner shall receive, and Respondent shall pay the amount of $5,640.00 in penalties, as provided in Section 19 (l) of the act.

Section (16) states as follows: "Whenever the commission shall find that the employer, his or her agent, service company or insurance come carrier has been guilty of delay or unfairness towards an employee in the judgment, settlement or payment of benefits to 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 underpayment of compensation benefits, or 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."

Petitioner suffered an injury which arose out of an accident that occurred in the course of Petitioner's employment by Respondent. Petitioner gave Respondent timely notice of the accident and injury. Respondent's own documents support Petitioner's claims. Furthermore, Petitioner testified that after every doctor's visit, Petitioner received a work status slips either keeping him off work or returning him to work with restrictions. Respondent would not accommodate Petitioner with work that included the restrictions placed on petitioner by his treating physician. Petitioner testified that he delivered these work status slips to his supervisor, Darrell Rouse. Respondent was aware that Petitioner was off work from the date of the accident of February 20, 2018 until the date of trial of August 27, 2018. During that entire period, Petitioner did not receive nor did the Respondent pay Petitioner any temporary total disability

benefits. Respondent also did not pay any medical bills except for $425.42, out of a total amount of medical bills of $19,257.62. (See Res. Ex. #4) Respondent did not offer any evidence or have anyone testify to repudiate Petitioner's testimony. Nor did Respondent offer any proof as to why there was any delay or no payment of any compensation at trial. Respondent, in fact, did not present any defenses of real controversy within the purview of the provisions of paragraph (k) of section 19 of this Act.

Based on the foregoing, the Arbitrator finds Petitioner shall receive and Respondent shall pay $5,889.09 as attorney's fees as provided in Section 16 of the Act.

Issue (M): Is the Respondent due any credit, the Arbitrator finds and concludes as follows:

Respondent introduced into evidence a Payment Listing which indicates that Respondent made payments on behalf of Petitioner in the amount of $425.52. (See Res. Ex. #4) Petitioner did not object to this exhibit going into evidence. In fact, Petitioner stipulated that Respondent paid $425.52 on behalf of the Petitioner. Based on the foregoing, Respondent is due a credit of $424.52.

Robert M. Harris

Robert M. Harris, Arbitrator

Dated: October 18, 2018

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JASON REEVES,

Petitioner,

vs. NO: 16 WC 2362 & 17WC28549

LOVE'S TRAVEL STOPS & COUNTRY STORE,

Respondent.

20IWCC0180

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 16, 2018 is hereby affirmed and adopted.

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

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission.

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

20IWCC0180

DATED MAR 16 2020

LEC/ck

O: 3/3/2020

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L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Stephen J. Mathis

Stephen Mathis

D. Douglas McCarthy

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REEVES, JASON
Employee/Petitioner

Case# **16WC002362**
17WC028549

LOVE'S TRAVEL STOPS & COUNTRY STORES INC
Employer/Respondent

20IWCC0180

On 8/6/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.16% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5354 STEPHEN P KELLY AAL LLC
MATTHEW A BREWER
2710 N KNOXVILLE AVE
PEORIA, IL 61604

0766 HENNESSY & ROACH PC
THOMAS CRONIN
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

20IWCC0180

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

Jason Reeves
Employee/Petitioner

v.

Case # **16** WC **2362**

Consolidated cases: **17** WC **28549**

Love's Travel Stops & Country Stores, 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 **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Kankakee**, on **June 22, 2018**. After reviewing all of the evidence presented, the undersigned Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On January 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 not* sustain an accident that arose out of and in the course of employment as explained *infra*.

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

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

In the year preceding the injury, Petitioner earned $45,391.45; the average weekly wage was $872.91.

On the date of accident, Petitioner was 38 years of age, *married* with 3 dependent children.

Petitioner *has* received all reasonable and necessary medical services as explained *infra*.

Respondent *has* paid all appropriate 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 $0 under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner failed to establish that he sustained a compensable accident at work as claimed. By extension, all remaining issues are rendered moot and all requested benefits and compensation are denied.

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

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

Signature of Arbitrator

August 1, 2018
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Jason Reeves
Employee/Petitioner

v.

Case # **16** WC **2362**

Consolidated cases: **17** WC **28549**

Love's Travel Stops & Country Stores, Inc.
Employer/Respondent

FINDINGS OF FACT

A consolidated hearing was held in both of Petitioner's above-captioned cases. Arbitrator's Exhibit[1] ("AX") 1; AX2. The issues in dispute in this case include accident, causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement to a period of temporary total disability benefits from March 28, 2016 through July 25, 2016 and April 27, 2017 through May 23, 2017, and the nature and extent of Petitioner's injury. AX1. The parties have stipulated to all other issues. *Id.* The issues in Petitioner's consolidated case, No. 17 WC 28549, are addressed in a concurrent decision issued in that case. AX2.

Background

Jason Reeves (Petitioner) was employed by Love's Travel Stops & Country Stores, Inc. (Respondent) as a Tire Care Manager and had been so employed for approximately 4½ years. He explained that his duties included mounting tires, placing stock orders, putting away stock, maintenance, mowing, changing filters, disposing of trash, helping at the desk, etc. Petitioner acknowledged that he was never worked for Respondent as a diesel mechanic.

Petitioner testified that he would put away stock such as alternators and batteries. He estimated that he handled items weighing anywhere from three pounds to 125 pounds. Petitioner also estimated that he lifted heavier items two-to-four times per week, but only sometimes had help lifting the heavier items. He also climbed a ladder or staircase going up to the second floor to put away stock. Petitioner testified that he would also change batteries on trucks that weighed 25-30 pounds. He would also bend, stoop and squat when working on trucks around the tires.

Petitioner testified that he would mount tires anywhere from once to 30 times per day, depending on the customers that came in on the given day. Petitioner testified that this entire tire mounting process took approximately 45 minutes from the time that he takes in the customer through completion (i.e., meet the customer, pull them into the bay, remove nuts off tire, lay it flat, break it down with bead breaker, dismount the tire with bars or a "golden" tool, etc.). Petitioner testified that semi-truck tires weigh 75-150 pounds and that the truck would be jacked up 3-6 inches. He would use a dolly to bring the tire assembly to the truck. Petitioner explained that daily he used a one-inch impact gun and 20-ton floor jacks that weighed 50-75 pounds, on wheels.

[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. _)."

Petitioner estimated that he was on his feet about 95% of the day, mounting/dismounting tires maybe 50% of the time, as well as stocking and counting items daily. However, on cross examination he testified that the vast majority of his work hours were spent on managerial and administrative work. Petitioner testified that he worked 50-65 hours per week.

On cross-examination, Petitioner testified that he had to conduct safety meetings and "buddy lifts" were supposed to take place when lifting certain heavy items.

Prior Medical History

Petitioner testified that he was involved in a moped incident 16 years ago in which he wrecked the moped and landed on the asphalt. He acknowledged that his December 2014 records from Oak Orthopedics reflect a 15-year history of chronic low back pain since his moped accident. PX7. Petitioner reported that he had sought care with a chiropractor five years' prior with minimal improvement. *Id.* He reported that his pain was constant, but waxed and waned. *Id.* The pain was worst at night and first thing in the morning. *Id.* He also complained of occasional spasms in the back. *Id.* He also complained of tingling and numbness that radiates down the right lower extremity past the knee. *Id.*

On December 11, 2014, Petitioner filled out a questionnaire at Oak Orthopedics. PX7. He checked a box indicating that he has had constant pain ever since it first began. *Id.* Petitioner rated his average pain over the previous two weeks as 5 out of 10 with his worst pain over that same period as 10 out of 10. *Id.* He reported that driving, sitting, walking and lying down all made his pain worse. In the past, he had taken Norco and had been seen by a chiropractor, orthopedic surgeon and his primary care physician as a result of the low back pain. *Id.* He admitted that over the past four weeks he had cut down on things he usually did because of the pain. *Id.*

Petitioner testified that this pre-existing back pain was constantly present according to the records prior to the alleged accident. He admitted that the back pain varied in intensity, but denied that it occurred before 2014. Petitioner acknowledged that he had spasms as well as tingling and numbness in the right lower extremity past the knee. He also agreed that he had injections performed as a result of this back pain, prior lumber MRIs, and has been on long term narcotic medications, including Norco, through the present.

Petitioner also testified that the injections he had received prior to January of 2016 provided temporary benefit but that the benefit of the injections eventually wore off. PX7. When this happened, Petitioner explained that the pain would increase. *Id.* Petitioner had facet injections performed on December 17, 2014. *Id.*

Petitioner followed up with Juan Santiago-Palma, M.D. (Dr. Santiago-Palma) on October 15, 2015. PX7. A pain diagram, from that date, reveals low back pain and numbness and tingling down the right leg. He rated his pain to be 6 out of 10 with his worst pain at 9 out of 10. *Id.* He reported that his symptoms were worsening and that driving, sitting, standing, walking, and lying down all worsened his pain. *Id.* Dr. Santiago-Palma recommended and performed facet injections at L3-L4, L4-L5 and L5-S1. *Id.*

Petitioner testified that between October of 2015 and his date of accident, his low back condition depended on the day. He did not have any work restrictions or medical care from October of 2015 through January of 2016 with his primary care physician, Dr. Thomas, or Dr. Santiago-Palma. Petitioner testified that he could perform the basic functions of his job. No surgery had been recommended during this period. On re-direct, Petitioner testified that before the accident his pain was not as strong and it was "doable," but progressively worse after surgery and after surgery not that great.

January 8, 2016

On January 8, 2016 at approximately 11:00 a.m., Petitioner explained that he was stacking tires for scrap in the back into a container. While engaged in this activity, Petitioner testified that he lifted a tire that ricocheted off the container hitting the ceiling and bounced back striking him. He explained that the tire struck him in the chest "folding him backwards" and, at that point, "I was done." Petitioner testified that he experienced severe low back pain as well as radiating pain into his right hip and leg. Petitioner testified that he did not seek care right away because he thought his symptoms would subside.

Petitioner testified that he had an in-person conversation with the store's General Manager, Don Mahler, with the store's District Manager, Steve Robertson, on the phone. He testified that he was notified that his employment was being terminated for receiving a grade of "F" on his most recent inspection report. Petitioner acknowledged that he did not report his accident at the time of this conversation.

Petitioner also acknowledged that he had responsibilities to document accidents and this job duty is contained on the Tire Care Inspection report entered as Respondent's Exhibit 7. He testified that he did not complete an incident or accident report for this January 8, 2016 occurrence.

Continued Medical Treatment

Petitioner testified that he was suffering from 10 out of 10 pain after the accident. Petitioner did not seek treatment until January 18, 2016 when he was seen by Dr. Santiago-Palma. PX7. He reported 7 out of 10 pain with 10 out of 10 as his worst pain. *Id.* The duration of the pain had been ongoing for months and the timing could not be identified. *Id.* The condition was aggravated by sitting and walking. *Id.* The note reveals that the complaints are not work related and Petitioner reported that he was working full duty. *Id.* Dr. Santiago-Palma's notes do not reference Petitioner's alleged work accident. *Id.* Petitioner testified that he told Dr. Santiago-Palma about the accident, but he must not have written it down. Petitioner testified that he also told other doctors about the accident.

An MRI was performed on February 3, 2016. PX7. The reason for the exam was listed as chronic lower back pain radiating into both legs, numbness ongoing for months. *Id.* There is no reference to an accident at work. *Id.*

Petitioner followed up with Dr. Santiago-Palma on February 4, 2016. PX7. The pain complaints remained unchanged and the note did not contain any reference to the January 8, 2016 work incident. *Id.* In the history portion of the note, Petitioner's reported complaints and condition were stated as not work related. *Id.* Dr. Santiago-Palma did not place any work restrictions on Petitioner and simply recommended a home exercise program. *Id.*

Petitioner followed up with his primary care physician, Dr. Thomas, on February 15, 2016. PX8. He testified that he went to see Dr. Thomas to obtain a referral to Dr. Jimenez. *Id.* The note reveals that Petitioner was there for follow up on his hypertension and was seeking a referral for his ongoing low back pain. *Id.* There is no history of any recent work accident in the note. *Id.* Petitioner followed up with Dr. Thomas one week later, on February 22, 2016, for an unrelated coccyx fracture. *Id.* This note contains no reference to any work accident. *Id.* On cross-examination, Petitioner acknowledged that Dr. Thomas' records are silent as to his alleged work accident.

Petitioner presented to Juan Jimenez, M.D. (Dr. Jimenez), a neurosurgeon, for the first time on March 4, 2016. PX9. Dr. Jimenez noted that Petitioner was a 38-year-old right hand dominant male presenting for evaluation of back pain that has been ongoing since December of 2014, without accident or injury. *Id.* His pain was rated at 4 out of 10 and 7 out of 10 at its worst. *Id.*

Dr. Jimenez performed a laminotomy, foraminotomy and microdiscectomy at L5-S1 on March 29, 2016. PX9. Petitioner testified that he noted some improvement after the surgery although he felt stiffness and aching. He also testified that he felt new symptoms in his right leg that felt numb and tingling. Petitioner testified that while participating in post-operative physical therapy, he "blew up the left side of his vertebrae." After this he had pain that was worse than before the first surgery.

Dr. Jimenez's records from June 30, 2016 reveal that physical therapy had caused increased pain and Petitioner discontinued the treatment. PX9. The same note reveals that, about two weeks prior, Petitioner was getting off the couch and felt something pop in the center of his low back and that he was feeling worse than before the first surgery. *Id.* On cross-examination, Petitioner did not recall reporting to Dr. Jimenez that he was ok until he got up off a couch.

Dr. Jimenez performed a second surgery on April 27, 2017, consisting of a L5-S1 decompression and fusion. PX11. Dr. Jimenez examined Petitioner at a follow up visit on July 24, 2017. PX9. Petitioner was doing well at the time and a physical examination revealed normal strength and reflexes. *Id.* Physical therapy was discussed, but Petitioner did not believe it was necessary. *Id.* Petitioner was released from Dr. Jimenez's care without restrictions. *Id.* Petitioner has not seen a doctor since that time and has no appointments have been scheduled.

Deposition Testimony – Dr. Jimenez

Dr. Jimenez testified via evidence deposition on October 26, 2016. PX3. Dr. Jimenez is a board-certified neurosurgeon who began treating Petitioner on March 4, 2016. *Id.* He acknowledged that he had not reviewed any medical treatment records from any doctors prior to assuming Petitioner's care. *Id.*, at 38-39. He did not review the 2014 MRI. *Id.*, at 39.

Dr. Jimenez was not aware of any specific trauma accident in January of 2016. PX3 at 48. He was never provided a work history from Petitioner other than he was a diesel mechanic. *Id.*, at 35-36. He only reviewed the job description prepared by Petitioner at the time of his deposition. *Id.*, at 36-37. In response to a hypothetical question, Dr. Jimenez testified that if Petitioner worked as a diesel truck mechanic, and given his review of the job description created by Petitioner, those duties could be a contributing factor to the development of the lumbar disc herniation. *Id.*, at 30-32.

Dr. Jimenez testified that "with the simple description of mechanic, and specifically diesel, I mean, that, I think, is a heavy type labor work and certainly under repetitive type work as both outlined here." PX3 at 32. He also based his opinion on having gone to tire shops and the fact that his dad was a mechanic. *Id.*, at 32, 34-35. Dr. Jimenez admitted that his understanding was that Petitioner was a diesel mechanic and his understanding of the job duties was based upon that premise. *Id.*, at 35-36.

Dr. Jimenez testified that Petitioner had significant underlying degenerative changes which pre-existed any alleged incident and that Petitioner was symptomatic. PX3 at 41. Dr. Jimenez agreed that degenerative disc disease is progressive even in the absence of trauma and that we all have it. *Id.*, at 42. The disease can progress

independent of occupation. *Id.*, at 42-43. He also agreed that the changes noted between the 2014 and 2016 MRIs could be explained by the natural progression of Petitioner's underlying disease even without trauma. *Id.*, at 43-44. Dr. Jimenez testified that Petitioner was a smoker and that smoking has a negative impact on spinal health, can contribute to the progression of degenerative disc disease. *Id.*, at 47-48.

Dr. Jimenez testified that the soft disc material found at the time of his first surgery would be consistent with a more recent herniation and that the calcification would be consistent with a more longstanding chronic situation. PX3 at 15. He admitted that a herniated disc can be the end result of degenerative disc disease and can result in the extrusion of soft material. *Id.*, at 47-48. He testified that if disc material extruded it could change the clinical course with changes in symptomatology and changes in the distribution of pain. *Id.*, at 49-50. Dr. Jimenez could not pinpoint when any aggravation occurred and testified it could be weeks to months. *Id.*, at 48-49.

On cross-examination, Petitioner testified that he always told Dr. Jimenez or his nurse about the work-related accident, but clarified that he always said that he was not sure if his symptoms were related.

Deposition Testimony – Dr. Fletcher

David Fletcher, M.D. (Dr. Fletcher) examined Petitioner at attorney's request and testified via evidence deposition on October 10, 2017. RX4. Dr. Fletcher is board certified in occupational and preventative medicine. *Id.*, (Dep. Ex. 1) Dr. Fletcher examined Petitioner on May 19, 2017 and was provided an accident history from January of 2016. *Id.*, at 14. Petitioner told Dr. Fletcher that he was lifting and mounting tires at Love's when he began to experience low back pain. *Id.* Petitioner told Dr. Fletcher that he had a long history of low back pain. *Id.* Petitioner gave Dr. Fletcher some description of his job duties, "doing a lot of lifting of tires, abnormal postures, going underneath cars, using a lot of torque forces." *Id.*

Dr. Fletcher opined that Petitioner's lumbar spine condition was aggravated by the January work incident. RX4 at 30. Dr. Fletcher stated that Petitioner had pathology before 2016 based upon a change in the anatomic structure. *Id.* He testified that the loss of lumbar lordosis indicated an acute injury. *Id.* Dr. Fletcher went on to state that Petitioner was subject to cumulative trauma for the type of job duties he did. *Id.*, at 31. "I basically would take the position that his situation was a cumulative trauma type of case because of the work demands, and the incident in January 2016 was sort of the straw that broke the camel's back and pushed him to surgical treatment. *Id.* He admitted on cross examination that the findings regarding the loss of lumbar lordosis was indicative of spasm and could simply be the result of Petitioner having a period of waxing or increasing pain without any trauma. *Id.*, at 40.

Dr. Fletcher admitted that for his causal opinion to be valid, Petitioner would have needed to have a specific accident in January of 2016. RX4 at 37. He also admitted that if the history provided by Petitioner was inaccurate, his opinions regarding causation could change. *Id.*, at 46.

Dr. Fletcher noted that Petitioner reported 10 out of 10 pain on the date of accident, which he described as "10 is the worst pain imaginable, call an ambulance, I'm going to die type of pain rating…" RX4 at 44. He expects that someone with that type of pain would tell someone about it and would seek immediate care. *Id.* He agreed that Petitioner did not seek treatment until 12 days after the accident, on January 18, 2016. *Id.*, at 47. Dr. Fletcher testified that the January 18 note did not contain any reference to a January work accident and the note actually stated it was not work related. *Id.* Dr. Fletcher also reviewed the records of Dr. Thomas and Dr. Jimenez and agreed that there was no accident history contained in those records. *Id.*, at 48-49.

Dr. Fletcher's admitted that his original report described Petitioner's condition to be related to repetitive trauma from lifting as a result of his job duties. RX4 at 49-50. Dr. Fletcher testified that for the lifting to be repetitive, "I would consider more than half of his day that he's lifting tires, mounting tires, and so he's in a variety of different positions." *Id.*, at 50. He testified that Petitioner gave him the history of lifting tires, mounting tires more than ½ of his day every day. *Id.* Dr. Fletcher acknowledged that if that history was inaccurate, that could change his opinions on causation. *Id.*

Dr. Fletcher testified that it would be important for him to know what duties Petitioner may have had as a supervisor and the breakdown of his day regarding supervisory duties and material handling. RX1 at 51-52. He admitted that he did not have that information and was relying upon the truth of what Petitioner told him. *Id.*, at 52.

Dr. Fletcher admitted that Petitioner's condition was chronic and had been present for 18 years according to the history provided by Petitioner. RX1 at 38. He admitted that the disc pathology was present at the same levels in 2014. *Id.* He testified that someone with chronic degenerative disc disease would have pain complaints that wax and wane or get better and worse. *Id.* Dr. Fletcher's review of the records revealed that Petitioner's condition was consistent with an individual whose pain waxes and wanes, increases and decreases. *Id.*, at 41. He agreed that the benefit of facet injections could be temporary and after the effect of the injection wore off the pain could worsen. *Id.*, at 39. Dr. Fletcher testified that degenerative disc disease is progressive and can worsen in the absence of trauma. *Id.* He agreed that Petitioner's condition had worsened over time. *Id.*, at 40. He agreed that the changes between the 2014 and 2016 MRIs could be consistent with the natural progression of Petitioner's degenerative disease. *Id.*, at 42-43.

Deposition Testimony – Dr. Phillips

Frank Phillips, M.D. (Dr. Phillips) testified via evidence deposition on April 24, 2018. RX1. Dr. Phillips is a board certified orthopedic surgeon. *Id.*, 4-6. Dr. Phillips examined Petitioner at Respondent's request on two occasions and authored additional reports. *Id.* He estimated that 85% of his practice involves treatment of individuals with degenerative disc disease. *Id.* Degenerative disc disease is progressive in nature and discs frequently herniate without trauma. *Id.*, at 6. It is common for individuals to describe pain that waxes and wanes, to have flare ups of worsening pain and periods where the pain is not as bad. *Id.*, at 7. Dr. Phillips stated that facet injections are not permanent solutions and the effects of these injections will wear off over time resulting in a recurrence of symptoms. *Id.*, at 7-8.

Dr. Philips first evaluated Petitioner on July 21, 2016. RX1 at 9. Petitioner told Dr. Phillips that while stacking tires on January 6, 2018, he felt a pop in his back. *Id.* Petitioner reported that the pain got worse after that with increased back pain and numbness in his right leg. *Id.* Dr. Phillips examined Petitioner and diagnosed underlying lumbar disc degeneration that was symptomatic up to the alleged 2016 injury. *Id.*, at 11-12. Dr. Phillips testified that while Petitioner alleged the injury worsened his pain there were no records documenting an injury of a worsening of pain related to an injury. *Id.*

Subsequent to the first report, Dr. Phillips reviewed MRI films from December 9, 2014, February 3, 2016 and July 11, 2016. RX1 at 15-16. Dr. Phillips testified that the disc herniation present on the December 9, 2014 films was somewhat larger in 2016 as compared with 2014. *Id.* He testified that there are a lot of reasons discs get larger in a degenerative condition with chronic wear and tear. *Id.* This was part of the progression of the disease. *Id.* Dr. Phillips stated that the herniated disc at L5-S1 predated the alleged work incident. *Id.*, at 17.

Dr. Phillips testified that if the accident history provided by Petitioner was accurate, then it could be the type of incident that could aggravate an underlying degenerative condition. RX1 at 17. He went on to state that he had never seen any materials supporting the accident. *Id.* The only support was Petitioner's history to him. *Id.* "I just made it clear, which I think was my opinion throughout, that any opinions of aggravation of symptoms in January 2016 was based entirely on Mr. Reeves' description of the event. If there's no other documentation or corroboration of an incident, obviously I would not attribute symptoms around that time to an incident that probably didn't happen." *Id.*, at 18.

Dr. Phillips testified that there was no evidence to support that Petitioner's job duties accelerated or worsened the condition. RX1 at 13. He stated that Petitioner has a degenerative condition and the natural history of that condition results in it worsening. *Id.*, at 22, 41-42. The change in MRIs over the two-year period demonstrated the typical slow continued degenerative changes you'd expect as part of the natural history. *Id.* Dr. Phillips further stated that the complaints Petitioner presented with in 2014 and 2015, before the accident, were similar to the complaints he presented with post-accident. *Id.*, at 42. He also testified that a surgeon would not be able to determine whether a disc herniation had acute components at the time of surgery. *Id.*, at 33, 40.

Petitioner's Employment

Petitioner acknowledged that he had been disciplined in the past for poor performance. In January of 2016 he knew he was subject to a final warning, which became effective in September of 2015. Petitioner admitted that after a discussion with his General Manager about his performance, he turned in his keys and left the facility indicating that he might not be in on Monday, because he was tired of everything. He admitted he was angry at that time. Petitioner testified that he came back the following Monday met with his General Manager and spoke with the Regional Manager, Mr. Robertson, by phone. He testified that he was reinstated, but was told that it was his final warning.

Petitioner testified that he also met with his Area Tire Care Manager, Matt Scheurich (Mr. Scheurich) on January 4, 2016 and was made aware of the site inspection and "F" grade as a result. Petitioner testified that he was not aware that he was going to be terminated after the inspection report.

Petitioner testified that he created the job description contained in Respondent's Exhibit 5, at the request of his attorney. He testified that it did not contain any discussion of his supervisory duties because he was not asked to put those duties down.

Petitioner acknowledged that the majority of his work time was spent in his managerial and supervisory capacity. He reviewed the flow sheet admitted as Respondent's Exhibit 8 and agreed that it was the flow sheet he used on a daily basis and that he was required to complete the tasks listed on the flowsheet on a daily basis.

Petitioner testified that he supervised other employees who had first responsibility for the physical duties listed on his self-created job description. He would only engage in these activities when coverage was needed. Petitioner testified that these employees were always present when he was working.

Petitioner testified that he drafted the resumes which were contained in Respondent's Exhibits 3 and 4.

Petitioner is currently employed at Pilot as a Truck Care General Manager earning $65,000.00 per year. RX2. The subpoenaed documents from Pilot reveal that Petitioner was required to demonstrate a variety of skills as

part of the hiring process. *Id.* The skills included, but were not limited to, mounting and demounting of tires, handling rim wheels, installation and removal of rim wheels. *Id.* The documents contain initials confirming the successful completion/demonstration of these skills. *Id.* Petitioner testified he did not perform the physical activities as a manager, and that the documents were erroneous.

Steve Robertson

Steve Robertson (Mr. Robertson) testified on behalf of Respondent. Mr. Robertson had been employed by Love's for 12 years and was the District Manager for North Central Illinois, which included Petitioner's location. He testified to a variety of duties which included following up on inspection reports and monthly visits to stores in his territory.

Mr. Robertson testified that Petitioner was not a diesel mechanic and was always employed as a Tire Care Manager. He testified that he had the opportunity to speak with Petitioner on August 3, 2015 in follow up of a prior action plan that had been put in place for Petitioner. Mr. Robertson created a report verifying that a 16-point action plan had been put in place in May but that none of the issues from that action plan had been addressed. Mr. Robertson concluded that if the store was formally inspected on that date, it would receive an F. RX6. Robertson testified that he met with Petitioner and created a 34-point action plan that was to be worked to completion within 6 weeks. *Id.*

Robertson testified to his involvement in a September 2015 incident involving Petitioner. On September 25, 2015, after a discussion involving Petitioner's store performance with the store General Manager, Don Mahler, Petitioner turned in his keys and told Mr. Mahler that "I might not be in on Monday, I am tired of all the bullshit." RX6. Robertson spoke on the telephone with Petitioner and Mr. Mahler on Monday, September 29, 2015, and put Petitioner on notice that this was a final warning. *Id.*

Mr. Robertson testified to receiving and reviewing a January 2016 inspection report completed by Mr. Scheurich, which resulted in a grade of F. RX6. A group, corporate decision was made to terminate Petitioner's employment. On January 8, 2016, Mr. Robertson spoke by phone with Petitioner and General Manager, Mr. Mahler, and notified Petitioner of his termination. Mr. Robertson testified that Petitioner made no report of any work injury during the telephone conversation. Mr. Robertson stated that if Petitioner had made an accident report he would have entered the claimed accident in the company system as was protocol. Mr. Robertson testified that Petitioner had responsibilities for filling out accident reports and had been trained to do so. Mr. Robertson stated that no accident report was ever made or completed by Petitioner.

Mr. Robertson testified that the job description created by Petitioner was not an accurate description for a Tire Care Manager since it did not contain any of his management responsibilities. Mr. Robertson more than 50% of Petitioner's job should have been engaged in managerial, not physical, duties. He reviewed resumes prepared by Petitioner and admitted as part of Respondent Exhibits 3 and 4 and testified that those more accurately described Petitioner's responsibilities as Tire Care Manager.

Mr. Robertson testified that the job description created by Petitioner was more accurate for a tire tech, which Petitioner had never been. He explained tire tech's worked under Petitioner.

Mr. Robertson testified that the volumes listed on the description were not accurate. Mr. Robertson stated that Petitioner's store was one of the lowest volume stores in the region and there would never have been a time that

Petitioner had 30 mounts/demounts in shift. He testified the facility would not sell anywhere near 30 tires in an entire week.

Matt Scheurich

Matt Scheurich (Mr. Scheurich) testified on behalf of Respondent. Mr. Scheurich had been employed by Respondent for seven years. During the relevant period, he was the Area Tire Care Manager for the area including Petitioner's store. In this role, Mr. Scheurich would visit locations in person, conduct inspections and speak with tire care managers at various locations. He testified that he spoke with Petitioner at least one time per week.

Mr. Scheurich testified that Petitioner was always a Tire Care Manager and was never employed as a diesel mechanic or a mechanic of any kind. Mr. Scheurich described his own job duties which included performing inspections. He stated that he had performed multiple inspections of Petitioner's location including the last one which was completed on January 4, 2016. In conjunction with that inspection, he prepared a Tire Care Inspection report which was admitted as Respondent's Exhibit 7. Based on his inspection, Petitioner was given an "F" rating. Mr. Scheurich testified that he met in person with Petitioner to discuss the results and the grade. Mr. Scheurich noted that the first page summary of the inspection and the grade related to Petitioner's various managerial and administrative duties. *Id.*

Mr. Scheurich had the opportunity to review the job description created by Petitioner and testified that it did not accurately describe the job of a tire care manager. He testified that the job description was actually more accurate for a tire tech. Petitioner was never a tire tech; they worked under Petitioner. Mr. Scheurich also testified that portions of the job description were clearly erroneous, including the fact that Petitioner would never have ever handled anywhere near 30 tire jobs in any given shift. Mr. Scheurich noted that this was one of the lowest volume stores in his territory which meant less service work was being performed at this location.

Mr. Scheurich testified that the majority of Petitioner's day would be taken up with his managerial and administrative duties as detailed in the Tire Care Manager Flowsheet.

Mr. Scheurich testified that Petitioner would not work alone on any shift. There were both tire techs and mechanics working at the same time. He testified that the tire techs and mechanics would be first responders for the physical tire work described by Petitioner in his job description. Petitioner would only engage in the physical work of a tire tech or tire care specialist when coverage was needed. Petitioner would be last in line to do this type of work.

Mr. Scheurich testified that the resumes created by Petitioner for Community GMC and Napleton's Autowerks more accurately described the breakdown of Petitioner's job as a Tire Care Manager.

Additional Information

Regarding his current condition, Petitioner testified that he continues to experience achy, stabbing pain in the lower back pretty much constantly. Activities such as driving, sitting, standing, lying down, and walking can cause him pain, but the severity depends on his daily activities. Petitioner testified that he used to mow the lawn, walk his dogs, hunt, fish, make repairs, and provide more care for his children, but he is very limited in performing these activities now. Petitioner testified that he no longer hangs drywall or makes repairs. He also

testified that his sleep is affected such that he tosses and turns throughout the night. Petitioner also continues to experience constant right leg numbness.

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 Issues (C) and (D), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent and the date of the accident, the Arbitrator finds the following:

An employee's injury is compensable under the Act only if it arises out of and in the course of the employment. 820 ILCS 305/2 (LEXIS 2003). The "in the course of employment" element refers to "[i]njuries 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...." *Metropolitan Water Reclamation District of Greater Chicago v. IWCC*, 407 Ill. App. 3d 1010, 1013-14 (1st Dist. 2011). The "'arising out of' component refers to the origin or cause of the claimant's injury and requires that the risk be connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Metropolitan Water Reclamation District*, 407 Ill. App. 3d at 1013-14 (*citing Caterpillar Tractor Co. v. Indus*the hearing *Comm'n*, 129 Ill. 2d 52, 58 (1989)). A claimant must prove both elements were present (i.e., that an injury arose out of and occurred in the course of his employment) to establish that his injury is compensable. *University of Illinois v. Indus*the hearing *Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006).

Petitioner asserts that he sustained an unwitnessed, traumatic injury at work while lifting a truck tire that ricocheted off a container hitting the ceiling and then striking him. He explained that the tire struck him in the chest with such force that it folded him backwards and he had an immediate onset of severe low back pain. According to Petitioner, this event occurred at approximately 11:00 a.m. On the same day, Petitioner's employment was terminated during a conversation with General Manager, Mr. Mahler, in person, and District Manager, Mr. Robertson, present via telephone. Mr. Robertson testified that a corporate decision had been made to terminate Petitioner's employment after attempts to correct his work deficiencies had failed. Respondent provided documentation reflecting Petitioner's failed inspection reports in the months leading up to January 8, 2016. Petitioner testified that he did not report his injury at work, or complete an accident report, in compliance with Respondent's safety protocol. Mr. Robertson and Petitioner both testified that Petitioner did not report any injury at work at the time of that conversation.

That Petitioner met with Mr. Scheurich about his "F" inspection report grade on January 4, 2016 then sustained an unwitnessed accident on January 8, 2016 in the hours before his employment was terminated during which time he purportedly felt severe low back pain, is not, in and of itself, dispositive on Petitioner's credibility. However, the record contains further evidence bringing the reliability of Petitioner's testimony, and the occurrence of a traumatic injury or "cumulative" injury 10 days later into serious question.

None of Petitioner's treatment records reflect Petitioner's report of an accident at work. At the hearing, Petitioner explained that he told each and every medical provider about the accident, but he did not know why they failed to document his continuous reports. Later in his testimony, Petitioner explained that he told his

medical providers about the accident, but qualified that representation by explaining that he also told them that he did not know what exactly caused his symptoms. It is unnecessary for a patient to have medical training to explain to his physician that he had no low back pain or different symptoms prior to the alleged accident followed by severe low back pain or different symptoms thereafter. Petitioner had a long history of low back pain extending back 15 years prior to his alleged accident during which time he continuously received narcotic pain medication prescriptions and medical treatment. His most recent care occurred just months before the alleged accidents. Given the totality of the record, it is an unpersuasive assertion that all of Petitioner's physicians would fail to document his newly and consistently reported injury at work or a new or different onset of symptoms in their records. It is an equally unpersuasive assertion that Petitioner's physicians would specifically note his denial of an occupational injury as indicated by Dr. Santiago-Palma, Dr. Thomas, and Dr. Jimenez.

Moreover, the medical opinions of three physicians were offered into evidence. In consideration of the record as a whole, the Arbitrator finds the opinions of Respondent's Section 12 examiner, Dr. Phillips, to be persuasive.

Petitioner's neurosurgeon, Dr. Jimenez, admitted that he had not reviewed any medical treatment records from any doctors prior to assuming Petitioner's care. This would include over 15 years of medical treatment to the low back. Dr. Jimenez also admitted that he was not aware of any specific traumatic injury in January of 2016. Based on the foregoing, the Arbitrator finds that the opinions of Dr. Jimenez are not persuasive as he did not have a complete understanding of Petitioner's medical history, or any manner of occupational injury that could have contributed to the low back condition for which he provided treatment.

Petitioner's own medical examiner, Dr. Fletcher, testified that he understood that Petitioner was lifting and mounting tires at work when he began to experience low back pain. While he told Dr. Fletcher that he had a long history of low back pain, Dr. Fletcher opined that Petitioner's loss of lumbar lordosis indicated an acute injury. Dr. Fletcher went on to state that Petitioner was subjected to cumulative trauma for his type of job duties. Notwithstanding, Dr. Fletcher acknowledged that Petitioner would have to have sustained a specific accident in January of 2016 to substantiate his causal connection opinion. He added that, if Petitioner's history was inaccurate, his opinions regarding causation could change. Petitioner's testimony at the hearing about the physical duties of his job was rebutted by both Mr. Robertson and Mr. Scheurich. Petitioner's work was not nearly as physical as he explained. Moreover, the occurrence of acute trauma as claimed by Petitioner is controverted by all of his medical records in which his doctors fail to corroborate his purported reports of an injury at work and, instead, confirm his denial of any work-related injury. Indeed, Dr. Fletcher acknowledged that the January 18, 2016 treatment note did not contain any reference to a January work accident and, conversely, stated that Petitioner's condition was not work related. Based on the foregoing, the Arbitrator finds that the opinions of Dr. Fletcher are not persuasive as he admitted that the lack of corroborating reports by Petitioner of an acute injury or onset of symptoms as a result of cumulative trauma undermine the basis of his opinions.

Respondent's Section 12 Examiner, Dr. Phillips, noted Petitioner's initial report that he sustained an acute injury while stacking tires on January 6, 2018 when he felt a pop in his back followed by worsened pain and numbness in his right leg. He noted that no records documented any occupational injury worsening Petitioner's low back pain. Dr. Phillips also noted that his review of Petitioner's MRIs reflect a herniated disc at L5-S1 that predated the alleged work incident. He conceded that, if the accident history provided by Petitioner was accurate, then it could be the type of incident that could aggravate an underlying degenerative condition, but he went on to state that he had never seen any materials supporting the occurrence of the alleged accident.

Additionally, Dr. Phillips testified that there was no evidence to support the proposition that Petitioner's stated job duties accelerated or worsened his condition. Dr. Phillips explained that the change in MRIs over the prior two-year period demonstrated the typical slow, continued degenerative changes one would expect as part of the natural progression of the disease. Dr. Phillips further stated that the complaints with which Petitioner presented in 2014 and 2015, before the accident, were similar to the complaints with which he presented post-accident. Ultimately, he opined that Petitioner had a degenerative condition and the natural progression of that condition resulted in worsening symptoms. The Arbitrator finds the opinions of Respondent's Section 12 Examiner, Dr. Phillips, to be persuasive as they are based on a more complete understanding of Petitioner's medical treatment history. Moreover, Dr. Phillips noted that lack of corroborating complaints subsequent to the alleged accident on January 8, 2016, or any the effects of any cumulative trauma as a result of his work activities on January 18, 2016, that would be expected if Petitioner had any onset of symptoms after either date.

Based on the totality of the record, the Arbitrator finds no credible evidence to support Petitioner's claim that he sustained a traumatic injury on January 8, 2016 or an acute onset of symptoms ten days later as a result of cumulative trauma. The Arbitrator finds that Petitioner's testimony is not credible and that Petitioner has failed to establish that he sustained a compensable accident at work on January 8, 2016 or January 18, 2016 as claimed. Thus, all remaining issues are rendered moot and all requested benefits and compensation are denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LANCE WEST,

Petitioner,

20IWCC0181

vs. NO: 16 WC 018870

STATE OF ILLINOIS/ DEPARTMENT OF VETERANS AFFAIRS,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of nature and extent of 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.

Permanent Disability

The Commission views the evidence differently with respect to Section 8.1b(b) factor (v).

(v) evidence of disability corroborated by the treating medical records

In analyzing the evidence of disability as corroborated by the treating medical records, the Arbitrator documented Petitioner's aggravation of a pre-existing condition in his lumbar spine and the development of left sided radiculopathy which resolved with surgical extension of his prior three level fusion by one level. The Arbitrator noted Petitioner's "continued complaints of pain in his back and left leg and notes the impact that these complaints have on Petitioner's work activities." The Commission finds that Dr. Phillips IME report finding Petitioner to be completely asymptomatic and his return to all normal activities of daily living is highly persuasive.

20IWCC0181

Having weighed the evidence and analyzed Section 8.1b(b) factor(v), the Commission finds Petitioner sustained a 17.5% loss of use of the person as a whole under Section 8(d)2.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on August 5, 2019, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $776.03 per week for a period of 59 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 $698.53 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 17.5% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay for the medical services of Key Internal Medicine directly to Key Internal Medicine in the amount of $745.00, as provided in and subject to Section 8(a) and 8.2 of the Act. Respondent shall pay for the medical services of Access Physical Therapy directly to Access Physical Therapy in the amount of $5,193.00, as provided in and subject to Section 8(a) and 8.2 of the Act. Respondent shall pay for the medical services of Universal Pain Management in the amount of $2,195.00, directly to Universal Pain Management as provided in and subject to Section 8(a) and 8.2 of the Act. Respondent shall pay for the medical services of Presence St. Mary's directly to Presence St. Mary's in the amount of $367.72 as provided in and subject to Section 8(a) and 8.2 of the Act. Respondent shall pay for the medical services of Silver Cross Hospital directly to Silver Cross Hospital in the amount of $95,491.70, as provided in and subject to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $600.00 in order to reimburse him for his out of pocket medical expenses.

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 medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which receiving this credit, as provided for in Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit for medical benefits that have been paid by its group health plan or by Medicare and Respondent shall hold Petitioner harmless from any claims by the providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

20IWCC0181

Pursuant to Section 19(f)(1) of the Act, this decision is not subject to judicial review.

DATED: MAR 16 2020
SJM/msb
d: 2/11/20
44

Stephen J. Mathis

Douglas D. McCarthy

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WEST, LANCE
Employee/Petitioner

Case# **16WC018870**

STATE OF ILLINOIS DEPT OF VETERANS' AFFAIRS
Employer/Respondent

20IWCC0181

On 8/5/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3269 SPIROS LAW PC
SANDRA LOEB
2807 N VERMILION ST SUITE 3
DANVILLE, IL 61832

6212 ASSISTANT ATTORNEY GENERAL
DREW DIERKES
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

AUG -5 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

FINDINGS

On **May 18, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**60,158.00**; the average weekly wage was $**1,164.05**.

On the date of accident, Petitioner was **69** years of age, ***single*** with **0** dependent children.

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

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

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

Respondent is entitled to a credit for any payments made by its group health insurance plan or by Medicare under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$776.03**/week for **59** weeks, commencing 5/21/16 through 7/7/17, as provided in Section 8(b) of the Act.

Respondent shall pay the medical services of Key Internal Medicine directly to Key Internal Medicine in the amount of **$745.00**, as provided in and subject to Section 8(a) and 8.2 of the Act.

Respondent shall pay the medical services of Access Physical Therapy directly to Access Physical Therapy in the amount of **$5,193.00**, as provided in and subject to Section 8(a) and 8.2 of the Act.

Respondent shall pay the medical services of Universal Pain Management directly to Universal Pain Management in the amount of **$2,195.00**, as provided in and subject to Section 8(a) and 8.2 of the Act.

Respondent shall pay the medical services of Presence St. Mary's directly to Presence St. Mary's in the amount of **$367.72**, as provided in and subject to Section 8(a) and 8.2 of the Act.

Respondent shall pay the medical services of Silver Cross Hospital directly to Silver Cross Hospital in the amount of **$95,491.70**, as provided in and subject to Section 8(a) and 8.2 of the Act.

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

Respondent shall pay Petitioner **$600.00** in order to reimburse him for his out of pocket medical expense.

Respondent shall be given a credit for medical benefits that have been paid by its group health insurance plan or by Medicare 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 **$698.43**/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.

Charles M Watts

Signature of Arbitrator

August 1, 2019
Date

AUG 5 - 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

Lance West	)	
	)	
Employee/Petitioner,	)	Case No. 16 WC 18870
v.	)	
	)	
Illinois Department of Veteran's Affairs-Manteno	)	
	)	
	)	**Kankakee, IL**
Employer/Respondent.	)	

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he had worked for Respondent, State of Illinois, Department of Veteran's Affairs for approximately 23 years prior to his work injury on May 18, 2016. On that date, Petitioner was employed as a security officer and had been so employed for approximately 19 years. His job duties were documented in a job description offered into evidence by Respondent (RX2) as well as in a bid notice offered into evidence by Petitioner (PX1). Petitioner testified that he was working in a full duty capacity without limitation as of May 18, 2016

Petitioner testified and the medical records offered into evidence by both parties confirm that prior to his May 18, 2016 injury, Petitioner had undergone a 3-level lumbar fusion surgery from L3 to S1. That procedure was performed by Dr. Juan Jimenez on November 11, 2011. (PX19) Petitioner admitted that he experienced ongoing low back pain after his release from Dr. Jimenez's care on June 4, 2012. Petitioner testified that he had no ongoing prior symptoms involving his left leg or thigh. Dr. Jimenez's medical record for June 4, 2012 indicates that Petitioner had "minimal residual discomfort," had completed work hardening, and was "doing very well." (PX19) Petitioner rated his low back pain at 2/10 and indicated that his numbness in his left lower extremity was "much improved." (PX19) Petitioner was returned to full duty work as of June 4, 2012 with his only restriction being that he was limited to working an 8-hour day within a 24-hour period. (PX19) That restriction was later removed by his primary care physician, Dr. Anand of Key Internal Medicine on December 3, 2012. (PX18, RX5)

Following his release from Dr. Jimenez's care, Petitioner's ongoing low back complaints were documented in the medical records of Dr. Anand. Those records reveal that Petitioner saw Dr. Anand on a regular basis for "back pain" and pain medication refills from July 2, 2012 through May 5, 2016, (PX18, RX5) Petitioner testified that though this low back pain was mostly controlled with pain medications, he estimated that

it did cause him to miss approximately 2-3 days of work per month during this time period.

On May 18, 2016, Petitioner testified that he was attempting to show a newly-hired security officer, Terry Keigher, where the air handlers were located in the basement of one of the residential units when he slipped on some "leaves or vegetation" while descending a set of concrete steps. Petitioner testified that he fell, landing on his "hip, lower back on the spinal area, left cheek." Petitioner's fall was witnessed by Mr. Keigher who testified at trial. It was also documented in PX2, PX3, PX4, RX1, RX3, and RX4.

Petitioner testified that his job duties included training new security officers how to perform their job duties and that one of those duties was to reset the air handlers. He specifically testified that he was trained by Michael Brown, the "fire and health officer," to reset the air handlers. Mr. Keigher also testified that it was the security officer's job to "go down and reset those."

Respondent called Petitioner's supervisor, Noel Alexander, to testify at trial. Mr. Alexander testified that he has been the "chief security" at the VA in Manteno for 16 years. He testified that Petitioner was a senior security officer as of May 18, 2016 and that as such, he was responsible for helping to train newly hired security officers. He testified that Petitioner would have reason to go to the basement to with Mr. Keigher at the time of the accident if "he was instructing on how to turn off a fire alarm on the fire panel." He testified that the fire safety officer, Michael Brown, is the person who trains security officers on fire and safety equipment. He did admit on cross examination that it is possible that Petitioner received training on how to handle the fire and safety equipment from Mr. Brown.

Petitioner sought medical attention from Dr. Anand on May 19, 2016, the day after his fall. Dr. Anand's medical records report a history of the work injury and that Petitioner "thinks it may be his sciatic nerve acting up now." (PX6) An x-ray of Petitioner's lumbar spine was ordered that day and reviewed at a return visit with Dr. Anand on May 24, 2016. Dr. Anand's assessment for that date included "severe back pain," "fall at work," and "severe sciatica." (PX6) Dr. Anand ordered an MRI of Petitioner's lumbar spine on June 2, 2016 and referred him to a spinal surgeon after reviewing the results of the MRI on June 30, 2016. (PX6) Petitioner testified that he paid for that MRI out of pocket because it was not approved by the State's worker's compensation handler.

On August 17, 2016 Petitioner began treating with Dr. Khan, neurosurgeon at Northwestern Medicine. Dr. Khan's record for that date reflects the following history:

> 70 y/o with new onset low back pain and L buttock radiculopathy since a fall in May. Patient reports having done well prior. He underwent a lumbar decompression and fusion from L3-S1 by Dr. Jiminez [sic.] at Riverside in 2011. He did well since surgery until the recent fall. He

> denies other trauma. . . . He has tried medications with no relief. (PX9)

Dr. Khan reviewed the June 7, 2016 MRI which revealed "good fusion and decompression from L3-S1 with adjacent segment degen at L2-3." (PX9) Dr. Khan's assessment was "left-sided low back pain with left-sided sciatica."(PX9) Dr. Khan recommended that Petitioner undergo physical therapy and advised him to follow up in 4-6 weeks. (PX9)

On October 12, 2016, Petitioner returned to Dr. Khan after having participated in physical therapy with little relief. (PX9) Dr. Khan's assessment of Petitioner's condition remained the same and he referred Petitioner to Dr. Roland in order to undergo ESI injections at L2-3. (PX9) Dr. Khan also discussed the possibility of L 2-3 decompression or fusion at that time. (PX9)

Petitioner underwent two epidural steroid injections that were performed by Dr. Roland on November 14, 2016 and November 28, 2016. (PX10) He returned to Dr. Khan on December 5, 2016 reporting that those injections did not provide significant relief. (PX11) Dr. Khan ordered a CT and a series of x-rays of the lumbar spine in order to consider surgical options. (PX11) Those studies were performed at Silver Cross Hospital on December 28, 2016. (PX12) The radiologist who reviewed the CT Scan indicated that Petitioner's hardware was intact. (PX12) The radiologist who interpreted Petitioner's x-rays found a "fracture of the left fusion rod at L4-5." (PX12) Dr. Khan also reviewed both studies on December 28, 2016 and recommended a surgical procedure that he eventually performed on February 14, 2017 at Silver Cross Hospital. (PX11, PX13)

Dr. Khan's operative report indicates that Petitioner's pre-surgical and post-surgical diagnoses were "lumbar spondylosis with foraminal compression at L2-L3 and pseudoarthrosis from L3 to L5, post prior fusion." (PX13) It also indicates that the procedure he performed included:

1. Posterior revision, midline approach to lumbar spine from L2 to S1.
2. Removal of segmental instrumentation from L3 to S1 bilaterally.
3. Exploration of fusion mass from L3-S1 bilaterally.
4. Decompression with bilateral laminectomies at level L2-L3, medical facetectomies at level L2-L3, and foraminotomies at level L2-L3.
5. Use of loupes for decompression.
6. Left-sided microdiscectomy at level L2-L3.
7. A 360-degrees fusion at level L2-L3 by a transforaminal approach.
8. Use of a Stryker PEEK (polyetheretherketone) implant for interbody fusion at L2-L3.
9. Local laminectomy bone for interbody fusion.
10. Posterolateral intertransverse process fusion on the right at L2-L3.
11. Use of local laminectomy bone for posterolateral fusion.
12. Segmental posterior instrumentation from L2 to L5 using Stryker pedicle screws.

13. Intraoperative SSEP (somatosensory evoked potentials) and MEP (motor evoked potential) monitoring.
14. Use of radiographs for verbal level localization and confirmation of appropriate placement. (PX13)

Petitioner continued to treat with Dr. Khan post-operatively. (PX14, PX15) He attended physical therapy and work hardening at Dr. Khan's direction from March 23, 2017 through May 19, 2017. (PX16) Petitioner was released by Dr. Khan to resume full duty work without restriction as of July 7, 2017. (PX14) Petitioner's final visit with Dr. Khan occurred on December 6, 2017, at which time Petitioner reported being back to work without issue and resolution of his radicular symptoms. (PX15)

On December 12, 2017, Petitioner underwent a section 12 examination at Respondent's direction with Dr. Frank Phillips of Midwest Orthopedics at Rush. (PX5) Dr. Phillips took a history from the Petitioner concerning the May 18, 2016 work injury and reviewed medical records which predated that injury, ranging in date from October 13, 2011 through May 5, 2016. (PX5) He also reviewed Petitioner's First Report of Injury and some of his post-occurrence medical records from May 19, 2016 through April 17, 2017, including his June 7, 2016 MRI study. (PX5) According to Dr. Phillips, that MRI study revealed "disk degenerative change with loss of disk height and Modic changes and some foraminal narrowing" at the L2-L3 level. (PX5) Dr. Phillips indicated that Petitioner "appears to have developed radicular symptoms likely related to the proximal L2-L3 level." (PX5) Dr. Phillips opined that Petitioner "sustained an aggravation of an underlying condition with a flare-up of radiculopathy related to the fall in June [sic.] 2016." (PX5) He furthermore opined that the treatment Petitioner received subsequent to the injury, including the surgical intervention was "related to the aggravation of symptoms as a consequence of his alleged fall at work." (PX5)

Petitioner testified that the surgery of February 14, 2017 improved his condition such that the severity of his "left lower extremity complaints "lessened considerably" and "they got down to where it was very infrequent." Petitioner also testified that he continues to have low back pain and that he continues to take over-the-counter pain medications to address that pain 2 to 3 times per day. He has, however, been able to discontinue use of all prescription pain medications at present.

Petitioner testified that certain activities increase his pain, such as prolonged standing, prolonged sitting and walking long distances. He also testified that changes in the weather increase his pain. He furthermore testified that his job requires him be exposed to the elements outdoors and that it routinely requires both prolonged sitting and walking. Petitioner testified that he is currently 72 years old and that he has no plans for retirement.

CONCLUSIONS OF LAW

The Arbitrator adopts and incorporates the above Findings of Fact in support of the foregoing Conclusion of Law.

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). An injury is accidental within the meaning of the Act when it is traceable to a definite time, place, and cause and occurs in the course of employment, unexpectedly and without affirmative act or design of the employee. *Mathiessen & Hegeler Zinc. Co. V. Industrial Board,* 284 Ill. 378 (1918).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission,* 44 Ill. 2d 214 (1969).

The Arbitrator finds that the testimony of the Petitioner was credible because Petitioner's responses to questions showed candor and were consistent with the documentary evidence. Likewise, the testimony of Terry Keigher and Noel Alexander was credible and corroborated the testimony of Petitioner.

(C) <u>Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?</u>

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). Both elements must be present at the time of the claimant's injury in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill.2d 478,483 (1989).

"In the course of the employment" refers to the time, place, and circumstances under which the claimant is injured. *Scheffler Greenhouses, Inc. v. Industrial* Comm'n, 66 Ill.2d 361, 366 (1977) Injuries sustained at a place where the workers' compensation claimant might reasonably have been while performing his duties, and while 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. *Caterpillar Tractor Co.*, 129 Ill.2d at 57. "A compensable injury occurs 'in the course of' employment when it is sustained while a claimant is at work or while he performs reasonable activities in conjunction with his employment." *Springfied Urban League, v. Illinois Workers' Compensation* Comm'n,

2013 IL App (4th) 120219WC, ¶25 (citing *Wise v. Industrial Comm'n*, 54 Ill.2d 138 (1973).

In this case, the evidence establishes that the onset (or recurrence) of Petitioner's left-sided radicular complaints occurred at the time of his fall down the stairs on May 18, 2016. The Arbitrator furthermore finds that Petitioner's fall occurred in the course of his employment because the evidence clearly establishes that it occurred at a place where Petitioner might reasonably have been while performing his job duties. In support of this determination, the Arbitrator first notes that it was undisputed at trial that Petitioner job duties included training Mr. Keigher to perform the duties of a security officer. The Arbitrator also notes that both Petitioner and Mr. Keigher testified credibly that a security officer's duties included resetting the air handlers when necessary. Finally, the Arbitrator notes that one of documented duties of a security officer was to "perform work involving the safety and protection of residents and employees" and finds that resetting the air handlers would certainly qualify as such.

Having found that Petitioner's injury occurred "in the course of" his employment, the Arbitrator next considers whether it "arose from" her employment. For an injury caused by a fall to arise out of the employment, a claimant must present evidence which supports a reasonable inference that the fall stemmed from a risk associated with her employment. *Builders Square, Inc. v. Industrial Comm'n*, 339 Ill. App. 3d 1006 (3rd. Dist. 2003). Employment related risks associated with injuries sustained as a consequence of a fall are those to which the general public is not exposed such as the risk of tripping on a defect at the employer's premises, falling on uneven or slippery ground at the work site, or performing some work-related task which contributes to the risk of falling. See Illinois Consolidated Telephone Co., 314 Ill. App. 3d 347 (5th Dist. 2000).

In this case, the Arbitrator finds the wet leaves, "helicopters" or vegetation on the employer's stairway clearly caused Petitioner's fall and that the same clearly constitutes an employment-related risk. The Arbitrator cites the consistent account of Petitioner's accident in PX2, PX3, PX4, RX1, RX3, and RX4, the consistent history of accident set forth in Petitioner's medical records as well as Dr. Phillip's unrebutted opinion that the fall aggravated Petitioner's pre-existing condition and flared up his radiculopathy in support of his decision.

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

Petitioner bears the burden of proving by a preponderance of the evidence all of the elements of his claim. *R & D Thiel v. Workers' Compensation Comm'n,* 398 Ill. App. 3d 858, 867 (2010). Among the elements that the Petitioner must establish is that his condition of ill-being is causally connected to his employment. *Elgin Bd. of Education U-46 v. Workers' Compensation Comm'n,* 409 Ill. App. 3d 943, 948 (2011). The workplace injury need not be the sole factor, or even the primary factor of an injury, as long as it is a causative factor. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205 (2003).

"A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in a disability may be sufficient circumstantial evidence to prove a causal connection between the accident and the employee's injury." *Int'l Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64 (1982). If a claimant is in a certain condition, an accident occurs, and following the accident, the claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration. *Schroeder v. Ill. Workers' Comp. Comm'n*, 79 N.E.3d 833, 839 (Ill. App. 4th 2017).

The evidence is undisputed that Petitioner had a low back condition which caused him to undergo a three-level fusion prior to his May 18, 2016 accident. At issue is whether or not the accident of May 18, 2016 aggravated his pre-existing condition such that it contributed to cause Petitioner's current condition of ill-being and the need for his most recent surgery wherein a fourth level of his lumbar spine was fused.

The Arbitrator finds that Petitioner's accident of May 18, 2016 was a causative factor leading to Petitioner's current condition of ill-being. More specifically, the Arbitrator finds that the accident of May 18, 2016 aggravated Petitioner's pre-existing condition. In support of his determination, Arbitrator relies on the credible testimony of the Petitioner, the medical records which corroborate Petitioner's testimony as to the onset (or recurrence) of left-sided radicular symptoms on May 18, 2018, the unrebutted opinions offered by Respondent's section 12 examiner, Dr. Phillips, as well the chain of events.

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

Respondent's dispute with regard to medical expenses is based solely on liability. Based on the Arbitrator's findings with respect to issues (C) and (F) above, the Arbitrator finds that Respondent shall pay Petitioner any unpaid medical expenses reflected in Petitioner's exhibits 20-28. The Arbitrator furthermore finds that Respondent is entitled to credit for any medical bills paid by its group medical plan or by Medicare and is ordered to hold petitioner harmless pursuant to section 8(j) and stipulation of the parties.

The Arbitrator further finds that based on the medical records contained in Petitioner's Exhibits 5, 6, 7, 8, 9, 10, 11, 12, 13, 14 and 15, that the $1,045.00 in charges for Petitioner's visits to Key Internal Medicine from May 19, 2016, through November 7, 2016, that the $44,457.08 in charges for services performed by Northwestern Medicine from August 17, 2016 through December, 6, 2017, that the $5,193.00 in charges for services performed by Axcess Physical Therapy from August 29, 2016 through May, 19, 2017, that the $350.00 in charges for services performed by Accelerated Open MRI on June 7, 2016, that the $2,195.00 in charges for services performed by Universal Pain Management from November 5, 2016 through November 28, 2016, that the $19,485.30 in charges for services performed by Presence St. Mary's Hospital from May 20, 2016 through January 17, 2017, that the $95,491.70 in charges for services performed by Silver

Cross Hospital from December 28, 2016 through March 15, 2017, that the $137.00 in charges for services performed by Tallgrass Cardiology on February 1, 2017, were reasonable. The Arbitrator finds that the medical bills were put through Petitioner's group insurance.

Regarding the medical bill of Key Internal Medicine, Petitioner submitted a bill of $1,045.00, of which $300.00 was paid, leaving a balance of $745.00. (PX 20). Therefore, Respondent shall pay the medical services of Key Internal Medicine directly to Key Internal Medicine in the amount of $745.00, as provided in and subject to Section 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.

The Arbitrator finds no evidence of unpaid medical bills to Northwestern Medicine. (PX 21).

Regarding the medical bill of Axcess Physical Therapy, Petitioner submitted a bill of $5,193.00. (PX 22). Therefore, Respondent shall pay the medical services of Axcess Physical Therapy directly to Axcess Physical Therapy in the amount of $5,193.00, as provided in and subject to Section 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.

The Arbitrator finds no evidence of unpaid medical bills to Accelerated Open MRI. (PX 23).

Regarding the medical bill of Universal Pain Management, Petitioner submitted a bill of $2,195.00. (PX 24). Therefore, Respondent shall pay the medical services of Universal Pain Management directly to Universal Pain Management in the amount of $2,195.00, as provided in and subject to Section 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.

Regarding the medical bill of Presence St. Mary's, Petitioner submitted a bill of $19,485.30, of which $19,117.58 was paid, leaving a balance of $367.72. (PX 25). Therefore, Respondent shall pay the medical services of Presence St. Mary's directly to Presence St. Mary's in the amount of $367.72, as provided in and subject to Section 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.

Regarding the medical bill of Silver Cross Hospital, Petitioner submitted a bill of $95,491.70. (PX 26). Therefore, Respondent shall pay the medical services of Silver Cross Hospital directly to Silver Cross Hospital in the amount of $95,491.70, as provided in and subject to Section 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.

The Arbitrator finds no evidence of unpaid medical bills to Tallgrass Cardiology. (PX 27).

Regarding the medical bill of Presence Homecare, Petitioner submitted a bill of $840.01. (PX 28). However, no evidence regarding treatment rendered on the dates of service contained therein was provided, therefore the bill is denied.

In addition, the following reasonable, necessary and related medical expenses were admitted into evidence that were paid out of pocket by the Petitioner:

Northwestern Medicine	8/17/16	$ 30.00	(PX21)
Northwestern Medicine	9/14/16	$ 20.00	(PX21)
Northwestern Medicine	10/12/16	$ 30.00	(PX21)
Northwestern Medicine	12/5/16	$ 20.00	(PX21)
Northwestern Medicine	12/25/16	$ 30.00	(PX21)
Northwestern Medicine	1/25/17	$ 30.00	(PX21)
Northwestern Medicine	6/7/17	$ 30.00	(PX21)
Northwestern Medicine	12/6/17	$ 30.00	(PX21)
Accelerated Open MRI	6/7/16	$350.00	(PX23)
Universal Pain Management	11/5/16	$ 30.00	(PX24)
TOTAL		$600.00	

Respondent is ordered to reimburse Petitioner for the $600.00 he paid towards these medical bills.

(K) What temporary benefits are in dispute?

The parties stipulated at trial that if liability is found, the Petitioner would be awarded 59 weeks of TTD benefits for the period claimed between May 23, 2016 and July 7, 2017. In light of the Arbitrator's findings with respect to issues (C) and (F) above, the Arbitrator thus finds that Petitioner is entitled to 59 weeks of TTD.

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

Section 8.1(b) of the Act addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b. Section 8.1b states:

> the Commission shall base its determination on the following factors: (i) the reported level of impairment

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

820 ILCS 305/8.1b

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

In regard to factor (ii) the occupation of the injured employee, the record reveals that Petitioner was employed as a security officer at the time of his workplace accident and that he remains so employed. The Arbitrator notes that Petitioner testified that his current condition interferes with his ability to fulfill some of his duties that require prolonged sitting and walking long distances and that his symptoms are worsened with exposure to the outdoors. The Arbitrator gives some weight to this factor.

In regard to factor (iii) the age of the employee at the time of the injury, Petitioner was 69 years old at the time of his accident. The Arbitrator places some weight on this factor.

In regard to factor (iv) the employee's future earning capacity, there was no evidence presented to show that Petitioner's future earning capacity has been impacted, and the Arbitrator has no basis to expect he will have any decreased earning capacity in the future. The Arbitrator places little weight on this factor.

In regard to factor (v) evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner aggravated a pre-existing condition in his lumbar spine, causing a left-sided radiculopathy that was treated successfully by extending his prior three-level fusion by one level. The arbitrator notes Petitioner's continued complaints of pain in his back and left leg and notes the impact that these complaints have on Petitioner's work activities. The Arbitrator further notes Petitioner's testimony that he continues to take over-the-counter pain medicine at present in order to relieve his symptoms.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration, and based on the record in its entirety, the

Arbitrator finds that Petitioner has sustained a 20% loss of the man as a whole (100 weeks), or $69,843.00, pursuant to 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

David E. Harness,

Petitioner,

20IWCC0182

vs.

No. 17 WC 11654

City of Springfield,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issue of permanent disability and being advised of the facts and law, 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 disagrees with the Arbitrator's determination of Petitioner's disability. In determining permanent partial disability, the Commission considers the five factors enumerated in section 8.1b(b) of the Workers' Compensation Act (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 enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b).

Regarding factor (i), the Commission notes no impairment rating has been submitted into evidence. The Commission therefore gives no weight to this factor.

Regarding factors (ii) and (iii), the Commission notes Petitioner, who is 60 years old, is a retired auto body technician. Petitioner recently reopened the auto body shop he operated before

20 IWCC0182

he went to work for Respondent many years ago. Petitioner credibly testified that he works much slower than before the accident and has to subcontract some things out because of his limitations. The Commission finds Petitioner is a retired worker who has a part-time business. The Commission does not believe Petitioner should be compensated for a loss of occupation. Rather, Petitioner should be compensated mainly on the basis of his disability and restrictions (factor (v)).

Regarding factor (iv), the Commission agrees with the Arbitrator's analysis.

Regarding factor (v), the Commission notes that Petitioner obtained a fairly good result from the left shoulder surgery. However, Dr. Wottowa noted residual pain. Following a functional capacity evaluation, Dr. Wottowa imposed permanent restrictions at the light to medium physical demand level. Petitioner credibly testified that his left shoulder and arm hurt proportionately to the level of activity. Petitioner's wife credibly testified that Petitioner has pain and decreased strength in the left arm. He cannot do certain activities, such a tree trimming, carrying groceries, or putting tailgates on cars without help. The Commission gives significant weight to this factor.

Having carefully considered and weighed the foregoing factors, the Commission believes the proper measure of disability is 27.5 percent of the person as a whole.

Lastly, the Commission corrects paragraph 2 on page 3 of the Arbitrator's decision to reflect the injury was to the *left* shoulder.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 5, 2019, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $775.18 per week for a period of 137.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability to the extent of 27.5 percent of the person as a whole.

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

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

20IWCC0182

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.

MAR 16 2020

DATED:
d-03/03/2020
SM/sk
44

Stephen Mathis

L. Elizabeth Coppoletti

Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HARNESS, DAVID E
Employee/Petitioner

Case# **17WC011654**

CITY OF SPRINGFIELD
Employer/Respondent

20IWCC0182

On 6/5/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.25% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1157 DELANO LAW OFFICES LLC
CHARLES H DELANO IV
1 S E OLD STATE CAPITOL PLZ
SPRINGFIELD, IL 62705

0332 LIVINGSTONE MUELLER ET AL
L ROBERT MUELLER
620 E EDWARDS ST PO BOX 335
SPRINGFIELD, IL 62705

20IWCC0182

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

DAVID E. HARNESS,
Employee/Petitioner

v.

CITY OF SPRINGFIELD,
Employer/Respondent

Case # **17** WC **11654**

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 **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **5/24/19**. By stipulation, the parties agree:

On the date of accident, **1/25/17**, 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 $**72,916.48**, and the average weekly wage was $**1,402.24**.

At the time of injury, Petitioner was **56** years of age, ***married*** with **no** dependent children.

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

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**.

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 $775.18/week for a further period of **175** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **petitioner a 35% loss of use of his person as a whole**.

Respondent shall pay Petitioner compensation that has accrued from **1/27/15** through **5/24/19**, 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

6/3/19
Date

ICArbDecN&E p.2

JUN 5 - 2019

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 56 year old auto body technician, sustained an accidental injury that arose out of and in the course of his employment by respondent on 1/25/17. Petitioner worked for respondent for 15 ½ years in the same position. His duties included fixing anything that is owned by the respondent, such as firetrucks, dump trucks, police cars, etc. Petitioner reported that his duties required significant lifting at times. His job was classified as heavy duty. Petitioner could be required to lift up to 150-200 pounds. Petitioner was able to perform the duties of his job before his injury without any problems or restrictions. Petitioner testified that he is ambidextrous, with his right upper extremity being more dominant. Petitioner can write with both hands. Petitioner did most duties with both upper extremities. Petitioner testified that he injured his left shoulder in 2015. Petitioner testified that after he recovered from his injury his left shoulder was fully functional up to 1/25/17.

On 1/25/17 while straightening the hood on a pickup truck with a hammer and a dolly petitioner injured his right shoulder. Petitioner had his left arm up holding the dolly and had a hammer in his right hand hitting the metal hood trying to straighten it out. As he was doing this he noticed a stabbing sensation in his left arm. Petitioner reported the injury to respondent and sought treatment.

On 1/28/17 petitioner presented to Dr. David Pittman. He reported that he had pain in his left shoulder that started the day before and was much worse that morning. He stated that he did not injure his shoulder, but it just started to hurt. He reported that the pain radiated down his arm, and felt like a pulling sensation. He stated that "it hurts like hell". He denied an injury, but stated that he works as an autobody mechanic and could not pinpoint when he did it. X-rays revealed significant arthritis of the left shoulder. He reported a long history of working as an auto body mechanic. Dr. Pittman referred petitioner to the Ortho walk-in clinic. He also wrote him a prescription for Tramadol.

On 1/30/17 petitioner completed his worker's compensation injury paperwork for respondent.

On 1/30/17 petitioner presented to Dr. Rishi Sharma for his left shoulder pain. He reported constant discomfort. He reported pain all the time. He also reported a sudden onset of pain 4 days ago without a specific injury. Dr. Sharma examined petitioner, reviewed the x-rays and assessed left shoulder rotator cuff syndrome. Dr. Sharma prescribed rest, ice, compression, and elevating the arm. He also gave petitioner a steroid injection and a note for work that said no use of his left upper extremity. He prescribed a course of physical therapy.

On 2/15/17 petitioner began his course of physical therapy at Springfield Clinic. Petitioner was to be seen 2 times a week for 4-6 weeks. By 3/10/17 petitioner's range of motion and strength had improved, but with his recent set back in pain, both were decreased from a week prior.

On 3/13/17 petitioner returned to Dr. Sharma. His condition was essentially unchanged. He reported limited relief with the injection and physical therapy. Dr. Sharma was of the opinion that petitioner had failed conservative treatment. Dr. Sharma assessed persistent left shoulder pain, and restricted petitioner from use of the left shoulder. He ordered an MRI of the left shoulder to rule out internal derangement. That same day petitioner notified physical therapy that his therapy was being put on hold until after the MRI of his left shoulder.

On 3/30/17 petitioner followed-up with Dr. Sharma. His condition was unchanged. Dr. Sharma reviewed the MRI, examined petitioner and assessed left shoulder impingement syndrome. He also referred petitioner to an orthopedic surgeon. Dr. Sharma continued petitioner's restrictions of no use of the left upper extremity.

On 3/31/17 petitioner presented to Dr. Brent Wolters, an orthopedic surgeon, for evaluation of his left shoulder injury. He reported that he injured his left shoulder on 1/25/17 while repairing a truck at work. He gave a consistent history of the injury. He reported that his pain varied from a 6/10 to 10/10. He reported that use of the left shoulder, including overhead activities, increased his pain. He reported some radiation of pain up and down his arm, and pain at night. He reported that physical therapy made his pain worse, and the injection did not help. After Dr. Wolters examined petitioner, and reviewed the x-rays and MRI, he assessed a left shoulder near full-thickness subscapular rotator cuff tear; left shoulder severe acromioclavicular joint osteoarthritis; left shoulder biceps subluxation; left shoulder impingement syndrome; current everyday smoker; and, work related injury. Dr. Wolters discussed a left shoulder arthroscopic subscapularis rotator cuff repair, subacromial decompression, distal clavicle excision and open subpectoral biceps tenodesis.

On 5/1/17 petitioner underwent a Section 12 examination for his left shoulder, performed by Dr. Mitchell Rotman, an orthopedic surgeon, at the request of the respondent. Dr. Rotman interviewed petitioner, performed an examination and record review. His impression was that petitioner had a subluxed biceps tendon of the long head of the biceps at the level of the shoulder down to the bicipital groove. He was of the opinion that this was associated with rotator cuff tendinopathy and some impingement secondary to some degenerative changes around the AC joint. He was of the opinion that petitioner's work activities would be an aggravating factor with this type of problem in the shoulder. He believed it was possible that the beating of the truck may have been a significant re-aggravating factor for the biceps issues. Dr. Rotman was of the opinion that there were several findings about his left shoulder that were more chronic in nature that would not be related to the one isolated

incident on 1/25/17. He was of the opinion that the biceps tendon subluxation was more of a chronic finding in the left shoulder secondary to long-standing issues with wear and tear about the shoulder. Dr. Rotman was of the opinion that the need for further treatment was related to either petitioner's overall work activities as a body man for the respondent, as well as from the aggravation from the incident on 1/25/17. Dr. Rotman believed that petitioner's problems would be easily managed with a shoulder arthroscopy and a debridement and then a biceps tenodesis or tenotomy. Dr. Rotman did not see a full thickness lesion in the rotator cuff. He was of the opinion that if there was a full thickness rotator cuff tear, it would be a small one. He noted that the need the surgery and further treatment would be in part related to the 1/25/17 incident at work related to just the overall activities he did as a body mechanic for respondent.

On 6/7/17 petitioner presented to Dr. Christopher Wottowa, an orthopedic surgeon, for an evaluation of his left shoulder. Dr. Wottowa examined petitioner and assessed a left rotator cuff tendinitis.

On 6/29/17 petitioner underwent a left shoulder arthroscopy with arthroscopic subcromial decompression, open distal clavicle excision, and open biceps tenodesis in the subpectoral region. His post-operative diagnosis was left shoulder pain with severe AC joint arthritis and bicipital tendinosis. Petitioner followed up post-operatively with Dr. Wottowa through 2/7/18, and underwent another course of physical therapy.

On 7/13/17 petitioner began a course of physical therapy at the Springfield Clinic. Petitioner was last seen by physical therapy on 11/1/17. At that time petitioner had good passive range of motion, but seemed to have slight less tolerance for strengthening. Petitioner reported that he felt that his shoulder still ached. He still reported trouble with sleeping.

On 9/20/17 petitioner reported to Dr. Wottowa that he was doing some lifting and climbing of ladders, which was outside his restrictions. Dr. Wottowa told him that he did not want him doing any heavy lifting with his left arm. He noted that petitioner was doing well in physical therapy and his pain was getting better. He noted that petitioner's motion and strength were improving. Petitioner was continued on desk duty and physical therapy was continued.

On 11/2/17 petitioner returned to Dr. Wottowa. Petitioner had full range of motion and flexion/extension to 180 degrees. He also had external rotation to 60 and internal rotation to the lower thoracic region. His supraspinatus strength was 4+ to 5/5. Petitioner reported that his problems were the pain he had over the anterior aspect of the left shoulder. He also felt a cramping sensation, and a pulling sensation to his brachium area. Petitioner reported that he still had a lot of discomfort. Dr. Wottowa certainly expected petitioner to be better. Dr. Wottowa performed a postoperative injection to the subacromial space today. However, petitioner

did not really see much improvement. Dr. Wottowa had petitioner stop physical therapy and do exercises on his own. He continued petitioner on light duty.

Petitioner followed up with Dr. Wottowa on 12/4/17. Petitioner still had pain over his shoulder. He reported that it might be a little better than when he was last seen. He reported improvement since his last visit. Petitioner still had a lot of subjective discomfort despite having reasonable objective improvement in his range of motion and strength. Dr. Wottowa ordered a Functional Capacity Evaluation.

On 12/18/17 petitioner underwent a Functional Capacity Evaluation at Midwest Industrial Rehab. Petitioner gave maximal effort and did all that was asked of him. Petitioner reported pain that got as high as 8/10. Petitioner had excellent range of motion of his left shoulder with excellent strength, but had continued subjective discomfort over his shoulder area with lifting activities. Following the FCE it was determined that petitioner's physical abilities did not match his job requirements. He was functioning in the Medium Physical Demand Level. Petitioner was able to lift 20-50 pounds floor to waist, front carry lift of 40 pounds; and an overhead lifting of 11-20 pounds, all on an occasional basis. Also, petitioner was able to lift 20 pounds waist to crown.

On 2/8/18 petitioner las followed-up with Dr. Wottowa. Dr. Wottowa reviewed the results of the FCE. Dr. Wottowa gave petitioner permanent restrictions. Petitioner was able to lift 21-50 pounds; 40 pounds floor to waist, front carry lift of 40 pounds; and an overhead lifting of 11-20 pounds, all on an occasional basis. Also, petitioner was able to lift 15 pounds waist to crown.

After being released from care by Dr. Wottowa, petitioner returned to work for respondent within his restrictions. He worked a modified position for respondent where his duties included getting parts and cleaning the shop. Petitioner performed these duties until the shop closed in November of 2018. Petitioner testified that he wanted to remain employed by the respondent, but this did not work out, and he retired on 11/9/18 because he needed the medical insurance. Otherwise, he would have had to buy Cobra.

On 3/7/19 Dr. Rotman issued an addendum to his report of 5/1/17, after reviewing additional medical records for petitioner. Dr. Rotman noted that one of these records was an MRI of the left shoulder from 10/27/15. Dr. Rotman noted that the MRI after the injury on 1/25/17 showed worsening of the articular sided lesion of the subscapularis associated with a dislocation of the long head of the biceps and worsening of the tendinosis. Dr. Rotman could not even appreciate a normal signal in the biceps on the MRI scan taken in 2015. He also noted a couple views that would suggest that the biceps tendon was dislocated out of the groove in 2015. He also saw the biceps tendon perched far out away from the groove with quite a bit of swelling in the

bicipital sheath. He was of the opinion that the scan from 2017 showed the biceps out of the groove, and in a pretty similar displaced position that the 2015 MRI showed. He also noted that both the 2015 and 2017 MRIs showed a similar appearance with regards to the bone spurs. Dr. Rotman's impression was that the findings noted on 2015 MRI showed a biceps dislocation and AC joint arthritis, similar to what was noted on the 2017 MRI. He noted that the 2017 MRI was of a greater quality than the 2015 MRI. He was of the opinion that nonetheless, petitioner's AC joint arthritis and the biceps dislocation were old and preexisted the injury on 1/25/17. He was of the opinion that petitioner merely triggered discomfort from this chronic condition that had been going on for quite some time.

On 10/13/15 petitioner presented to Dr. Sharma for evaluation of his left shoulder. He reported that the pain started on 10/12/15 while turning a tool and experiencing a pop and tug on the left shoulder. He stated that since then he has had an inability to lift his arm above his head. He also reported pain at night. An x-ray of the left shoulder showed mild to moderate osteoarthritis. He was assessed with questionable internal derangement and left shoulder pain.

On 10/27/15 petitioner underwent an MRI of the left shoulder that showed severe acromioclavicular joint osteoarthritis; subluxation of the biceps tendon medially from the bicipital groove with associated tendinopathy; mild narrowing of the coracohumeral distance with a small amount of edema within the less tuberosity; the deep fibers of the superior aspect of the subscapularis were likely torn; glenohumeral joint effusion; and tendinopathy of the supraspinatus.

On 10/29/15 petitioner followed up with Dr. Sharma. He reported that all his pain was primarily affecting the top of his left shoulder as well as deep inside his shoulder. He reported that using it makes it worse. Dr. Sharma assessed shoulder pain. Petitioner was given Pennsaid, and formal physical therapy with a home exercise program. An injection was recommended. He was released to regular activities.

On 11/5/15 petitioner underwent a cortisone injection into the left glenohumeral joint.

Petitioner is currently working. He recently reopened his body shop, which he had closed when he went to work for respondent. He testified that he does flat rate time on insurance work. Petitioner testified that he cannot do all the work he did before, and sometimes subcontracts some of the work. He stated that when he does the work himself it may taken him longer to do than the flat rate time the insurance was paying him for. He testified that he does not do a lot of insurance work, and only did his first job last week on his daughter's car. He testified that the insurance company allotted 23 hours to complete the job, and he took 32 hours to do it. He believed that he could have done the work within the allotted time before the injury.

Currently, petitioner experiences a lot of cramping if he exceeds his restrictions. He testified that at the end of the day his arm feels "trashed out". Petitioner takes CBD oils and Flexeril for the pain. Petitioner reported that he still has pain. He testified that when he does not use it, it feels great.

Petitioner is currently running Dave's Auto Body. He testified that he had this business since he was 16 years old and ran it until he was hired by respondent on 7/22/02. After the respondent's body shop closed petitioner reopened his business, a week before this hearing, after he received his business license. He testified that while he was working for respondent he did some work on the cars of his friends and family.

Respondent offered petitioner vocational rehabilitation knowing that the body shop was going to close, but petitioner did not want to do it unless he could choose his own vocational counselor. Petitioner and his attorney also told respondent that they could pick a different vocational counselor. This was never done, and no vocational rehabilitation services were ever performed.

Petitioner testified that he is a drummer that jams with some guys once a week. He testified that his first paid gig was coming up the next weekend.

Judy Harness, petitioner's wife, was called as a witness on behalf of petitioner. Judy has been married to petitioner for 31 years. She testified that she was aware of the injury on 1/25/17. She testified that prior to the injury on 1/25/17 petitioner had no problem with his left arm functions. She also testified that after 1/25/17 petitioner had restrictions. Judy stated that after 1/25/17 petitioner had difficulty sawing a tree. She testified that she carries the groceries in the house, and helps petitioner put tailgates on cars he is working on. She noted that during the night his left shoulder hurts.

The parties stipulate that the body shop closing was agreed to in a contact between the union and respondent in 2015. The parties agreed that the body shop would close on 11/10/18.

WHAT IS THE NATURE AND EXTENT OF THE INJURY?

For injuries that occurred after 9/1/11, according to 820 ILCS 305/8.1B(b) the Commission shall base its determination of permanent partial disability based upon five factors including an AMA report, the occupation of the injured employee, the age of the employee at the time of injury, the employee's future earning capacity and evidence of disability corroborated by treating medical records.

With regard to subsection (i) of §8.1b(b), neither party offered into evidence an AMA impairment report 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 petitioner was a 56 year old body technician. However, following his injury and recuperation, petitioner was given restrictions that allowed him to only work at the Medium Physical Demand Level. Petitioner's regular duty job was in the Heavy Physical Demand Level. Following his release to work with permanent restrictions, petitioner worked modified duty work for respondent until 11/10/18, the date the respondent's body shop closed. No vocational rehabilitation services were ever performed, and petitioner retired. Since retiring, petitioner recently reopened Dave's Auto Body, his own personal body shop. Petitioner testified that it takes him longer to do any work due to his permanent restrictions. For these reasons the arbitrator gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that the petitioner was a 56 year old body technician at the time of the injury. Petitioner was released from care with permanent restrictions that did not allow petitioner to return to his regular duty job. Petitioner retired and reopened a body shop that he ran before he worked for respondent. Petitioner just opened the shop a week before this hearing. To date he has only done one insurance job, on his daughter's car, and it took 50% longer than the hours the insurance company allotted due to his restrictions. Petitioner continues to experience a lot of cramping if he exceeds his restrictions. By the end of the day his left arm "feels trashed". Petitioner takes Flexeril and CBD oils for pain. The Arbitrator notes that given that petitioner's age and the fact that he has retired, the petitioner work life expectancy is not the same as someone in their 30's or 40's. However, the problems petitioner is currently having, he may have for the remainder of his life. For these reasons the arbitrator gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the arbitrator notes that parties offered no credible evidence on this issue. All that is known is that the respondent could not accommodate petitioner's restrictions and petitioner retired in order to maintain his medical benefits. Petitioner just recently reopened his own business. It is unknown what petitioner's current wages are, therefore trying to define petitioner's future earnings capacity would be purely speculative. Therefore, the arbitrator gives little weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator finds the petitioner sustained an injury to his left shoulder for which he underwent a left shoulder arthroscopy with arthroscopic subacromial decompression, open distal clavicle excision, and open pectoral region. Post-operatively petitioner continued with pain and had a post-operative injection. When petitioner was released from care by Dr. Wottowa on 2/8/18 he had excellent strength and excellent motion in his shoulder. Petitioner was given permanent restrictions in the Medium Physical Demand Level, which

precluded him from working his regular duty job that was at the Heavy Physical Demand Level. Petitioner worked modified duty for respondent until the respondent's body shop closed in November of 2018. At that time petitioner retired, and just recently reopened his own body shop.

Petitioner had a previous injury to his left shoulder in 2015 for which he underwent conservative treatment. After being released from care at that time, petitioner returned to full duty work and worked without incident until the injury on 1/25/17. Currently, petitioner experiences a lot of cramping if he exceeds his restriction. He testified that at the end of the day his arm feels "trashed". Petitioner takes Flexeril and CBD oil for the pain. Petitioner reported that he still has pain. He testified that when he does not use his left shoulder it feels great. Therefore, the arbitrator gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds the petitioner sustained a permanent partial disability to the extent of 35% loss of use of person as a whole pursuant to Section 8(d)2 of the Act.

STATE OF ILLINOIS)	☒ Affirm and adopt (with explanation)	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF MADISON)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Verna Roberts,

Petitioner,

vs.

20IWCC0183

NO: 18 WC 14096

DaVita, Inc. d/b/a DaVita Dialysis,

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 all issues, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part thereof. 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 agrees with the Decision of the Arbitrator and further acknowledges that the objections raised by Petitioner's counsel during the deposition of Dr. John Krause were properly overruled. The parties deposed Dr. Krause, Respondent's §12 examiner, on January 23, 2019. During the direct examination of Dr. Krause, Petitioner's counsel objected to numerous questions as well as the admission of Dr. Krause's §12 report. Although the Arbitrator did not mark his rulings on the deposition transcript regarding these objections, the Commission understands these objections to have been overruled, because the Arbitrator considered Dr. Krause's testimony and §12 report in making his findings. Additionally, Petitioner's counsel represented that her objections were based on Dr. Krause's failure to specify that his answers were based on a reasonable degree of medical certainty. However, Dr. Krause did confirm for the record that all of his answers were based on a reasonable degree of medical certainty.

The Commission thus clarifies that Petitioner's objections to Dr. Krause's testimony and §12 report were properly overruled. The Decision of the Arbitrator is accordingly affirmed and adopted in its entirety.

20IWCC0183

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner's objections to Dr. Krause's testimony and §12 report are overruled.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 28, 2019 is hereby affirmed and adopted.

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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $35,000.00. 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 16 2020

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/met
O- 2/6/20
46

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

20IWCC0183

ROBERTS, VERNA
Employee/Petitioner

Case# **18WC014096**

DaVITA INC D/B/A DaVITA DIALYSIS
Employer/Respondent

On 5/28/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.34% 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:

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

0560 WIEDNER & McAULIFFE LTD
JAMES A TELTHORST
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

20IWCC0183

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Verna Roberts
Employee/Petitioner

v.

DaVita, Inc. d/b/a DaVita Dialysis
Employer/Respondent

Case # **18** WC **14096**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **March 26, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **January 13, 2018**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$41,600.00**; the average weekly wage was **$800.00**.

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

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

Respondent shall be given a credit of **$12,647.77** for TTD, **$5,368.75** for TPD, $- for maintenance, and **$0** for other benefits, for a total credit of **$18,016.52**.

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

ORDER

Respondent shall pay the reasonable and necessary expenses outlined in Petitioner's group exhibit pursuant to § 8(a) and § 8.2 of the Act, the medical fee schedule. Respondent shall have credit for any amounts paid through its group carrier provided that it holds Petitioner harmless from any claims made by any provider arising out of the expenses for which it claims credit pursuant to § 8(j) of the Act.

Respondent shall authorize and pay for the medical care and treatment recommended by Dr. Bradley, including but not limited to surgery.

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

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

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

Signature of Arbitrator

5/19/19
Date

ICArbDec19(b)

MAY 28 2019

FINDINGS OF FACT

This matter came before the Arbitrator on Petitioner's Motion pursuant to Section 19(b). Disputed issues were causation and prospective medical care. (AX1, T.4)

At the time of the injury, Petitioner was a 57-year-old dialysis technician for Respondent. (AX1; T.8) She travels to various patients' homes and provides kidney dialysis to keep them alive. (T.8-9) Petitioner is a high school graduate with some college, and she received her dialysis tech position with 18 months of on the job training and is now State certified. (T.8-10)

The parties stipulated that on January 13, 2018, Petitioner sustained accidental injuries. (T.10) At Arbitration, Petitioner testified as to how the accident occurred:

> I went into a storage room to get something off the shelf and I didn't realize that my foot had slid behind the wheel of a two-wheel truck and when I turned my foot hit the truck and my knee turned instead of my whole leg and it popped. (T.10)

Prior to January 13, 2018, Petitioner had no injuries or symptoms and had undergone no diagnostic testing on her right knee. (T.10-11) Because she could not stand, Petitioner was taken by ambulance to Belleville Memorial Hospital. (T.11; PX4, 1/13/18) The history of the accident was taken, and Petitioner was noted to have severe medial sided right knee pain. Dr. Franks, the emergency room physician, believed that Petitioner had a meniscal injury. (PX4, 1/13/18)

Petitioner was next seen by P.A. Laura Kidd on January 17, 2018. (PX5, 1/17/18) She diagnosed Petitioner with a knee injury and recommended an orthopedic consult. *Id.* This happened on January 23, 2018, when Petitioner saw Dr. Angela Freehill at the Orthopaedic Center of Southern Illinois. (PX6, 1/23/18) Dr. Freehill's noted in the "OFFICE USE ONLY" portion of the intake questionnaire that Petitioner had no prior injuries, therapy, or injections to her right knee. *Id.* Dr. Freehill took the history during the examination and documented positive orthopedic signs and medial sided knee pain. Like Dr. Franks, Dr. Freehill believed that Petitioner had a meniscus tear and recommended an MRI. *Id.* This was done on January 30, 2018, and it showed findings consistent with a tear of the anterior horn of the lateral meniscus and a medial collateral ligament sprain. (PX7, 1/30/18) Dr. Freehill recommended an injection and physical therapy. (PX6, 2/6/18)

On March 6, 2018, Dr. Freehill documented medial and lateral joint line tenderness. Since conservative treatment had failed, Dr. Freehill recommended surgery for both anterior and medial sided knee pain. (PX6, 3/6/18) Surgery was performed on March 26, 2018. Intraoperative objective findings consisted of a tear of the anterior horn and midbody lateral meniscus of the right knee which Dr. Freehill described as "complex," and grade 2 chondromalacia of the lateral facet of the trochlea. (PX9, 3/26/18) Following surgery Petitioner attempted further physical therapy and rehabilitation at NovaCare Rehabilitation in Benton, IL. (PX8, 4/4/18 to 5/21/18)

Petitioner returned to Dr. Freehill on May 1, 2018, with the following history:

> Ms. Roberts is a 57-year-old woman I have been following for her RIGHT knee. She is now 5 weeks out from a RIGHT knee arthroscopy and arthroscopic partial lateral meniscectomy. She is here today for follow-up. She is not doing well. She is still doing her physical therapy. Her pain is high at 8 out of 10. She says her pain is mostly medial and posterior. She is unhappy with how things are going. (PX6, 5/1/18)

Despite letting Dr. Freehill know that her condition was not doing well and that her pain was an 8 out of 10, Dr. Freehill indicated in her assessment that "she [Petitioner] is now doing well." (PX6, 5/1/18) Dr. Freehill thought that Petitioner's symptoms were due to hamstring tightness and patellofemoral pain. She wanted to try to manage Petitioner's arthritis pain with medication; but if Petitioner was not doing well, she would consider an injection. *Id.*

Petitioner returned to Dr. Freehill on May 22, 2018, and she still reported significant pain. Dr. Freehill reported crepitus with active extension particularly in the patellofemoral joint, a finding which had been reported on May 1, 2018. (PX6, 5/1/18 & 5/22/18) Dr. Freehill's initial examination of January 23, 2018, showed no crepitus, and x-rays of the right knee showed Petitioner to have no evidence of osteoarthritis. (PX6, 1/23/18) Dr. Freehill performed an injection into the right knee on May 22, 2018, and she recommended continued physical therapy. (PX6, 5/22/18) When Petitioner returned on June 27, 2018, the history was taken as follows:

> Ms. Roberts is a 58-year-old woman I have been following for her RIGHT knee. She is now 3 months out from a RIGHT knee arthroscopy and arthroscopic partial lateral meniscectomy. She is here today for follow-up and she's not doing well. She's still having burning pain. Her pain is at 8 out of 10. I gave her a cortisone injection last time and that did not help her at all. She does have grade 2 chondromalacia of the trochlea, however this kind of pain is worrisome to me. She is doing 4 hours per day at work. (PX6, 6/27/18)

Dr. Freehill's assessment was post right knee arthroscopy and arthroscopic partial lateral meniscectomy. (PX6, 6/27/18) Because Petitioner's pain was significantly greater than what Dr. Freehill would have expected given the findings of her knee at the time of surgery, Dr. Freehill was concerned about reflex sympathetic dystrophy. Dr. Freehill noted that Petitioner had scheduled an appointment with Dr. Bradley; and she stated that if Petitioner had RSD, only physical therapy - which Respondent had denied - would be of assistance. *Id.* During this time, Petitioner was working only four hours per day, and Respondent was paying temporary partial disability benefits. *Id.*; (AX1)

On July 16, 2018, Petitioner saw Dr. Matthew Bradley, a Board certified orthopedic specialist. (PX10, 7/16/18) He took the history of the injury and noted that prior to the accident / twisting event, Petitioner's knee was perfectly normal and had normal range of motion without any pain. *Id.* Petitioner was able to perform all activities of daily living as well as work. *Id.* Dr.

Bradley's examination showed slight pain to palpation over the medical portal with no swelling. *Id.* He found pain to palpation along the medial joint line and severe pain and an objective click to McMurray-type testing. *Id.* This reproduced the pain Petitioner stated she had while walking. *Id.* X-rays showed very mild degenerative changes, more on the lateral than on the medial side. *Id.* Petitioner brought Dr. Bradley the arthroscopic pictures taken at the time of her surgery, which unfortunately were of very poor quality. *Id.* Dr. Bradley recommended an MRI scan utilizing contrast. *Id.*

Petitioner returned to Dr. Freehill for the last time on July 27, 2018. (PX6, 7/27/18) Petitioner was now having significant burning pain postoperatively. *Id.* Dr. Freehill noted that Dr. Bradley recommended that Petitioner think about knee replacement surgery, and that he believed that the injury / knee arthroscopy stirred up Petitioner's arthritis pain. *Id.* She did not think Petitioner had advanced arthritis. *Id.* Dr. Freehill changed Petitioner's medication and recommended a possible viscosupplementation injection. *Id.*

Petitioner returned to Dr. Bradley on August 16, 2018, after obtaining the recommended MRI. (PX10, 8/16/18) The recent MRI from Southern Illinois Healthcare/Memorial Hospital of Carbondale showed an extrusion of the lateral meniscus in combination with focal areas of bone-on-bone degenerative joint disease. (PX11, 7/23/18; PX10, 8/16/18) Dr. Bradley recommended a total knee replacement and did not see any other treatment that could reliably provide pain relief and function. (PX10, 8/16/18) Dr. Bradley stated in his notes that it was his opinion that the need for the total knee arthroplasty was a direct sequela of the meniscus tear and now extrusion of the meniscus status post-arthroscopy. *Id.* He provided a long legged hinged knee brace for pain and instability. Petitioner returned to Dr. Bradley on October 15, 2018; however, Dr. Bradley was unable to perform surgery as Respondent had denied that portion of her treatment. (PX10, 10/15/18)

Respondent had Petitioner examined on October 1, 2018, by Dr. John Krause. (RX1, Dep.Exh.3) Dr. Krause took the history of the injury and noted that Petitioner was still having symptoms. *Id.* He agreed that the MRI done in January of 2018 showed findings consistent with a tear of the anterior horn of the lateral meniscus and a medial collateral ligament sprain. *Id.* He reviewed the operative report and the notes from Dr. Freehill noting that Petitioner continued to experience symptoms. *Id.* He also reviewed the notes of Dr. Bradley. *Id.* He noted that Dr. Bradley recommended a total knee arthroplasty. *Id.* Dr. Krause's examination showed medial and lateral joint line tenderness, minimal pain with hyperflexion, mildly positive medial McMurray test, and negative lateral-sided McMurray test. *Id.* Dr. Krause reviewed the MRI dated July 23, 2018, and stated that it showed changes in the lateral meniscus consistent with a partial lateral meniscectomy with some extrusion of the meniscus. *Id.* He also noted some change in the articular cartilage on both the medical and the lateral sides of her knee. *Id.* He took x-rays in his office which he believed showed minimal degenerative joint disease. *Id.*

Dr. Krause's opinions on page 4 of his report state that he believes Petitioner's injury of January 13, 2018, caused a medial collateral ligament sprain. *Id.* He believed that the right knee arthroscopy done by Dr. Freehill was not indicated and that there was no evidence to suggest that the injury of January 13, 2018, aggravated Petitioner's preexisting degenerative joint disease. *Id.* He believed that it would be a mistake to do a total knee arthroplasty, and that Petitioner shouldn't have had the first knee arthroscopy. *Id.* Despite the recommendations of both Dr. Freehill and Dr. Bradley, Dr. Krause believed that Petitioner could work full duty without restrictions and believed that Petitioner was going to have poor prognosis because she needed an ambulance to go to the hospital after the injury. *Id.* Lastly, despite Petitioner's ongoing symptoms, Dr. Krause believed she had no disability attributed to the accident. (RX1, 10/1/18)

Dr. Krause also testified by way of deposition. (RX1) On direct examination, none of Dr. Krause's opinions were given within a reasonable degree of medical certainty. (RX1, p.15, 17) On cross-examination, Dr. Krause acknowledged that he performs three to five medical legal examinations at either $1,600.00 or $1,800.00 per week and that the majority of those would be for insurance carriers or employers. (RX1, p.17-18) Dr. Krause admitted that he does not perform total knee replacements and would refer them to another physician. (RX1, p.19) He acknowledged that Petitioner had no prior treatment for any right knee symptoms or complaints before the accident and no subsequent injuries to her right knee between the time of the incident and the time he testified. (RX1, p.23) He admitted that there was edema and swelling reported in the records of Memorial Hospital which could indicate an acute trauma, and he admitted that a twisting type injury could cause either a medial or lateral meniscal tear. (RX1, p.25-26)

Dr. Krause acknowledged that a degenerative tear or degenerative finding can be asymptomatic and in fact testified that "most of them are, yes." (RX1, p.30) When asked if they could be made symptomatic by an injury, he stated "they could be, sure." (RX1, p.30) When asked the following question, Dr. Krause testified:

> Q: Okay. So we have a woman who is now I think ten weeks out from her injury, she's got positive physical exam findings, she's got a confirmed lateral meniscus tear on an MRI. So it's your opinion that even in spite of all of that the surgery that was done was not appropriate for her?
>
> A: That is absolutely correct. (RX1, p.35)

Dr. Krause admitted that he was the only physician that ever released Petitioner to full duty despite acknowledging that she never returned to pre-injury status or baseline. (RX1, p.45-47)

Dr. Bradley also testified by way of deposition. (PX12) He is a Board certified orthopedist who specializes in treatment of the lower extremities. (PX12, p.4) His practice is mostly a trauma and degenerative disease type practice, where he takes care of a lot of acute injuries to the lower extremities. He performs total joint replacements, and total hip and knee replacements make up about 30% of his practice. (PX12, p.5) He gets referrals from a wide

variety of places and performs independent medical examinations; but he stated, "If I do one IME a month it would be a lot." (PX12, p.7) Dr. Bradley reviewed Petitioner's prior records, diagnostic studies, and the report of Dr. Krause. (PX12, p.8) He noted that Petitioner had been operated on by Dr. Freehill without relief and underwent injections without relief. (PX12, p.10) He stated that she had never been able to return to work in her full capacity since the injury occurred, and he has no information of any prior knee injury or treatment to her right knee prior to the accident. (PX12, p.10-11)

His examination showed a significant amount of pain along the medial / inside of her knee, with a positive McMurray test, which is specifically designed to look for meniscus injury or meniscal pathology. (PX12, p.11) After his review of prior records, the diagnostic studies and his clinical examination, he believed Petitioner suffered a tear to her medial meniscus. (PX12, p.12) He explained Petitioner's lateral symptoms as follows:

> No, quite frequently it's difficult for patients to isolate pain coming from inside of a joint. The nerve endings and the pain fibers inside the joint are not as precise and interpreted the same as nerve fibers on, for instance, our skin. If I'm touching the palm of my hand I know I'm touching the palm of my hand. It feels like that. But inside a joint, particularly a knee, patients will often think that their pain is coming from the outside of the knee but the pathology is on the inside or vice versa.
>
> So I utilize the patients pointing to where the pain is as one particular piece of information, but quite frequently the pathology is not where the pain is perceived. (PX12, p.13)

Dr. Bradley acknowledged that meniscal tears are very common tears that every orthopedic surgeon sees almost on a daily basis if not multiple times per day. Despite them being common, quite frequently when they're treated there are recurrences. He believed they can either be incompletely treated or treatment / surgery can weaken the meniscus to where a secondary tear can occur. (PX12, p.14) With regard to causation, he stated:

> At this point I had no reason to believe that there was anything other than that injury in January contributing to it. She had not given me any history of an injury or trauma before this. She had not given me any history of an injury or trauma subsequent to her surgery, so at this time I was going off the opinion that we were – this was a continued treatment of her injury sustained in January of 2018. (PX12, p.15)

With regard to findings on the new MRI, he stated:

> The new MRI showed a couple of pertinent findings, one is which the lateral meniscus was in a more extruded -- meaning it was no longer in between the bones in the knee. It was pushed outside of the bones in the knee, which is a very significant finding for the first MRI.

> Secondly is there were areas on both the inside as well as the outside of the knee in which the cartilage was completely gone and there was bone-on-bone deformity or bone-on-bone areas. (PX12, p.17)

He explained that when the meniscus is torn and becomes extruded, there was no shock absorber to prevent the bones from hitting each other. This leads to deep-seated pain and significant propagation of arthritis and loss of the articular cartilage, leading to bone-on-bone deformities. (PX12, p.17-18)

When comparing the two MRIs, Dr. Bradley reported the significant change in the position of the lateral meniscus which was easily seen. (PX12, p.17-19) The second MRI clearly showed areas of full thickness cartilage loss or bone-on-bone arthritis for which Dr. Freehill did not dictate in her initial operative report. *Id.* at 18-19. He believed that finding was a change in Petitioner's condition. (PX12, p.18-19) Given everything he reviewed, especially the extrusion of the lateral meniscus and the new developing bone-on-bone arthritis, the recommended that Petitioner should consider a right total knee arthroplasty. (PX12, p.19) The reason for this is that Petitioner had multiple factors to look at. (PX12, p.20) She had areas on both the inside and outside of the knee in which she had lost all of her cartilage in addition to the meniscus being extruded. *Id.* Those two findings are very difficult to treat without replacement. *Id.* The extruded lateral meniscus is almost impossible to treat, especially when there are areas of bone-on-bone arthritis and no bump or cushion. *Id.*

Dr. Bradley noted that the Petitioner had already tried injections and therapy. (PX12, p.20) Given her age of 58, he believed that the knee replacement was a reasonable procedure to consider. *Id.* As a joint replacement specialist, he believed that this procedure would alleviate all her pain and that the risk of the knee wearing out and needing a revision was very small. *Id.* He noted that technology had advanced greatly in the area of joint replacement and all indications through lab studies showed that if the total knee was put in good alignment with good balance, he could easily expect 15 to 30 years of lifetime. (PX12, p.21) He did not believe that Petitioner's age of 58 was a contraindication to knee replacement and that his recommendation of a total knee replacement was a continuation of the treatment that Dr. Freehill had already instituted. (PX12, p.21, 23, 29-30) He testified that the acute injury that the Petitioner sustained was an acute injury to the meniscus, but that the injury and subsequent treatment caused a very significant exacerbation and acceleration of some underlying early degenerative problems. (PX12, p.23)

Dr. Bradley's diagnostic ultrasound showed moderate joint effusion in Petitioner's knee which showed Petitioner definitely had more fluid inside her knee than was normal. (PX10, 10/15/18; PX12, p.26-27) He stated this meant that there was some sort of a process going on inside the knee relating to an acute injury, chronic injury, or arthritis that was contributing to her pain. (PX12, p.27) Dr. Bradley strongly disagreed with Dr. Krause's belief that the extrusion of the lateral meniscus was of no clinical significance. (PX12, p.29) Because of the meniscal

extrusion, it was no longer providing the cushioning and support to the knee and was a very significant problem. *Id.*

Dr. Bradley had the opportunity to view Petitioner multiple times and stated, "As usual, she always wanted to get back to work. Her goal was always to get back to work." (PX12, p.25) Petitioner never gave Dr. Bradley any indication to think she was malingering, exaggerating or trying not to return to work. *Id.* In fact, on her last appointment, she came in to get an injection so that she could go back to work. *Id.* Dr. Bradley did not understand why taking an ambulance to the hospital for a knee injury had any relevance and did not agree with that Dr. Krause's statement that no one should perform this type of operation. (PX12, p.30-31) Regarding this, Dr. Bradley stated:

> I find that statement to be very telling of Dr. Krause. I have treated every single patient I have seen to the best of my abilities regardless of my board certification, my board anything. I think as a physician you're obligated to treat the patients to the best of your ability using your thing. I've never changed my treatment nor would I based upon my board certification, if I'm in a recertification period, if I'm studying for my boards. I think that's a ludicrous statement. (PX12, p.31)

On cross examination, Dr. Bradley was questioned extensively concerning the MRIs. However, he continued to testify that the MRI showed there was intrasubstance degeneration of the medial meniscus which was either postoperative or degenerate in nature and that the fluid within the medial meniscus was a result thereof. (PX12, p.41) Respondent's counsel asked Dr. Bradley if he had any sort of exclusive arrangement with the manufacturers of the joint replacements to use his product. (PX12, p.61-62) Dr. Bradley testified that he had never been paid a single penny by any manufacturer to use a product and receives no additional fees for doing total knee replacements for any sort of manufacturer, stating: "Nothing I do, no sir." *Id.*

This hearing lastly approximately 45 minutes to an hour, and the Arbitrator viewed Petitioner to be soft-spoken and very stoic with regard to her symptoms. She testified to no prior right knee problems whatsoever before the accident and stated that her left / uninjured knee had no problems. (T.10-11) When asked what she wanted, she stated "I would like to have my knee fixed... I'd like to have the total knee replacement so I can get back to hopefully a normal life, enjoy my grandkids." (T.15) Because Dr. Krause released her to work with no restrictions and Petitioner was not being paid temporary partial disability benefits, she returned to work full duty. (T.16) She is currently working from 3:15 a.m. until 6:00 a.m. (T.16) The night before the hearing, she didn't get off work until 7:00 p.m. (T.16) She stated that at the end of her shift, her knee is very, very painful. (T.16) She is not taking any narcotic pain medication; she is only taking Tylenol. (T.16) She testified that her knee hurts, and she stated she experiences a lot of burning. (T.16) She cannot get down on her knee or put any weight on it. (T.16-17)

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

A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability is sufficient circumstantial evidence to prove a causal nexus between the accident and the workers' compensation claimant's injury. *Shafer v. Illinois Workers' Comp. Comm'n*, 2011 IL App (4th) 100505WC, 976 N.E.2d 1 (2011). In addition, the employee is entitled to benefits where a second injury occurs due to treatment for the first. *See Shell Oil Co. v. Indus. Comm'n*, 2 Ill. 2d 590, 119 N.E.2d 224 (1954); *International Harvester Co. v. Indus. Comm'n*, 46 Ill.2d 238, 263 N.E.2d 49 (1970); *Lincoln Park Coal & Brick v. Indus. Comm'n*, 317 Ill. 302, 148 N.E. 79 (1925); *Harper v. Indus. Comm'n*, 24 Ill.2d 103, 180 N.E.2d 480 (1962), *Brookes v. Indus. Comm'n*, 78 Ill.2d 150, 399 N.E.2d 603 (1979); *Tee Pak, Inc. v. Indus. Comm'n*, 141 Ill.App.3d 520, 490 N.E.2d 170 (1986). Courts have consistently held that for an employer to be relieved of liability by virtue of an intervening cause, the intervening cause must completely break the causal chain between the original work-related injury and the ensuing condition. *Vogel v. Indus. Comm'n*, 354 Ill.App.3d 780, 821 N.E.2d 807, 813 (2005). "Every natural consequence that flows from an injury that arose out of and in the course of the claimant's employment is compensable unless caused by an independent intervening accident that breaks the chain of causation between a work-related injury and an ensuing disability or injury." *Id.* at 821 N.E.2d 807, 813 (2005). Where the second injury occurs due to treatment for the first, there is no break in the causal chain. *International Harvester supra.*

The law also holds that accidental injury need not be the sole causative factor or 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 (2003). [Emphasis added]. "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. *A.C. & S. v. Indus. Comm'n*, 710 N.E.2d 837 (Ill. App. 1st Dist., 1999) citing *General Electric Co. v. Indus. Comm'n*, 433 N.E.2d 671, 672 (1982). If a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Rock Road Constr. v. Indus. Comm'n*, 37 Ill.2d 123, 227 N.E.2d 65, 67-68 (1967); see also *Illinois Valley Irrigation, Inc. v. Indus. Comm'n*, 66 Ill.2d 234, 362 N.E.2d 339 (1977).

Based on the clear chain of events and the irrefutable objective medical evidence in the record, the Arbitrator finds that Petitioner's current condition of ill-being remains causally connected to her undisputed accidental work injury of January 13, 2018. Petitioner credibly testified to no prior problems or treatment with her right knee before the January accident. (T.10-11) Her testimony is corroborated by the absence of any such prior complaints or treatment in the record, and the records of her treating physicians consistently reflecting the absence of any prior

complaints or treatment. (PX6, 1/23/18; PX10, 7/16/18) The Arbitrator is not persuaded by the opinion of Dr. Krause, who believed that Petitioner suffered only a strain despite acknowledging that Petitioner has not returned to baseline and acknowledging that there is absolutely no prior evidence of treatment or complaints. (RX1, p.23, 35, 45-47; RX1, Dep.Exh.3)

On the other hand, Dr. Bradley credibly testified that Petitioner's meniscal injury and the subsequent surgery directly caused Petitioner's need for total knee replacement. (PX12, p.13-15) He testified that the acute injury that the Petitioner sustained was an acute injury to the meniscus, but that the injury and subsequent treatment caused a very significant exacerbation and acceleration of some underlying early degenerative problems. (PX12, p.23) Since the circumstantial, medical, and opinion evidence shows that Petitioner sustained a new injury along with aggravation of her preexisting condition, the Arbitrator finds pursuant to *Sisbro* and *International Harvester* that Petitioner has met her burden of proof on the issue of causal connection.

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

Issue (K): Is Petitioner entitled to any prospective medical care?

Upon establishing causal connection and the reasonableness and the necessity of recommended medical treatment, employers are responsible for necessary prospective medical care required by their employees. *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill.App.3d 705, 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*, 325 Ill.App.3d 527, 758 N.E.2d 18 (2001). The Arbitrator finds that the evidence clearly reflects that Petitioner has not reached maximum medical improvement. Petitioner continues to be symptomatic from her accidental work injury, and Dr. Bradley testified that the only reasonable means of offering Petitioner substantial relief is a right total knee replacement. (PX12, p.20)

Based upon the above findings as to causation and reasonableness and necessity of medical care and treatment, Respondent is hereby ordered to pay the reasonable and necessary medical expenses contained in Petitioner's group exhibit, and Respondent is hereby ordered to authorize and pay for the prospective medical care and treatment recommended by Dr. Bradley, including but not limited to surgery.

This award shall in no instance be a bar to further hearing and determination of any additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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: Medical Expenses	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ARIEL ROSARIO,

Petitioner,

20IWCC0184

vs.

NO: 14 WC 10807

LABOR TEMPS,

Respondent.

DECISION AND OPINION ON REVIEW

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

I. FINDINGS OF FACT

On February 14, 2014, Petitioner was sent by Respondent to work at a recycling facility where he had to pick up objects that had fallen from or did not belong on a conveyor line. These objects included chairs, desks, and large pieces of furniture weighing 50 to 80 pounds. As Petitioner attempted to push and pull a sofa off the conveyor line through a large hole, the sofa got stuck and Petitioner noticed a stabbing left low back pain.

Petitioner first presented for treatment at Holy Cross Hospital on February 20, 2014 with complaints of low back pain radiating down his left leg. Petitioner displayed a positive straight leg raise but was noted to have no examination limitations. The emergency room doctor diagnosed him with a low back strain, prescribed Norco, and advised him to follow up with orthopedic specialist Dr. Chandrasekhar Sompalli.

The following day, Petitioner saw Dr. Peter Sorokin of Occupational Health Centers of Illinois. Dr. Sorokin diagnosed Petitioner with a lumbosacral strain and recommended physical

therapy, cyclobenzaprine, ibuprofen, and a muscle rub. He also placed Petitioner on work restrictions of no lifting more than 20 pounds, no pushing or pulling more than 40 pounds, and no bending more than six times per hour. Petitioner testified that after being placed on the restrictions, he called and informed Respondent. A third-party company then called Petitioner back and offered him a light duty position. Petitioner testified that he did not take the position, because the job was over an hour from his home and he was unable to drive due to his pain. Petitioner requested a job closer to his home and spoke with the person who had sent him the light duty offer letter about other job opportunities several additional times over a two or three-month period.

On March 3, 2014, Dr. Dan Paloyan, also of Occupational Health Centers of Illinois, modified Petitioner's work restrictions to no lifting over 20 pounds, no pushing or pulling over 40 pounds, and no bending. Petitioner also began physical therapy on March 3, 2014. He attended one additional physical therapy session before presenting to Dr. Ravi Barnabas, a physician of his own choosing, at the Herron Medical Center on March 6, 2014. Dr. Barnabas diagnosed Petitioner with lumbago, a lumbosacral sprain, lumbar radiculitis, and a lumbar disc herniation. He also took Petitioner off work, issued a back brace, ordered therapy with chiropractic visits, and prescribed Naprosyn, Prilosec, and pain gel. Dr. Barnabas noted that if Petitioner chose his practice for the therapy, he would be seen by Dr. Ambrosino.

Petitioner began the chiropractic treatments with Dr. Ambrosino on March 10, 2014. He continued to see Dr. Ambrosino at both the Herron Medical Center and Alivio Physical Therapy for chiropractic treatment, acupuncture, and physical therapy through June 27, 2014. During this period, Petitioner also continued to treat with Dr. Barnabas. On March 14, 2014, Dr. Barnabas noted that Petitioner's pain had worsened despite the therapy and referred him to a pain specialist.

Petitioner presented to Dr. Ossama Abdellatif at ProClinics Pain Management on March 18, 2014. Dr. Abdellatif noted that Petitioner had been referred by Dr. Barnabas. In addition to lumbar pain, Petitioner complained of radiculopathy to the bilateral lower extremities, more so on the left side, at this visit. Dr. Abdellatif diagnosed Petitioner with lumbar radiculopathy, lumbar facet/SI syndrome, and myofascial pain. He took Petitioner off work, ordered an EMG and nerve test, and recommended a series of lumbar injections. Petitioner thereafter underwent the EMG and nerve conduction study on March 25, 2014 with Dr. Carlos Halwaji of Midwest Neurodiagnostic Specialists. The testing revealed radiculitis at L4-S1 bilaterally.

On April 2, 2014, Petitioner underwent the series of injections, which included lumbar and thoracic trigger point injections, multi-level lumbar and sacral medial branch block injections, and a L4-L5 lumbar epidural steroid injection. When he returned to Dr. Abdellatif on April 8, 2014, Dr. Abdellatif kept Petitioner off work and recommended more injections with a radiofrequency ablation. Petitioner underwent the second series of lumbar injections and the radiofrequency ablation on April 16, 2014. Petitioner subsequently reported 50% improvement to Dr. Abdellatif on May 6, 2014. Dr. Abdellatif ordered more injections, kept Petitioner off work, and recommended work conditioning.

On May 9, 2014, Petitioner presented for a §12 examination with Dr. Andrew Zelby at Respondent's request. Dr. Zelby's diagnoses were lumbosacral spondylosis and lumbar disc protrusion. He conceded that Petitioner's accident was work-related but opined that the facet and

trigger point injections had not been reasonable nor necessary. Dr. Zelby further opined that Petitioner's chiropractic visits and physical therapy should be stopped, because he had plateaued with that treatment. Additionally, Dr. Zelby indicated that Petitioner's reported right lower extremity symptoms did not follow a dermatomal or nerve distribution pattern and did not represent radiculopathy. He found that Petitioner had no radicular findings on examination, and therefore, Petitioner did not warrant surgical consideration. Instead, Dr. Zelby recommended a third epidural steroid injection followed by three to four weeks of work conditioning. He believed that Petitioner would then reach maximum medical improvement and would need no additional diagnostic studies nor treatment as a result of his work injury.

On May 12, 2014, Petitioner underwent a third series of injections, including multi-level lumbar epidural steroid injections, thoracic and lumbar trigger point injections, and lumbar/sacral medial branch block injections. Dr. Abdellatif then ordered a discogram and CT on May 22, 2014. The lumbar discography, which was administered on May 30, 2014, revealed pain concordant with L4-L5 and L5-S1 discogenic pain. At the same time of the discography, Petitioner also received lumbar trigger point injections and a L4-L5 epidural steroid injection. The CT taken the same day further showed degenerative lumbar changes with central stenosis most marked at L4-L5.

Petitioner returned to Dr. Abdellatif on June 5, 2014. Dr. Abdellatif ordered a surgical consultation and recommended work conditioning followed by a functional capacity evaluation. Additional thoracic and lumbar trigger point injections were also administered at this visit.

On July 2, 2014, Petitioner then presented for an initial visit with Dr. Robert Erickson at the Herron Medical Clinic. Dr. Erickson noted that Petitioner had been referred by Dr. Barnabas. SSEP testing of the lower extremities was performed at this visit and showed moderate delays on the right side at L5-S1 and minor delays on the left side at L5-S1. Dr. Erickson's diagnosis was mechanical back pain with right-sided radicular symptoms. He recommended an instrumented lumbar fusion at L4-L5 and L5-S1.

On July 22, 2014, Dr. Abdellatif placed him at maximum medical improvement from his standpoint. He discharged Petitioner from his care but instructed Petitioner to continue treating with Dr. Erickson and Dr. Barnabas. From August 14, 2014 to January 16, 2015, Petitioner returned for monthly follow-up appointments with Dr. Barnabas. At these visits, Dr. Barnabas continued Petitioner's medication management and kept him off work as he awaited surgical approval. At his December 4, 2014 visit, Petitioner informed Dr. Barnabas that he wanted to obtain a second opinion. On January 16, 2015, Petitioner then told Dr. Barnabas that he was going for the second opinion on January 21 with a surgeon picked by his lawyers.

While Petitioner attended his monthly visits with Dr. Barnabas, Dr. Zelby also provided a §12 addendum at Respondent's request on August 18, 2014. Dr. Zelby indicated that he had reviewed additional records from Dr. Abdellatif and Dr. Erickson, who he noted Petitioner had been referred to by Dr. Barnabas. Dr. Zelby opined that Petitioner had mild L4-L5 degenerative disc disease without loss of disc space height and normal height/signal intensity at L5-S1. As such, he believed that Petitioner did not have a condition that should be treated with a lumbar fusion. Dr. Zelby further opined that Petitioner had been treated in a cavalier nature with great excess. He stated that based on a disparity between Petitioner's subjective complaints and the

objective findings, no further treatment was necessary. Nevertheless, Dr. Zelby recommended that Petitioner pursue three to four weeks of work conditioning before returning to full duty work. He opined that Petitioner would be at maximum medical improvement after that work conditioning.

Petitioner thereafter presented for his second opinion with Dr. Theodore Fisher of Illinois Bone and Joint on January 21, 2015. Petitioner testified that he had been sent to Dr. Fisher by his attorney. Dr. Fisher diagnosed Petitioner with a L4-L5 herniated nucleus pulposus, degenerative disc disease, and discogenic pain. He opined that Petitioner was a surgical candidate and explained that Petitioner's two options were either to pursue an L4-L5 discectomy and PLIF surgery or continue with an exercise program at maximum medical improvement without the surgery. Dr. Fisher indicated that the L5-S1 level should not be included in the surgery, because Petitioner had normal findings at that level on both MRI and CT scans. He further opined that additional epidural steroid injections, facet injections, SI injections, or trigger point injections were not warranted.

Petitioner eventually returned to Dr. Fisher on June 24, 2015. Dr. Fisher indicated that Petitioner would need a new MRI for preoperative planning; however, Petitioner was not interested in the surgery at that time. Dr. Fisher instead recommended an exercise program and told Petitioner to talk to his primary care physician about long-term medications. Dr. Fisher indicated that Petitioner could return to his office as needed or if he wanted to pursue surgery in the future. Thereafter, on July 24, 2015, Dr. Barnabas noted that Petitioner wanted to pursue the recommended surgery with Dr. Erickson instead of Dr. Fisher. Dr. Barnabas kept Petitioner off work, renewed his medications, and indicated that they would try to get the recommended surgery.

On August 13, 2015, Dr. Fisher again discussed surgery with Petitioner and ordered a new MRI. On August 30, 2015, the lumbar MRI showed a L4-L5 disc bulge, annular tear, and mild bilateral lateral recess stenosis. When Petitioner returned to Dr. Fisher on September 16, 2015, his diagnoses included a L4-L5 herniated nucleus pulposus, lumbago, and bilateral lower extremity radiculopathy, right greater than left. Petitioner indicated that he now wished to proceed with surgical intervention.

Petitioner last saw Dr. Fisher on December 10, 2015. At that time, Petitioner reported that he had called earlier to cancel the proposed surgery, because he had to leave town due to a family emergency. However, he stated that everything had since been taken care of and he again wanted to move forward with the proposed surgery. Although Dr. Fisher indicated that the surgery would be scheduled at Petitioner's earliest convenience, the record contains no additional treatment records for Petitioner until 2018 and does not suggest that the surgery was ever rescheduled.

On September 21, 2016, Dr. Zelby provided another §12 addendum, which opined that Petitioner had extensive treatment with no meaningful symptom relief. Dr. Zelby found that the reported persistence and severity of Petitioner's symptoms were inconsistent with the objective findings and natural history of his medical condition. He reiterated his belief that Petitioner did not have a condition that should be treated with extensive injections or surgery. Instead, Dr. Zelby opined that Petitioner had been at maximum medical improvement and capable of regular duty work for the last two years.

After last seeing Dr. Fisher in December of 2015, Petitioner's next treatment note in the record was from Dr. Ferdinand Menendez Morales dated April 11, 2018. The Commission notes that the April 11, 2018 treatment note was the only legible record in PX 11, as the other included pages were unreadable due to their poor printing quality. Petitioner testified that he had moved to Puerto Rico, and in Puerto Rico, his primary group was Grupo Medico De Cayey and his primary care physician was Dr. Menendez Morales. The April 11, 2018 visit with Dr. Menendez Morales was a general physical and not specifically focused on any low back symptoms. This record is also largely illegible due to its poor printing quality; however, it indicates that Petitioner was positive for fibromyalgia, lumbar pain, and lumbar disc disease.

At the hearing, Petitioner explained that he had scheduled the lumbar surgery recommended by Dr. Fisher, but he moved prior to the surgery. Petitioner first moved to Orlando around November of 2016 and was there for approximately one month. Petitioner testified that he was not able to see a doctor while in Orlando. He thereafter moved to Puerto Rico on December 27, 2016. Petitioner testified that he then decided not to undergo the recommended surgery, because he had to move to Puerto Rico for personal reasons. He testified that when he moved, he brought his records and saw a doctor in Puerto Rico who gave him pain medication. Petitioner testified that he was still seeing a physician in Puerto Rico named Dr. Arnoldo Fernandez and continued to see Dr. Menendez Morales every six months. He testified that he currently takes tramadol, Flexeril, and Relafen to manage his ongoing pain.

Petitioner testified that he still has horrible pain that starts after 15 minutes when he attempts vigorous activities. He described the pain as starting in his lower back near his damaged discs and going all the way to his right side due to his sciatic nerve. He testified that his right leg down to his ankle was also damaged, and he experienced cramping sensations in his foot. Petitioner testified that although he did not have any problems walking normally without jumping or climbing, he could not play any sports nor ride a bike. Petitioner also has not worked in any capacity since February 14, 2014 and was receiving Social Security disability at the time of the hearing. Petitioner indicated that his basis for Social Security disability was diabetes, fibromyalgia, three damaged discs, and one destroyed disc. Petitioner was unable to work while on Social Security disability and had not looked for any jobs since his injury occurred.

This matter proceeded to a bifurcated hearing on March 15, 2018 and June 18, 2018. The Decision of the Arbitrator, which was issued on August 10, 2018, found that Petitioner's current condition of ill-being was causally related to his compensable work accident on February 14, 2014. Petitioner was awarded 17.5% man as a whole in permanent partial disability in addition to temporary total disability benefits from March 6, 2014 to June 24, 2015. The Arbitrator further determined that Petitioner had not exceeded his choice of physicians afforded by §8(a) of the Illinois Workers' Compensation Act.

Respondent thereafter filed a Petition for Review on September 11, 2018. On review, Respondent argued, in part, that Dr. Erickson represented Petitioner's second choice of physician, and as such, Petitioner's subsequent treatment with Dr. Fisher had exceeded his choice of physicians afforded by §8(a) of the Act. Respondent argued that it was therefore not liable for any medical bills relating to Dr. Fisher's care.

II. CONCLUSIONS OF LAW

Following a careful review of the entire record, the Commission finds that Dr. Erickson did not represent Petitioner's second choice of physician under §8(a). At Petitioner's first visit with Dr. Erickson on July 2, 2014, Dr. Erickson clearly noted that Petitioner had been referred to him by Dr. Barnabas. Both Dr. Erickson and Dr. Barnabas work at the same practice, Herron Medical Center. Moreover, Respondent's own §12 examiner, Dr. Zelby, acknowledged in his August 18, 2014 addendum that Petitioner had been referred to Dr. Erickson by Dr. Barnabas. As such, Dr. Erickson fell within the chain of referrals from Dr. Barnabas.

Although the Commission agrees with the Decision of the Arbitrator that Dr. Barnabas was Petitioner's first physician choice and Dr. Erickson represented a referral, the Commission disagrees that Dr. Fisher was another one of the doctors within Dr. Barnabas' chain of referrals.

In relevant part, §8(a) states that the employer's liability to pay for medical services selected by the employee shall be limited to:

> "(1) all first aid and emergency treatment; plus (2) all medical, surgical and hospital services provided by the physician, surgeon or hospital initially chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said initial service provider or any subsequent provider of medical services in the chain of referrals from said initial service provider; plus (3) all medical, surgical and hospital services provided by any second physician, surgeon or hospital subsequently chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said second service provider or any subsequent provider of medical services in the chain of referrals from said second service provider. Thereafter the employer shall select and pay for all necessary medical, surgical and hospital treatment and the employee may not select a provider of medical services at the employer's expense unless the employer agrees to such selection..." 820 ILCS 305/8(a).

In the present matter, Dr. Fisher constitutes Petitioner's second choice of physicians under §8(a). On January 16, 2015, Petitioner told Dr. Barnabas that he was going for a second opinion on January 21 with a surgeon picked by his lawyer. Petitioner thereafter presented for his second opinion with Dr. Fisher on January 21, 2015. There was nothing in the record to suggest that Petitioner had presented to Dr. Fisher upon a referral from Dr. Barnabas. Instead, Petitioner testified that he had been sent to Dr. Fisher by his attorney. Dr. Fisher was therefore Petitioner's second physician choice, and as such, Dr. Menendez Morales represents Petitioner's third physician choice that is not covered by §8(a). After moving to Puerto Rico, Petitioner chose to see Dr. Menendez Morales without a referral from either his first or second choice physician.

For the reasons stated above, the Commission modifies the Decision of the Arbitrator to find that Dr. Fisher was Petitioner's second choice of physician and to deny Petitioner's treatment with Grupo Medico De Cayey and Dr. Menendez Morales, as it exceeds his choice of physicians

20IWCC0184

under §8(a). The Commission denies the medical expenses related to the services provided in PX 11 accordingly. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated August 10, 2018 is modified as stated herein. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS FURTHER ORDERED that all medical expenses for services provided by Grupo Medico De Cayey and Dr. Menendez Morales are denied, as they exceed Petitioner's choice of physicians afforded by §8(a) of the Act. The award of other medical expenses as outlined in the Decision of the Arbitrator is otherwise affirmed.

IT IS FURTHER ORDERED that Respondent shall pay temporary total disability benefits to Petitioner in the sum of $253.00 per week for 68 weeks, commencing 3/6/14 through 6/24/15, as provided in §8(b) of the Act.

IT IS FURTHER ORDERED that Respondent pay to Petitioner the sum of $253.00 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 a 17.5% loss of use of the person as a whole.

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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $40,000.00. 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 16 2020

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/met
O- 1/23/20
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0184

ROSARIO, ARIEL
Employee/Petitioner

Case# **14WC010807**

LABOR TEMPS
Employer/Respondent

On 8/10/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% 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:

0274 HORWITZ HORWITZ & ASSOC
TYLER BERBERICH
25 E WASHINGTON STE 900
CHICAGO, IL 60602

2337 INMAN & FITZGIBBONS
JACK SHANAHAN
33 N DEARBORN ST STE 1825
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ariel Rosario
Employee/Petitioner

v.

Labor Temps
Employer/Respondent

Case # **14** WC **10807**

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

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **March 15, 2018 and June 18, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 14, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**340.00**; the average weekly wage was $**340.00**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **1** dependent child.

Petitioner ***has in part*** received reasonable and necessary medical services.

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $253.00/week from March 6, 2014 through June 24, 2015, a period of 68 weeks, as provided in Section 8(b) of the Act.

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner did not exceed the choices of physicians afforded by Section 8(a) of the Act. Respondent shall pay Petitioner the following fee schedule expenses (see PX 10): Alevio Physical Therapy, only those expenses associated with the care provided between March 14, 2014 and April 7, 2014; Delaware Place MRI, $1,262.92; Flexeon Rehabilitation, $324.00; Herron Medical Center, only those expenses associated with office visits, drug screenings and clearly identified, causally related medication, including Meloxicam; Holy Cross Hospital, $554.87; Illiana Anesthesia, $403.45; Illinois Bone & Joint Institute, $824.16; Industrial Pharmacy Management, $509.13; Lakeside Surgery Center (facility), only the four $1,200 charges relating to the epidural injections administered on April 2 and 16, 2014, subject to the fee schedule; Lakeside Surgery Center (physician), $70.80; Midwest Imaging, $256.87; ProClinics, only those expenses associated with Petitioner's office visits to Dr. Abdellatif from March 18, 2014 through May 22, 2014 and the three lumbar epidural steroid injections; and St. Joseph Hospital, $1,603.03. The Arbitrator declines to award the remaining claimed fee schedule and prescription expenses, for the reasons set forth in the attached decision.

Respondent shall pay Petitioner permanent partial disability benefits of $253.00/week for 87.5 weeks, because the injuries sustained caused the 17.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

20IWCC0184

Molly C Mason

Signature of Arbitrator

8/10/18
Date

Summary of Disputed Issues

The parties agree Petitioner, a staffing agency worker, sustained an accident on February 14, 2014, while working on a line at a recycling plant. They also agree Petitioner provided Respondent with timely notice of the accident. The disputed issues include causal connection, medical expenses, whether Petitioner exceeded the choices afforded by Section 8(a), temporary total disability and nature and extent. Arb Exh 1.

Summary of Petitioner's Testimony

Petitioner testified through a Spanish-speaking interpreter at the initial hearing of March 15, 2018. Petitioner testified he worked for Respondent as of February 14, 2014. T. 3/15/18, p. 11. Respondent sent him to various locations to work. As of February 14, 2014, he was working at a recycling plant. T. 3/15/18, p. 11. His duties included lifting and moving heavy pieces of furniture, including chairs and desks, off a moving line. The items he moved varied in weight from 50 to 80 pounds. T. 3/15/18, p. 12. He stood throughout his workday. His shifts varied in duration from 8 to 12 hours. T. 3/15/18, p. 12.

Petitioner testified he began working at the recycling plant about a month before his accident of February 14, 2014. If there are records showing he only worked about a week, he is not sure if these records are correct. T. 3/15/18, p. 12.

Petitioner testified that, on February 14, 2014, he spent the first part of his workday collecting trash. He then switched to the line. He was working alone. T. 3/15/18, p. 15. A sofa came down the line. It was 7 or 8 feet long. He had to remove it from the line by pulling it through a big hole that was twice the size of the counselor desks in the Arbitrator's hearing room. The sofa got stuck. He turned to the left and started pushing on the sofa, with his arms extended, to try to force it through the hole. As he did this, he felt stabbing pain in his lower back, worse on the left. T. 3/15/18, pp. 13-16.

Petitioner testified the accident occurred on a Friday. The following Monday, he could not go to work due to his pain. He reported to work on Tuesday and was sent to a different location, a sugar plant, where he was assigned the task of cutting big bags to allow sugar to fall into a tank. He felt pain as he performed this work but was able to do it. T. 3/15/18, pp. 16-17.

Petitioner testified he first sought treatment on February 20, 2014, when he went to the Emergency Room at Holy Cross Hospital. T. 3/15/18, p. 17. The Arbitrator notes February 20, 2014 fell on a Thursday. The Emergency Room records (PX 1) reflect complaints of 9/10 low back pain radiating down the left leg to the left knee. One history reflects Petitioner "was lifting furniture on Sunday and started having back pain on Monday." Another reflects a two-day history of low back pain "after lifting heavy object at work 2 days ago." The records reflect a past history of back pain more than five years earlier. The examining physician, Dr. Allegretti, noted no ecchymosis, tenderness on palpation of the paraspinal muscle and positive straight leg raising. The doctor diagnosed a low back strain and diabetes. He prescribed Norco and directed Petitioner to follow up with Dr. Sompalli, an orthopedic surgeon. PX 1.

The following day, February 21, 2014, Petitioner saw Dr. Sorokin at Occupational Health Centers of Illinois. T. 3/15/18, p. 17. The doctor noted a history of an acute onset of back pain on February 14, 2014, while pulling furniture at work. He described Petitioner's gait as normal. He did not note any radicular symptoms. On examination, he noted a decreased range of lumbar spine motion, normal reflexes, negative Waddell's signs and negative straight leg raising bilaterally. He obtained lumbar spine X-rays, which showed no fractures or subluxation on preliminary reading. He diagnosed a lumbosacral strain. He prescribed physical therapy and medication. He released Petitioner to light duty with no lifting over 20 pounds, no pushing/pulling over 40 pounds and bending 6 times per hour. He directed Petitioner to return in four days. PX 2. T. 3/15/18, pp. 17-18.

Petitioner testified he contacted Respondent to inquire about light duty. He spoke with "Maria" and explained his restrictions. Later, someone who was not directly affiliated with Respondent called him back and offered him a light duty job. T. 3/15/18, pp. 18-19. He did not go to this job because it was more than an hour away from his house. He was not able to drive that distance. His pain was so intense he was not able to put on his pants or shoes. T. 3/15/18, p. 19.

Petitioner returned to Occupational Health Centers on February 25, 2014 and again saw Dr. Sorokin. The doctor described Petitioner's symptoms as unchanged. His examination findings were unchanged. He discontinued some of the medication and started Petitioner on Skelaxin and Naproxen. He again prescribed therapy and continued the work restrictions. PX 2.

On March 3, 2014, Petitioner began a course of physical therapy at Occupational Health Centers. The therapist described Petitioner as injuring his back at work on February 14, 2014, while "reaching up and to the side to pull something off the line." She also noted that Petitioner reported developing radicular symptoms after sitting for five minutes. She described Petitioner as "working at regular duty status prior to injury with no history of injuries or impairments to the affected area." She noted an antalgic gait and positive straight leg raising bilaterally, "with reports of shooting pain down posterior leg." PX 2.

Petitioner also saw Dr. Paloyan at Occupational Health Centers on March 3, 2014. The doctor noted that Petitioner had attended one therapy session to date and was performing light duty. He also noted that Petitioner denied radicular symptoms. He described Petitioner's gait as normal but slow. He indicated that Waddell's axial loading testing was negative. He directed Petitioner to continue therapy and increased the prior restrictions by eliminating bending. He started Petitioner on Tramadol. PX 2.

Petitioner attended another therapy session at Occupational Health Centers on March 6, 2014. The therapist noted ongoing complaints and indicated Petitioner was off work because his employer was unable to accommodate his restrictions. She described Petitioner as "not progressing." PX 2.

Petitioner also saw Dr. Barnabas, a physician of his own selection, on March 6, 2014. T. 3/15/18, p. 20. Dr. Barnabas is affiliated with Herron Medical Center. The doctor described Petitioner as injuring his back at work while trying to remove a sofa from a recycling line. He noted a complaint of 8/10 low back pain going down both legs, left greater than right, with associated numbness and tingling. He also noted a past medical history of diabetes.

On initial examination, Dr. Barnabas noted tenderness to palpation of both sacroiliac joints and the paraspinal muscles, limited extension and lateral bending, positive straight leg raising bilaterally and

intact sensory. He dispensed a back brace, prescribed a lumbar spine MRI, medication and therapy and took Petitioner off work. PX 4. T. 3/15/18, pp. 20-21.

The MRI, performed the same day, showed a 2-3 millimeter protrusion/herniation at L2-L3, without significant stenosis, a 3-4 millimeter protrusion/herniation at L4-L5, with mild central stenosis, and a 3-4 millimeter protrusion/herniation at L5-S1 indenting the thecal sac with mild stenosis and no significant neuroforaminal narrowing. PX 4.

A signed prescription form in PX 4 reflects that Dr. Barnabas prescribed three weeks of chiropractic visits on March 7, 2014.

On March 10, 2014, Petitioner began a course of chiropractic care and acupuncture with Dr. Ambrosino at Alevio Physical Therapy and Chiropractic. T. 3/15/18, p. 21. The doctor's note reflects that Petitioner reported injuring his back at work on February 14, 2014, while lifting and carrying a sofa. The doctor noted a complaint of 9/10 low back pain radiating into both legs, worse on the right. He described straight leg raising as positive bilaterally. PX 4.

On March 14, 2014, Petitioner returned to Dr. Barnabas. The doctor noted that Petitioner had seen Dr. Ambrosino twice and was now complaining of increased leg pain and numbness. The doctor referred Petitioner to a pain specialist and directed him to continue therapy.

Petitioner also saw Dr. Ambrosino on March 14, 2014, with the doctor noting radiating symptoms into the left gluteus and hip and down the right leg to the foot.

Petitioner saw Dr. Hassan Abdellatif at Pro Clinics on March 18, 2014. The doctor noted a referral from Dr. Barnabas. He also noted that, on February 19, 2014, Petitioner injured his low back at work when he twisted to the left while placing a 60- to 80-pound sofa on the ground. He indicated that Petitioner worked for a couple of days after this injury but stopped working as of approximately February 19th due to persistent pain. He noted complaints of 7/10 low back pain occasionally radiating to both legs, occasional headaches due to pain and constant mid back pain. He indicated that Petitioner denied having back pain prior to the injury. On examination, he noted "increased lumbar radiculopathy to bilateral lower limbs, more so on left side," bilateral tenderness in the sacroiliac joint area and multiple tender points at the mid and low back. After reviewing the MRI results, he recommended EMG/NCV testing, a lumbar epidural steroid injection, trigger point injections "if needed" and continued therapy. He directed Petitioner to remain off work.

Carlos Halwaji, D.C., a "chiropractic neurologist", conducted EMG and nerve conduction testing on March 25, 2014. T. 3/15/18, p. 22. He noted a referral from "Dr. Hassan." He indicated that Petitioner injured his low back at work on February 19, 2014, when he turned to his left while lowering a heavy sofa to the ground. He described Petitioner's past medical history as unremarkable. On examination, he noted positive straight leg raising bilaterally. He described the test as showing a "radiculitis affecting the L4-S1 bilaterally." PX 5.

On April 2, 2014, Dr. Abdellatif administered a facet block at L5 and bilaterally at L3-L4, along with a lumbar epidural steroid injection. Petitioner testified these injections did not help. T. 3/15/18, p. 22.

On April 4, 2014, Dr. Ambrosino noted ongoing pain in the low back, left gluteal area and hip and right leg. He indicated that Petitioner was "feeling extremely sore" as a result of the injection administered two days earlier. He directed Petitioner to remain off work. PX 4.

Petitioner returned to Dr. Ambrosino on April 7, 9, 11 and 14, 2014, with the doctor noting improvement of the left-sided complaints.

On April 16, 2014, Dr. Abdellatif administered a second lumbar epidural steroid injection, at L4-L5. He also performed a "RF" [presumably radiofrequency] block procedure at various lumbar levels and the sacroiliac joints along with trigger point injections. PX 8.

Petitioner returned to Dr. Abdellatif on May 6, 2014, with the doctor noting a report of 50% improvement in pain and range of motion following the second round of lumbar injections. Petitioner testified he agreed with the doctor's notation of 50% improvement. T. 3/15/18, p. 23. The doctor described Petitioner's current pain level as 4/10, noting it was primarily localized to the low back but occasionally radiated to both legs.

Dr. Abdellatif recommended a "third lumbar procedure" along with four weeks of work conditioning, followed by a functional capacity evaluation. He directed Petitioner to return to him in four weeks. PX 8.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Zelby, a neurosurgeon, on May 9, 2014. Based on a Managed Care Consultants, Inc. report of May 15, 2014 that is included in PX 4, it appears a nurse case manager accompanied Petitioner to Dr. Zelby's office and met with the doctor after he conducted his examination.

In his report, Dr. Zelby indicated that Petitioner described feeling sharp pain in his back "for a couple of seconds" while pulling a large sofa off a line at work on February 14, 2014. He indicated that Petitioner described the pain as going away completely in fewer than five minutes. He noted that Petitioner was able to complete his shift on February 14th but developed increasing low back pain, along with bilateral anterior leg pain, worse on the left, over the next two days. He described Petitioner as starting physical therapy at one facility and then changing to a different clinic at the direction of his lawyer. He indicated that Petitioner reported resolution of his left-sided symptoms during the initial three or four weeks of therapy and then plateauing. He further indicated that Petitioner had undergone two low back injections to date, with benefit, and was scheduled for a third. He noted complaints of constant 6/10 low back pain and "numbness in the anterior aspect of the right foreleg." He indicated Petitioner reported being able to drive and put on his socks and shoes. He noted that Petitioner denied any prior episodes of similar symptoms. He described Petitioner as taking one medication for diabetes and two medications for pain.

On examination, Dr. Zelby noted tenderness with deep palpation of the lower lumbar spinous processes in the midline, positive lying straight leg raising "in the back only," negative sitting straight leg raising bilaterally and normal heel/toe walking. He described Petitioner's gait as "a little slow but otherwise normal." On sensory examination, he noted that sensation to pin in the lower extremities was "diminished in the entire circumference of the right foreleg from the knee to the ankle but preserved in the thigh and foot." He described lower extremity strength as "normal with some encouragement for the right lower extremity."

Dr. Zelby noted the following inconsistent behavioral responses: pain on simulation and diminished pain on distraction. He described the sensory changes as "non-anatomic."

Dr. Zelby indicated he reviewed the March 6, 2014 lumbar spine MRI along with records from Concentra, Dr. Barnabas, Dr. Abdellatif and Alivio Physical Therapy and Chiropractic.

Dr. Zelby noted that the MRI showed a disc protrusion at L4-L5 to the right and that Petitioner was now describing his symptoms as worse to the right. He found no reason to continue chiropractic care or physical therapy, since Petitioner reported having plateaued. Based on Petitioner's report of improvement following the first two lumbar epidural steroid injections, he found it "reasonable to pursue a third injection." He characterized the facet and trigger point injections as not reasonable or necessary and indicated they should not be repeated. He saw no reason to pursue additional injections following the third epidural injection, noting this was scheduled to be performed in three days. He indicated that, once Petitioner underwent this injection, he should pursue three to four weeks of work conditioning. He opined that Petitioner would be at maximum medical improvement following the work conditioning.

Dr. Zelby described Petitioner's right lower leg symptoms as "not representing radiculopathy" since they "do not follow a dermatomal or nerve distribution pattern." He saw no reason to pursue surgery "because [Petitioner] has no radicular symptoms or findings on exam."

Dr. Zelby found Petitioner "qualified to safely work in at least a light physical demand level now" with occasional lifting of 20 pounds and frequent lifting of 10 pounds. He indicated Petitioner would be capable of unrestricted duty after completing three to four weeks of work conditioning. RX 1.

On May 12, 2014, Dr. Abdellatif administered a third lumbar epidural steroid injection along with lumbar facet blocks and trigger point injections. PX 8.

On May 22, 2014, Dr. Abdellatif noted 50% overall improvement following a "third lumbar procedure." He indicated Petitioner was still experiencing 6/10 low back pain occasionally radiating to both legs. He again recommended four weeks of work conditioning, followed by a functional capacity evaluation. He also recommended a CT lumbar discogram. He directed Petitioner to stay off work while undergoing the work conditioning. PX 8.

On May 30, 2014, Dr. Abdellatif performed a lumbar discogram. He also administered a fourth lumbar epidural steroid injection along with trigger point injections. He interpreted the discogram as showing "pain concordant with L4-L5 and L5-S1 discogenic pain." He recommended a percutaneous disc decompression procedure at these levels. He also directed Petitioner to continue therapy and medication. PX 8. T. 3/15/18, p. 24.

Petitioner testified that Dr. Abdellatif administered additional trigger point injections on June 5, 2014. T. 3/15/18, p. 24. The bill concerning these injections is in evidence but the records are not.

On June 27, 2014, Dr. Barnabas issued two work release forms. In the first, he released Petitioner to light duty, imposing restrictions "per IME" of no lifting or carrying over 20 pounds, no pulling over 40 pounds and no bending or stooping more than six times per hour. In the second, he imposed restrictions of no lifting, carrying or pulling over 15 to 20 pounds and no stooping or bending. He indicated that Petitioner should remain off work until completing work conditioning. PX 4.

Petitioner testified he saw Dr. Erickson at Herron Medical Center on July 2, 2014. T. 3/15/18, p. 25. In his note of that date, Dr. Erickson acknowledged a referral from Dr. Barnabas. He documented a history of the work accident and subsequent care. He indicated he reviewed the MRI, EMG and discogram. He noted that Petitioner was able to walk for 20 to 30 minutes but experienced significant pain when sitting for more than 15 minutes.

On initial examination, Dr. Erickson noted moderate paraspinal tenderness, positive straight leg raising on the right and no motor weakness or atrophy. He saw no signs of symptom magnification. He performed SSEP testing. He described this as showing "moderate delays on the right side at L5 and S1" and "minor delays on the left side at L5 and S1." He diagnosed "mechanical back pain with right-sided radicular symptoms." He indicated that Petitioner should seriously consider an instrumented fusion at L4-L5 and L5-S1. T. 3/15/18, p. 26. He attributed the need for this surgery to the work accident, noting that Petitioner was able to tolerate vigorous activity prior to the accident. PX 4.

Petitioner underwent an initial work conditioning evaluation at Flexeon Rehabilitation on July 14, 2014. T. 3/15/18, p. 27. The evaluating therapist, Catherine Malooly, PT [hereafter "Malooly"], noted that Petitioner reported feeling lower back pain at work when he twisted while pulling on a sofa that had become stuck on a recycling line. She also noted that Petitioner had undergone some injections but that they were "[discontinued] secondary to liver problems." She noted complaints of low back pain radiating down the right leg to the heel and occasionally down the left leg. PX 9.

Petitioner returned to Dr. Erickson on July 16, 2014. The doctor performed repeat SSEP testing that day. He interpreted this testing as showing moderate delays at L5 on the right and S1 on the right. He noted that toe walking provoked pain and that dorsiflexion was somewhat weak on the right side. He indicated he viewed Petitioner as a "good surgical candidate." He placed therapy on hold. PX 4.

Petitioner was discharged from work conditioning the same day, July 16, 2014, with Malooly noting he had seen a surgeon who discontinued therapy. PX 9.

On July 17, 2014, Dr. Barnabas noted that the surgery recommended by Dr. Erickson was being denied. He issued a note directing Petitioner to remain off work through August 14, 2014. PX 4.

On August 14, 2014, Dr. Barnabas noted that Petitioner was awaiting surgical approval. He issued a note directing Petitioner to remain off work through September 4, 2014. PX 4.

Dr. Zelby, Respondent's Section 12 examiner, issued a second report on August 18, 2014, after reviewing the discogram report and Dr. Abdellatif's accompanying notes along with Dr. Erickson's note of July 14, 2014. Dr. Zelby described the discogram report as a "completely generic, boiler plate note." He indicated that Dr. Abdellatif provided no explanation for his concordant findings at L4-L5 and L5-S1. He saw no indication for a lumbar fusion based on the MRI results. He indicated that "consideration and pursuit of a fusion exceeds the guidelines for the treatment of [Petitioner's] objective medical condition and should not be pursued." He found the SSEP studies performed by Dr. Erickson to have "no diagnostic value." Based on the nature of Petitioner's job and "his unnecessarily prolonged absence from work," he again recommended three to four weeks of work conditioning prior to resuming full duty. He reiterated that Petitioner would be at maximum medical improvement once he completed the work conditioning. RX 2.

Petitioner testified he continued seeing Drs. Barnabas and Erickson throughout 2014. PX 4. RX 4. [There is no indication Petitioner returned to Dr. Erickson after July 14, 2014.] On December 4, 2014, Dr. Barnabas described Petitioner as "doing much worse" and wanting a second opinion. He directed Petitioner to return in ten weeks. On January 16, 2015, Dr. Barnabas noted that Petitioner's attorneys had arranged for him to see another surgeon for a second opinion. RX 4.

On January 21, 2015, Petitioner saw Dr. Fisher, an orthopedic surgeon affiliated with Illinois Bone and Joint. T. 3/15/18, p. 27.

Dr. Fisher wrote to Dr. Barnabas on January 21, 2015, acknowledging his referral of Petitioner. He recorded a history of the work accident and subsequent care. He noted that Petitioner reported "no change in his symptoms" following extensive therapy and multiple injections. He indicated Petitioner was currently taking Tramadol and a muscle relaxant.

On initial examination, Dr. Fisher noted tenderness to the paraspinous muscles from L3 to S1, increased lumbar spine pain with any range of motion testing, 5/5 strength throughout both lower extremities and a complaint of left-sided posterior thigh and leg symptoms at the end of the examination.

Dr. Fisher indicated he disagreed with the radiologist's reading of the March 6, 2014 lumbar spine MRI. He saw a central herniation at L4-L5 and no abnormalities at any other level. He interpreted the post-discogram CT scan as showing some posterior annular disruption at the L2-L3 and L4-L5 levels.

Dr. Fisher indicated he reviewed some notes from Dr. Barnabas, Dr. Erickson's initial note of July 16, 2014, the EMG/NCV report, Dr. Zelby's reports from May 9 and August 18, 2014 and some of Dr. Abdellatif's notes.

Dr. Fisher assessed Petitioner as having a herniated disc and degenerative disc disease at L4-L5 and discogenic pain at the same level. He found Petitioner to be a candidate for surgery, given his continued symptoms and lack of improvement from conservative care. He described Petitioner as having two treatment options: 1) a continued exercise program at maximum medical improvement without surgery; or 2) an L4-L5 discectomy and posterolateral fusion with instrumentation. He did not include the L5-S1 level in this surgery "given [the] essentially normal findings on both MRI and CT scan" at this level. He did not view a simple decompression surgery as appropriate since Petitioner primarily complained of back pain and only experienced leg pain when his back flared up. He indicated that Petitioner opted for surgery. PX 7.

Petitioner returned to Dr. Barnabas on March 4, 2015, with the doctor noting Dr. Fisher's surgical recommendation. The doctor directed Petitioner to remain off work through April 29, 2015. PX 4. RX 4, p. 9.

Dr. Fisher's records reflect Petitioner failed to appear for scheduled appointments on March 18 and May 21, 2015. PX 3.

Petitioner returned to Dr. Barnabas on May 4, 2015, having last seen him two months earlier. The doctor indicated that Petitioner's lawyer was attempting to secure authorization for him to see Dr. Fisher but that Petitioner wanted to return to Dr. Erickson. He issued a note directing Petitioner to remain off work through May 25, 2015. PX 4. RX 4, p. 10.

Petitioner returned to Dr. Fisher on June 24, 2015 and described his symptoms as unchanged. The doctor recommended an exercise program. He again discussed surgery, indicating Petitioner would require a repeat lumbar spine MRI. He described Petitioner as "not interested in surgery at this time." He released Petitioner from care on a PRN basis. PX 7.

On July 24, 2015, Dr. Barnabas noted that Petitioner remained symptomatic and wanted to pursue surgery but with Dr. Erickson rather than Dr. Fisher. He renewed Petitioner's medications and signed a note directing Petitioner to remain off work through August 7, 2015. PX 4. RX 4, p. 11.

There are no treatment records in evidence indicating Petitioner returned to Dr. Barnabas after July 24, 2015.

Petitioner next saw Dr. Fisher on August 13, 2015. On re-examination, the doctor noted a normal gait, tenderness to the paraspinal muscles from L4 through S1, increased pain with range of motion testing, 5/5 lower extremity strength and positive straight leg raising on the right only. He again informed Petitioner he would need a repeat MRI scan before undergoing surgery. PX 7. T. 3/15/18, p. 28.

The repeat lumbar spine MRI, performed on August 30, 2015, showed bulging with posterior midline annular tearing and mild bilateral recess stenosis at L4-L5. The interpreting radiologist noted no abnormalities at any other level. PX 3, p. 3. T. 3/15/18, p. 28.

On September 16, 2015, Dr. Fisher indicated that the repeat MRI showed a herniation and desiccation at L4-L5. He noted that Petitioner was now expressing interest in the previously recommended L4-L5 discectomy and posterior fusion. PX 7.

Petitioner testified he continued seeing Dr. Fisher through December 10, 2015. T. 3/15/18, p. 29. In his note of that date, the doctor indicated that Petitioner told him he "had to leave town because of a family emergency" but wanted to move forward with surgery. On re-examination, the doctor noted a normal gait, tenderness to the paraspinal muscles from L4 through S1, 5/5 lower extremity strength "with subjective decreased sensation" in both thighs and the medial right leg and negative straight leg raising. He indicated he planned to schedule the surgery. PX 7.

Respondent's examiner, Dr. Zelby, issued a third report on September 21, 2016, after reviewing additional records, including the repeat lumbar spine MRI report of August 30, 2015. The doctor described Petitioner as having undergone "treatment for the sake of treatment," with "apparently no meaningful or sustained relief of his symptoms." He reiterated that Petitioner was not a candidate for extensive injections or surgery. He found it "curious" that Dr. Fisher was recommending only an L4-L5 fusion, based on the discogram, since that study suggested concordant pain at L5-L1 as well as at L4-L5. He went on to state that the report of concordant pain at L5-S1 was a report of pain "in a practically normal disc, revealing the lack of usefulness" of the discogram. He indicated that Petitioner had been at maximum medical improvement and capable of resuming full duty for more than two years. RX 3.

Petitioner testified the surgery recommended by Dr. Fisher was scheduled for a specific date but he could not recall the date. Before that date, he moved to Orlando, Florida. On December 27, 2016, he moved again, this time to his native Puerto Rico. T. 3/15/18, p. 30. He felt he had to move, for personal reasons. He decided not to undergo the surgery, due to the move and for personal reasons. T.

3/15/18, p. 30. He has continued to undergo back-related treatment in Puerto Rico, using a card that affords "Obama care." He sees Dr. Fernandez and a personal care physician, Dr. Menendez Morales, at Molina Healthcare. T. 3/15/18, pp. 31-33.

Petitioner testified he has not returned to work in any capacity since the accident, due to his back condition. He is currently receiving Social Security disability benefits. T. 3/15/18, p. 34.

Petitioner denied experiencing any specific reinjury since the February 14, 2014 accident. If he just walks normally, without jumping or climbing, he does not have a problem. If, however, he tries to wash his car, he experiences a lot of pain within fifteen minutes. He no longer rides a bicycle or participates in sports. If he tried to perform this type of activity, he would experience pain within fifteen minutes. The pain goes down his right leg into his right ankle and foot. He experiences cramping in his foot. He takes Tramadol, Flexeril and Relafen to address these symptoms. Dr. Menendez Morales prescribes these medications, along with medication for his diabetes. T. 3/15/18, pp. 34-35.

In addition to the exhibits previously described, Petitioner offered into evidence records from Dr. Menendez Morales, a physician practicing in Cayey, Puerto Rico. Some of these records are not legible. A patient information sheet reflects the doctor first saw Petitioner on November 1, 2017 and last saw him on April 11, 2018. The notes from April 11, 2018 reflect Petitioner saw the doctor for several general health conditions, including diabetes. The notes describe Petitioner's history as positive for fibromyalgia, lumbar pain and lumbar disc disease. There is no indication the doctor examined Petitioner's back or prescribed back-related care. PX 11.

Under cross-examination, Petitioner testified that, before the accident, he worked for a different temporary agency. T. 3/15/18, p. 36. After the contract with that agency expired, he drew unemployment for about six months before he began working for Respondent. T. 3/15/18, p. 36. He does not have a good recollection but he thinks he worked for Respondent for about one week before the accident. The accident took place on a Friday. He did not work on Saturday or Sunday. T. 3/15/18, p. 37. He is not sure whether he worked on Monday, which was President's Day. As of that time, he and his wife were planning to travel to Puerto Rico for his birthday. T. 3/15/18, p. 38. His wife packed suitcases over the weekend but he did not. It was his wife who dealt with the suitcases and clothes. He denied moving furniture at home over that weekend. T. 3/15/18, pp. 37-38.

Petitioner testified he completed accident-related paperwork at Respondent the day after he reported the accident. Once he completed the paperwork, Respondent sent him to Occupational Health Centers. If records show he went to this facility on Friday, February 21st, that makes sense. T. 3/15/18, pp. 37-38.

Petitioner testified the doctor he saw at the Emergency Room did not speak Spanish. He is not sure whether this doctor understood him. If the Emergency Room records describe him as unemployed and feeling pain when "lifting furniture on Sunday," the records are not correct. He told hospital personnel he was injured while moving something that required strength. He is not sure whether the employees he spoke with understood him. He complained of his left leg at that time but both of his legs hurt. T. 3/15/18, pp. 39-40.

Petitioner could not recall whether the light duty job he was offered was in Addison. If the letter offering him light duty mentioned an Addison location, he would not disagree. T. 3/15/18, p. 40. He spoke with the woman who sent him this letter on several occasions. During these conversations, he

explained his pain was making it difficult for him to walk or drive. He asked to be sent to a job that was closer to home. He talked with this woman over a 2- to 3-month period. T. 3/15/18, p. 41.

Petitioner testified that Dr. Ambrosino is not a psychiatrist. Dr. Ambrosino just gave him medicine. T. 3/15/18, p. 41. Dr. Barnabas took X-rays, gave him medicine and recommended therapy. Dr. Abdellatif gave him injections. T. 3/15/18, p. 42. His attorney sent him to Dr. Fisher. T. 3/15/18, p. 43. He moved to Orlando about one month before he moved to Puerto Rico. He has remained in Puerto Rico since moving there in December 2016. T. 3/15/18, p. 43. One of his providers had an affiliate office in Miami but no office in Orlando. T. 3/15/18, p. 44. He did not see any doctors while he was in Orlando.

Petitioner testified he has not sought employment because he feels he is physically unable to work. He applied for Social Security disability benefits the same year he injured his back. He believes he applied in October 2014 and was awarded benefits in February 2015. T. 3/15/18, p. 46. When asked whether his diabetes is part of the basis of the award, he indicated he has fibromyalgia as well as damaged discs. He sees Dr. Menendez Morales every six months. He last saw him three months before the hearing. T. 3/15/18, p. 46.

Petitioner did not recall being examined by Dr. Zelby in May 2014 but would not disagree with a record showing this. The complaints he voiced to his treating physicians were honest. T. 3/15/18, p. 47. The injections he underwent relieved his pain only for a "very short time." T. 3/15/18, p. 47. Between 2014 and 2015, he felt better when he was inactive. He experienced pain when he climbed stairs or moved quickly. This is still true. T. 3/15/18, p. 48.

On redirect, Petitioner testified he was not subject to any back-related restrictions before he began working for Respondent. He was on unemployment for six months before he started working for Respondent. He did not undergo low back treatment during that period. T. 3/15/18, p. 49. Dr. Ambrosino is the only physician who provided pain relief. Dr. Ambrosino treated him via acupuncture, E-stimulation and stretching exercises. If his records show he saw Dr. Hawaji once, for purposes of an EMG study, he would not disagree. T. 3/15/18, p. 50.

Under re-cross, Petitioner testified his job with Respondent was the first job he held following a period of unemployment. T. 3/15/18, p. 51. By his third visit to Dr. Ambrosino, he felt better when he got up after lying down. The acupuncture resulted in improvement over a three-month period. Then he plateaued. T. 3/15/18, p. 52. It was at that point that they sent him to a pain clinic. T. 3/15/18, p. 53.

No witnesses testified on behalf of Respondent.

Arbitrator's Credibility Assessment

Respondent stipulated to accident (Arb Exh 1) but correctly notes some inconsistent histories in the Emergency Room records of February 20, 2014. Those records (PX 1) set forth different accounts of the accident, with one note indicating Petitioner developed back pain while lifting furniture on Sunday, a day he did not work. Petitioner took issue with this history, indicating the Emergency Room physician did not speak Spanish. He acknowledged he was planning to travel to Puerto Rico as of the weekend following his injury but maintained his wife performed the physical tasks, such as packing, associated with travel. The Arbitrator found credible Petitioner's description of the circumstances of his work accident and its aftermath.

Respondent's examiner, Dr. Zelby, noted several inconsistencies on examination but the physicians at Occupational Health Centers, Respondent's selected medical facility, did not. They described Waddell's testing as negative. PX 2.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between his undisputed work accident of February 14, 2014 and his claimed current condition of ill-being?

Petitioner did not address his pre-accident back condition during the hearing. His Emergency Room records reflect he "had back pain before (i.e., before the February 14, 2014 work accident) but not for more than five years." PX 1. There is no evidence suggesting Petitioner had substantial back-related treatment in the past. He credibly testified to performing physical tasks for Respondent for about a week before the accident. He also credibly testified to an abrupt onset of pain when he twisted to the left while attempting to maneuver a sofa on his own. The physicians at Occupational Health Centers, a provider of Respondent's selection, diagnosed a lumbar spine condition resulting from this event. Respondent's examiner, Dr. Zelby, took issue with aspects of Petitioner's treatment but found causation to a lumbar spine condition that required three epidural steroid injections and work conditioning.

The Arbitrator finds persuasive the opinions Dr. Zelby voiced as to the nature and extent of the conservative care Petitioner required. The Arbitrator relies on those opinions in denying certain of the medical expenses claimed by Petitioner. See further below. The Arbitrator does not, however, find persuasive Dr. Zelby's opinion that Petitioner had "no radicular symptoms" and was thus not a candidate for any kind of lumbar spine surgery. RX 1, 3. The earliest medical records document leg as well as back complaints. PX 1. The therapist who saw Petitioner at Occupational Health Centers also noted radicular symptoms and positive straight leg raising. PX 2. On March 6, 2014, Dr. Barnabas noted bilateral leg complaints and left leg weakness. PX 4. Dr. Ambrosino noted bilateral leg complaints four days later, as did Dr. Abdellatif on March 18, 2014. PX 4. When Dr. Fisher first saw Petitioner, on January 21, 2015, he described Petitioner as primarily complaining of low back pain but developing leg symptoms as each day wore on.

The Arbitrator notes, but assigns little weight to, Dr. Zelby's criticism of Dr. Fisher's treatment recommendations. Although Dr. Zelby never viewed Petitioner as a surgical candidate, he did view him as requiring care. While he attempted to distance himself from Dr. Fisher, the two physicians interpreted Petitioner's lumbar spine MRIs in the same way, i.e., as showing pathology at only one level, L4-L5. They also expressed similar criticism of Dr. Abdellatif's finding that the discogram was concordant at another level, L5-S1.

Of the three physicians who commented on surgery, the Arbitrator finds Dr. Fisher most persuasive. Dr. Fisher did not rush to a surgical recommendation. When he first saw Petitioner, he offered a non-surgical option as well as a single-level discectomy and fusion. Dr. Zelby lost credence when, in his last report, he criticized Dr. Fisher for recommending surgery at only one level, given the discogram results, while simultaneously stating that discograms are generally unhelpful.

The Arbitrator, having considered the foregoing, finds that Petitioner established causation as to a lumbar spine condition that caused radicular symptoms. The Arbitrator further finds that Petitioner

established causation as to the need for a course of conservative care, including three lumbar epidural steroid injections, and surgery consisting of a discectomy and fusion at L4-L5. The Arbitrator finds it reasonable for Petitioner to have ultimately decided to forego surgery.

Is Petitioner entitled to temporary total disability benefits?

On March 15, 2018, Petitioner claimed he was temporarily totally disabled from March 6, 2014 through the hearing. Respondent disputed this claim, citing its causation defense and Petitioner's testimony concerning an accommodated job offer. The parties agree Respondent paid no temporary total disability or other weekly benefits. Arb Exh 1.

Petitioner conceded he had discussions with a Respondent representative concerning a light duty position. He further testified these discussions continued for two to three months after the accident. He acknowledged a job was offered but indicated it was far away. He testified the representative did not respond to his request to be placed closer to home. Respondent's counsel alluded to an offer letter during cross-examination but no such letter is in evidence. The medical records show that Petitioner was subject to significant restrictions, per physicians affiliated with an occupational medicine clinic, for several weeks following the accident, and that Dr. Barnabas took Petitioner off work altogether as of March 6, 2014.

The Arbitrator finds that Petitioner was temporarily totally disabled from March 6, 2014 through June 24, 2015, the date on which Dr. Fisher released him from care on a PRN basis. The Arbitrator recognizes that Petitioner returned to Dr. Fisher thereafter, to revisit the issue of surgery, but Dr. Fisher never commented on Petitioner's ability to work. Petitioner testified he moved to Puerto Rico on December 27, 2016, having earlier moved to Orlando. His activities between his last visit to Dr. Fisher, in December 2015, and his move to Puerto Rico are not well-explained. He testified to undergoing back-related care in Puerto Rico but he offered no treatment records covering the period between his last visit to Dr. Fisher and his initial visit to Dr. Menendez Morales on November 1, 2017. While the most recent records from Dr. Menendez Morales mention a diagnosis of lumbar pain, there is no indication the doctor is actively treating Petitioner's back condition.

Is Petitioner entitled to reasonable and necessary medical expenses? Did Petitioner exceed the choices afforded by Section 8(a)?

Petitioner claims unpaid fee schedule and prescription expenses of $86,877.28 from various providers. PX 10. Respondent denies liability for these expenses and further maintains Petitioner exceeded the choices of physicians afforded by Section 8(a) of the Act.

The Arbitrator initially addresses the choice-related argument. Section 8(a) provides that an employer's liability for medical services selected by an injured employee "shall be limited to": 1) all first aid and emergency care; "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 referral from said initial service provider." Petitioner initially sought care at an Emergency Room. This does not constitute a "choice." He then went to Occupational Health Centers, a facility of Respondent's selection. On March 6, 2014, he began a course of treatment with Dr. Barnabas at the Herron Clinic. He testified he elected to see this physician. The Arbitrator views Dr. Barnabas as Petitioner's first choice of physicians. Dr. Barnabas subsequently referred

Petitioner to Dr. Ambrosino, Dr. Abdellatif, Dr. Erickson and Dr. Fisher. Dr. Abdellatif referred Petitioner to a chiropractor, Dr. Halwaji, for purposes of EMG and nerve conduction testing. The referrals are clearly documented in the medical records. The Arbitrator finds Petitioner did not exceed his choices under Section 8(a).

The Arbitrator turns to the claimed fee schedule expenses. Those expenses are listed in alphabetical order in PX 10. The Arbitrator addresses the expenses in the same order.

The Arbitrator declines to award the claimed fee schedule expenses of $4,224.94 from Advanced Rehab Specialist and International Medical Equipment (duplicate bills). These expenses relate to a pneumatic compressor machine prescribed by Dr. Abdellatif. According to the bills in PX 10, this device was delivered to Petitioner's home on April 17, 2014. Dr. Abdellatif's records (PX 8) do not mention the prescription. Petitioner did not testify to receiving or using the machine. There is no evidentiary basis for awarding the claimed expenses.

As for the claimed fee schedule expenses of $8,106.71 associated with the chiropractic and acupuncture care provided by Dr. Ambrosino of Alevio Physical Therapy, the Arbitrator awards only those expenses associated with the initial three weeks of care, from March 14, 2014 through the visit of April 7, 2014. Dr. Barnabas prescribed three weeks of chiropractic care when he first saw Petitioner on March 7, 2014. Petitioner testified he obtained benefit from this care during the first few weeks he saw Dr. Ambrosino. The doctor's notes from that period document improvement of Petitioner's left-sided complaints.

The Arbitrator declines to award the claimed prescription expenses from Ashland Health, LLC. These expenses, totaling $4,883.42, relate to medication prescribed to Petitioner on May 12, 2015 and August 7, 2015. The "patient account summary" that appears in PX 10 does not identify the prescribing physician. The dates of the prescriptions do not correlate with the dates of Petitioner's visits to Dr. Fisher.

The Arbitrator awards Petitioner the claimed fee schedule expenses of $1,262.92 relating to the initial lumbar spine MRI performed at Delaware Place MRI on March 6, 2014. The Arbitrator finds it reasonable for Dr. Barnabas to have ordered MRI imaging on that date, given Petitioner's persistent symptoms. Dr. Zelby, Respondent's Section 12 examiner, expressed no criticism of the MRI prescription and utilized the MRI results in forming his opinions. RX 1-3.

The Arbitrator awards Petitioner the claimed fee schedule expenses of $324.00 relating to the work conditioning evaluation performed at Flexeon Rehabilitation on July 14, 2014. Dr. Abdellatif first prescribed work conditioning in May 2014 and Dr. Zelby agreed with the prescription. RX 1-3.

The claimed expenses of $11,549.68 from Herron Medical Center can only be described as a mystery. The itemized bills in PX 10 appear to set forth charges for office visits as well as an array of medications (apparently prescribed by Dr. Barnabas), including Methadone and non-specific "amphetamines", "methamphetamines", "barbiturates" and "opiates." Several charges, each in the amount of $1,103.00, are coded "do not use," with no further explanation. Of the claimed $11,549.68, the Arbitrator awards only those expenses relating to office visits, drug screenings and clearly identified, causally related medication, including Meloxicam.

The Arbitrator awards Petitioner the claimed fee schedule expenses of $554.87 relating to the initial Holy Cross Hospital Emergency Room visit of February 20, 2014.

The Arbitrator awards Petitioner the claimed fee schedule expenses of $403.45 relating to the injection-related anesthesia provided by Illiana Anesthesia on April 2, 2014, shortly before Dr. Zelby's Section 12 examination of May 9, 2014. Dr. Zelby endorsed Dr. Abdellatif's care to the extent of agreeing with the need for the lumbar epidural steroid injections. Dr. Abdellatif administered a second such injection (along with facet blocks, which Dr. Zelby did not endorse) on April 2, 2014.

The Arbitrator awards Petitioner the claimed fee schedule expenses of $824.16 relating to his visits to Dr. Fisher at the Illinois Bone and Joint Institute in 2015. The Arbitrator finds it reasonable for Dr. Barnabas to have arranged for Petitioner to obtain a second surgical opinion from Dr. Fisher.

The Arbitrator awards the claimed Industrial Pharmacy Management prescription expenses of $509.13. These expenses relate to medication prescribed by Dr. Abdellatif on March 18, 2014.

The Arbitrator declines to award the claimed fee schedule expenses of $4,224.94 relating to a pneumatic compressor home device provided by International Medical Equipment on April 17, 2014. Petitioner did not testify to using such a device. The bill in PX 10 does not identify the prescribing physician.

Of the claimed Lakeside Surgery Center facility fee schedule expenses, the Arbitrator awards the four $1,200.00 charges relating to the lumbar epidural steroid injections Dr. Abdellatif administered on April 2, 2014 and April 16, 2014, subject to the fee schedule.

The Arbitrator awards the claimed Lakeside Surgery Center physician fee schedule expenses of $70.80, relating to services provided on April 2, 2014, the date of the first epidural steroid injection.

The Arbitrator awards the claimed Midwest Imaging fee schedule expenses of $256.87 relating to the repeat lumbar spine MRI performed on August 30, 2015.

The claimed fee schedule expenses of $12,827.27 from ProClinics include expenses relating to care provided by Carlos Halwaji, D.C. and Dr. Abdellatif between March and June 2014. The Arbitrator initially addresses the claimed expenses associated with Dr. Halwaji's evaluation and EMG/NCV testing of March 25, 2014. The Arbitrator declines to award these expenses. The EMG/NCV report in evidence describes Dr. Halwaji as a "chiropractic neurologist." His training and qualifications are otherwise unexplained. As for Dr. Abdellatif, the Arbitrator relies on Respondent's examiner, Dr. Zelby, in awarding only those expenses associated with the office visits of March 18, 2014 through May 22, 2014 and the first three lumbar steroid epidural injections. The records reflect that Dr. Abdellatif administered the third injection on May 12, 2014, with Petitioner following up on May 22, 2014. The Arbitrator declines to award any of the other claimed expenses relating to trigger point injections, facet blocks, SI joint injections, CT discogram, etc.

The claimed expenses of $14,488.96 from RX Solutions relate to various medications Dr. Barnabas prescribed for Petitioner between August 31, 2015 and November 12, 2015. The Arbitrator declines to award these expenses. As noted earlier, there are no treatment records in evidence indicating Petitioner returned to Dr. Barnabas after July 24, 2015. [See the last two pages in PX 4, both of which are dated July 24, 2015.]

The Arbitrator awards the claimed fee schedule expenses of $1,603.03 relating to the repeat lumbar spine MRI performed at St. Joseph Hospital on August 30, 2015. The Arbitrator finds it reasonable for Dr. Fisher to have recommended a second MRI in 2015, pending surgery, since the first MRI dated back to March 2014.

What is the nature and extent of the injury?

At the hearing held on June 18, 2018, Petitioner's counsel indicated he is seeking permanency under Section 8(d)2 of the Act.

Because Petitioner's injury occurred after September 1, 2011, the Arbitrator looks to Section 8.1b of the Act for guidance in assessing the nature and extent of the injury. That section sets forth five factors to be considered in determining permanency, with no single factor to be assigned greater weight than any other. The Arbitrator views the first enumerated factor, i.e., any AMA Guides impairment rating, as irrelevant, since neither party offered such a rating into evidence. The Arbitrator assigns some weight to the second and third factors, Petitioner's occupation and age at the time of injury. Petitioner was a staffing agency worker who performed physical tasks on a line as of the accident. Petitioner testified to working for other similar agencies prior to being hired by Respondent. There is no evidence suggesting Petitioner has held other, more skilled, jobs in the past. Petitioner was 49 years old as of the accident. The Arbitrator views him as an older individual who could have reasonably anticipated working for another 10 to 15 years. As for the fourth factor, future earning capacity, the Arbitrator notes that, while Dr. Fisher recommended surgery, he never imposed restrictions or took Petitioner off work. With respect to the fifth and final factor, evidence of disability corroborated by the treating medical records, the Arbitrator notes the results of the lumbar spine MRIs and the examination findings of Petitioner's treating physicians. The Arbitrator assigns no weight to the EMG/NCV findings, since the EMG/NCV was performed by a chiropractor rather than a board certified neurologist. The Arbitrator also assigns no weight to Dr. Abdellatif's reading of the CT discogram, based on the opinions voiced by Dr. Fisher. Dr. Fisher reasonably questioned the finding of concordant pain at L5-S1 based on his reading of the MRI.

The Arbitrator, having considered the foregoing along with Petitioner's credible testimony concerning his ongoing symptoms and limitations, finds that Petitioner is permanently partially disabled to the extent of 17.5% loss of use of the person as a whole, representing 87.5 weeks of benefits under Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOHN PELTZER,

Petitioner,

20IWCC0185

vs.

NO: 11 WC 15758

DAKKOTA SYSTEMS,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary total disability, and permanent partial disability, and being advised of the facts of 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 thereof.

I. FINDINGS OF FACT

A. Pre-Accident Medical History

Petitioner was diagnosed with neurofibromatosis at four years old. Petitioner testified that up until February of 2010, his doctors were monitoring the neurofibromatosis with MRIs and physical visits to make sure nothing grew. The record contained only one pre-accident treatment note from Dr. Gregory Rauch dated February 26, 2010. Petitioner presented to Dr. Rauch on that date with complaints of non-radiating low back pain that had started months prior. Lumbar X-rays revealed no acute findings; however, Dr. Rauch noted that Petitioner's MRI from two years prior had showed neurofibroma in the lumbar spine. Dr. Rauch diagnosed Petitioner with new low back pain and indicated that further imaging may be needed. The treatment note did not otherwise indicate Dr. Rauch's treatment plan.

Petitioner testified that he did not receive any further medical care for back pain for 12 months after this February of 2010 office visit. He testified that from February 26, 2010 to

December 31, 2010, he did not notice much about his back and the back pain had subsided.

B. Accident

Petitioner began working for Respondent in 2011. Throughout his employment, Petitioner worked on both the production line assembling headliners, which are the parts on the roof of a car that hold the lights and visors, and in a forklift operator position. As a forklift operator, his job duties included loading and unloading trucks, receiving inventory, and loading racks with headliners. Petitioner testified that he was in the forklift operator position on the accident date. On April 12, 2011, Petitioner experienced sharp low back pain and right shoulder pain while moving a 15-pound headliner off a conveyor onto a metal rack.

C. Medical Treatment and Section 12 Examinations

Petitioner presented to Ingalls Occupational Health on April 12, 2011 with complaints of right shoulder and right low thoracic back pain. He denied numbness and tingling into his arms and legs. On examination, Petitioner had mild pain with range of motion, bilateral paraspinal soft tissue tenderness at L2-L3, and mild right paraspinal tenderness at T2-T3. Petitioner was diagnosed with back pain, prescribed ibuprofen, and given a back brace. He was kept on full duty work without restrictions.

Petitioner next presented to Dr. Rauch on April 15, 2011. In addition to the preexisting neurofibroma, Dr. Rauch noted that Petitioner had a history of chronic back pain. He diagnosed Petitioner with a lumbar strain and uncontrolled low back pain. Dr. Rauch indicated that this acute pain was reportedly different from Petitioner's mild chronic intermittent pain. Petitioner was given light duty restrictions of no lifting over 15 pounds, bending, or squatting.

On April 25, 2011, Dr. Rauch again noted that Petitioner's history of chronic back pain was mild and reportedly different in character than his current pain. Regarding Petitioner's shoulder pain, Dr. Rauch believed he likely had tendonitis, but noted full range of motion and improving pain. For the back pain, Dr. Rauch ordered an MRI and recommended that Petitioner avoid lifting over 15 pounds. On April 27, 2011, the lumbar MRI revealed degenerative changes most conspicuous around the thoracolumbar junction with L1-L2 disc bulging, rounded soft tissue signal intensity within the left L1-L2 neural foramen, and disc bulging with degenerative facet changes at L4-L5 resulting in mild to moderate central canal narrowing and mild left foraminal narrowing.

On April 28, 2011, a nurse's note from Dr. Rauch's office indicated that Petitioner's MRI showed his previously known neurofibroma along with some degenerative changes. The nurse reported that Petitioner had been advised to pursue an orthopedic evaluation. Petitioner then presented to Dr. Anis Mekhail of Parkview Orthopedic Group on May 16, 2011. Dr. Mekhail diagnosed Petitioner with a back strain, recommended anti-inflammatories, and continued his light duty restrictions.

Petitioner thereafter participated in physical therapy from May 23, 2011 until June 30, 2011, at which time he transitioned into work conditioning. Shortly after his first physical therapy

session, Petitioner returned to Dr. Mekhail on May 26, 2011. Dr. Mekhail then opined that Petitioner's L1-L2 neurofibromatosis was not related to his current condition and did not cause his symptoms. Instead, he opined that Petitioner's back pain was related to a work-related back strain.

Petitioner next presented for a §12 examination at Respondent's request with Dr. Richard Egwele on June 13, 2011. At the examination, Petitioner reported having back pain four years prior, but he did not remember the etiology of that back pain. Dr. Egwele's diagnoses included a resolved back strain and neurofibromatosis. He agreed that Petitioner conceivably strained his back while lifting headliners at the time of his accident, but he did not think that the clinical findings at the §12 examination demonstrated signs of a persistent acute injury. As such, he opined that Petitioner's lumbar strain had resolved. Dr. Egwele believed that further treatment was not necessary, but nevertheless, he indicated that Petitioner needed to complete the final week of his four-week physical therapy course to reach maximum medical improvement.

Petitioner thereafter participated in work conditioning from July 5, 2011 to July 15, 2011. He discharged himself on July 15, 2011, because he said he needed to return to work or he would lose his job. At that time, Petitioner was estimated to be at the medium physical demand level, which was the goal demand level for his job. Also on July 15, 2011, Dr. Egwele authored a §12 addendum reiterating his belief that Petitioner required no further treatment after he completed the final week of his physical therapy program. Dr. Egwele also clarified that he had found Petitioner's resolved low back strain to be work-related, but not his neurofibromatosis.

On July 18, 2011, Dr. Mekhail opined that Petitioner could do his job, because the work conditioning note had placed him at the medium demand level of his job. However, Petitioner responded that he was in pain and would be required to lift repeatedly over the day. For that reason, Dr. Mekhail indicated that Petitioner could aggravate his pain and referred him to a pain management doctor for possible injections. Nevertheless, a work status note from this visit returned Petitioner to regular duty without restrictions.

Petitioner saw Dr. Anas Alzoobi for pain management on August 16, 2011. Dr. Alzoobi recommended an epidural steroid injection and restricted Petitioner to no prolonged standing, walking, or sitting and no bending or lifting more than 25 pounds. Petitioner received the L4-L5 epidural steroid injection on August 23, 2011.

On August 31, 2011, a functional capacity evaluation classified Petitioner's occupation in the medium strength category and found that he did not meet the necessary strength requirements to return to work. Instead, it placed Petitioner in the light strength category with a maximum lifting capacity of 15 pounds and a maximum carrying capacity of 10 pounds.

On September 6, 2011, Dr. Alzoobi took Petitioner off work and administered a second epidural steroid injection with medial branch facet joint injections at L3-L4, L4-L5, and L5-S1. When Petitioner returned to Dr. Alzoobi on September 20, 2011, he reported pain improvement for one and a half days post-procedure. Dr. Alzoobi then recommended a radiofrequency ablation.

Petitioner saw Dr. Zaki Anwar, another pain management doctor at the same practice as Dr. Alzoobi, on October 11, 2011. Dr. Anwar noted that Petitioner had sustained a work-related

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injury and suffered from chronic axial low back pain with difficulty standing and sleeping. Dr. Anwar recommended that he first proceed with lumbar facet joint injections for confirmation purposes before proceeding with any radiofrequency neurolysis procedure. On October 26, 2011, Petitioner underwent bilateral L4-L5 facet joint injections. He thereafter reported a 40% reduction in his pain on November 8, 2011. Based on that pain relief, Dr. Anwar found that Petitioner was a candidate for radiofrequency neurolysis and ablation therapy at the bilateral L2 through L5 nerves. He kept Petitioner off work pending the procedure.

On December 5, 2011, Petitioner underwent the radiofrequency ablation on the right L3 and L4 medial branch facet nerves and bilateral dorsal ramus of the L5 nerve root. When he returned to Dr. Anwar on December 20, 2011, Petitioner reported a 40% to 50% pain reduction. Dr. Anwar stated that given Petitioner's significant benefit with the first facet joint injections, he would receive maximum benefit with more radiofrequency neurolysis in the future. Dr. Anwar advised Petitioner to follow up in one month and placed him on light duty work with a 10-pound weight restriction and no bending or twisting. He also recommended four additional weeks of physical therapy, which Petitioner participated in from January 9, 2012 to February 16, 2012.

On February 29, 2012, Petitioner underwent another radiofrequency ablation on the right L3 and L4 medial branch facet nerves and bilateral dorsal ramus of the L5 nerve root. On March 13, 2012, Dr. Anwar indicated that Petitioner was also a good candidate for a left-sided radiofrequency neurolysis due to his left-sided facetogenic pain on examination. Dr. Anwar also updated Petitioner's work status to include limited duty with no lifting, carrying, pulling, or pushing more than 15 pounds. On May 9, 2012, Petitioner underwent the radiofrequency ablation on the left L2, L3, and L4 medial branch facet nerves and left dorsal ramus of the L5 nerve root.

On May 22, 2012, Dr. Anwar kept Petitioner on light duty restrictions and indicated that he would need another left-sided radiofrequency neurolysis if his symptoms worsened. Regarding the right-sided radiofrequency neurolysis, Dr. Anwar reported that Petitioner had a 60% reduction in overall pain and would continue to receive maximum benefit from this treatment. Dr. Anwar repeated the same recommendations at Petitioner's next visit on August 14, 2012. Petitioner thereafter underwent a radiofrequency ablation on the right L2, L3, and L4 medial branch facet nerves and left dorsal ramus of the L5 nerve root on November 5, 2012. Another left-sided radiofrequency ablation treatment followed on January 7, 2013.

On January 29, 2013, Dr. Anwar indicated that Petitioner was getting maximum benefit with the treatments, because he had a 50% to 60% reduction in symptoms and improvement in function with the radiofrequency neurolysis on the right and left sides. Dr. Anwar also reported that Petitioner was on light duty status but dealt with intense pain when he moved boxes in the packaging area. When Petitioner returned on March 12, 2013, Dr. Anwar noted that Petitioner had achieved a 60% reduction in symptoms and had excellent relief with the radiofrequency ablations for a period of up to six months. He indicated that he would monitor Petitioner and continued his prescriptions for Naproxen, Tramadol, and Ambien.

On June 18, 2013, Petitioner reported an overall 70% reduction in his pain symptoms. Dr. Anwar again indicated that he would continue to monitor Petitioner and suggested intervention treatment on an as-needed basis. On October 23, 2013, Petitioner underwent another right-sided

lumbar radiofrequency ablation treatment. On November 19, 2013, Petitioner reported that his pain episodes were not as severe, and he continued to benefit from the treatments with greater than 70% reduction in his symptoms. Dr. Anwar opined that Petitioner would continue to benefit from the radiofrequency ablation treatments in the future. He specified that Petitioner's future medical needs consisted of the treatments two to three times a year. Dr. Anwar indicated that he would also need to see Petitioner for post-treatment follow-up visits as well as at least four times a year for medication management.

On January 14, 2014, Petitioner returned to Dr. Anwar with complaints of severe left-sided low back spasms. Dr. Anwar recommended another radiofrequency treatment and prescribed Vicodin as needed. He indicated that Petitioner was now receiving six months to one year of relief after each treatment and would require two treatments yearly. On July 23, 2014, Petitioner underwent another right-sided lumbar radiofrequency ablation treatment. When Petitioner complained of returning severe right-sided low back pain on October 21, 2014, Dr. Anwar also recommended short-term opioid medication with Baclofen on an as-needed basis. Petitioner thereafter underwent another right-sided lumbar radiofrequency ablation treatment on November 5, 2014 and left-sided radiofrequency ablation treatment on February 11, 2015.

On March 10, 2015, Petitioner returned to Dr. Anwar with complaints of soreness and tightness in the right paraspinal area. On examination, Dr. Anwar noted a paraspinal spasm in the right low back. He indicated that muscle soreness and spasms appeared to be an ongoing issue every four to six weeks after Petitioner received a treatment. Dr. Anwar recommended a month of physical therapy, which Petitioner thereafter participated in from May 20, 2015 to June 30, 2015. The physical therapist noted that Petitioner's job at that time was a warehouse manager at Reliable Wire and Cable that fell at the sedentary physical demand level. Petitioner's therapy discharge summary indicated that he was working full duty without restrictions and had reached maximum benefit from therapy.

Petitioner next saw Dr. Anwar on June 2, 2015. Dr. Anwar stated that since the radiofrequency treatments gave Petitioner up to 80% reduction in pain symptoms over a period of six to eight months, he remained a candidate for the treatment on an ongoing basis. Dr. Anwar reiterated that Petitioner's future medical needs included up to two radiofrequency neurolysis treatments a year and up to four yearly visits. He further stated that Petitioner's medication management included short-acting opioid medication like Vicodin, which was taken as-needed. Dr. Anwar indicated that Petitioner's Vicodin consumption was up to four prescriptions a year.

Dr. Egwele performed a second §12 examination on October 26, 2015 and authored a corresponding report dated November 4, 2015. Dr. Egwele's listed Petitioner's diagnoses at that time as multilevel lumbar degenerative disc disease and degenerative lumbar spondylosis with Type 1 neurofibromatosis. He opined that these conditions were not causally related to the work accident and stated that the degenerative lumbar disc and bony changes were not caused by one episode of a lumbar muscle strain. Instead, Dr. Egwele believed Petitioner had reached maximum medical improvement for his causally related strain upon the completion of his physical therapy program around the end of June 2011. He further opined that Petitioner's treatment had been excessive and the ongoing pain management was not likely to have any therapeutic effect. Dr.

Egwele clarified that although Petitioner might require further treatment, it would be related to the degenerative changes of his lumbar spine and not the work accident.

Petitioner last saw Dr. Anwar on November 18, 2015. At that time, Dr. Anwar reiterated that the radiofrequency treatments continued to give Petitioner an 80% reduction in his pain symptoms for a period of six to eight months, and therefore, he remained a candidate for therapeutic treatments on an ongoing basis. He again opined that Petitioner's future medical needs required two radiofrequency neurolysis treatments a year and up to four yearly visits. He also continued to prescribe Vicodin for Petitioner to take as needed.

D. Depositions of Dr. Richard Egwele

The parties deposed Dr. Egwele on December 4, 2015. Dr. Egwele testified that he was board certified in orthopedic surgery in 1979 and did not have to be thereafter recertified, as he was grandfathered in. He testified consistent with his §12 reports.

Dr. Egwele testified that at the first §12 examination, Petitioner had a resolved back strain related to his work accident as well as degenerative changes and neurofibromatosis that was not work-related. He testified that at the second §12 examination, Petitioner had multilevel lumbar degenerative disc disease, degenerative lumbar spondylosis, and Type 1 neurofibromatosis. He opined that none of these findings were related to the work accident, because they were degenerative changes that were not caused by a single episode of twisting his back. Instead, he opined that Petitioner had reached maximum medical improvement in 2011 for his work accident.

Dr. Egwele further explained that neurofibromatosis usually causes a scoliosis of the spine that leads to earlier degenerative changes, which can cause pain. He conceded that Petitioner's mechanism of injury could cause or aggravate degenerative changes or neurofibromatosis, and he believed that had happened in Petitioner's case. Nevertheless, Dr. Egwele testified that Petitioner needed one more week of physical therapy after his first §12 examination and then he would have been at maximum medical improvement for the lumbar strain and the aggravation of any degenerative changes. He explained that although the twisting motion Petitioner described can aggravate the degenerative changes, it would be temporary and would usually only last four to eight weeks. Dr. Egwele believed that Petitioner did not require any further treatment related to the work accident.

E. Deposition of Dr. Zaki Anwar

The parties deposed Dr. Anwar on January 14, 2016. Dr. Anwar is a board certified pain management doctor who testified consistent with his treatment notes. Dr. Anwar further testified that patients with neurofibromatosis, such as Petitioner, have a different spine anatomy and different ways of responding to nerve pain. He explained that it was uncommon for someone in Petitioner's age group to have his level of degenerative disc disease, spondylosis, and spinal stenosis; however, Petitioner had these conditions due to his neurofibromatosis and congenital issues in his early years.

Dr. Anwar opined that based on the anatomy of Petitioner's spine, his preexisting degenerative changes, and spondylitic conditions, Petitioner was prone to injuries in his facet joints and discogenic back pain. As such, he testified that Petitioner should not have been considered for the kind of job that required heavy lifting throughout the day. Dr. Anwar explained that with his condition, Petitioner was not capable of lifting heavy weights up to 50 pounds and that caused him to aggravate his symptoms. He testified that work had aggravated Petitioner's facet joint pain and inflammation, which caused his low back pain.

Dr. Anwar further testified that Petitioner's work accident made his condition symptomatic and traumatized his facet joints. He explained that with neurofibromatosis, axial loading on the spine causes symptoms to appear. As such, he opined that the lifting incident had aggravated Petitioner's pain, although it did not change his spine's underlying condition. He testified that the reason for the inflammation in Petitioner's facet joints was the damage to the cartilage that was caused by the axial loading from lifting the car parts. Dr. Anwar explained that Petitioner was chronically lifting, and then one day, lifting something again led to his inflammation and traumatized joints.

Dr. Anwar further testified that his opinion that Petitioner needed radiofrequency ablation treatments two to four times a year for the rest of his life was speculative based on his experience working with Petitioner over the last four years. He clarified that the radiofrequency ablation treatments were related to Petitioner's symptomatic facet joints and inflammation and not the neurofibromatosis. Dr. Anwar explained that the inflammation was caused by the pain from axial loading. He further testified that Petitioner was not capable of heavy-duty work, but he could work with a permanent 10 to 15-pound weight restriction.

F. Petitioner's Current Condition

At the time of the hearing, Petitioner did not have any upcoming appointments scheduled with Dr. Anwar, but he was in the process of scheduling another radiofrequency ablation treatment. Petitioner testified that he wanted to proceed with ongoing radiofrequency ablations, because he received a good amount of relief from them. Petitioner currently takes Codeine and Cyclobenzaprine for his back pain, as well as Vicodin about twice a week when needed. Petitioner testified that he was not on any medications for back pain prior to the accident. He further testified that with his current pain, there are periods where he does not feel well that can last a couple days. Petitioner uses heating pads to help him feel better on the days he is not doing well. He explained that cold weather affects his pain and being outside for just a few minutes can make his back hurt.

Petitioner further testified that he continued to work light duty for Respondent until August 18, 2011, at which time Respondent could no longer accommodate his restrictions. Petitioner then began working as a warehouse manager for Reliable Wire and Cable on September 4, 2012. In this position, which Petitioner still held at the time of the hearing, he oversees and does not do any lifting. Petitioner presently works full-time Monday through Friday from 8 a.m. to 5 p.m. at a $14.00 hourly wage.

Petitioner further testified that it takes him an hour to drive home from work, and when he gets home, he has back discomfort and sometimes sharp pain. Petitioner has to sleep on his

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stomach to relieve the pain and fall asleep, as it hurts too much to sleep on his back. Petitioner normally sleeps through the night, but his back is stiff when he wakes up and takes about 40 minutes to loosen up. Nevertheless, Petitioner testified that the pain is still present throughout his workday, and it sometimes gets worse. He indicated that he is in pain the majority of the time. Petitioner also testified that his pre-accident hobbies included fishing and biking, but he can no longer do those activities secondary to the back pain.

II. CONCLUSIONS OF LAW

Following a careful review of the entire record, the Commission finds that Petitioner sustained a loss of 20% MAW due to his work-related lumbar spine injuries and modifies the Decision of the Arbitrator accordingly.

The Commission first notes that since Petitioner's accident occurred before September 1, 2011, the Commission is not required to apply the enumerated factors in §8.1b of the Illinois Workers' Compensation Act when evaluating Petitioner's permanent partial disability.

After Petitioner's accident, he continued to work light duty for Respondent until August 18, 2011, at which time Respondent stopped accommodating his restrictions. Petitioner has since held the position of warehouse manager for Reliable Wire and Cable as of September 4, 2012. This current position does not require Petitioner to do any lifting. Although he can no longer return to performing heavy lifting, Dr. Anwar indicated that Petitioner should never have been doing heavy lifting in the first place due to his pre-existing neurofibromatosis.

The Commission further notes that Petitioner currently earns a higher wage in his warehouse manager position than he did prior to his work accident. As a warehouse manager, Petitioner works full-time Monday through Friday from 8 a.m. to 5 p.m. at a $14.00 hourly wage. These hours equate to 9 hours a day and 45 hours a week. There was no testimony presented as to whether lunch hours were further deducted from this time. If Petitioner works 45 hours a week at $14.00 an hour, his current average weekly wage is $630.00, which is greater than the average weekly wage of $459.35 that Petitioner earned while working for Respondent. Even if Petitioner was given an hour lunch for each of the five days per week he worked, his current average weekly wage would still be greater than his pre-accident average weekly wage.

The Commission further acknowledges that although the aggravation of Petitioner's lumbar condition required significant treatment, including radiofrequency ablations, Petitioner's condition did not result in surgical intervention. Even though his condition was complicated by his pre-existing neurofibromatosis, Petitioner was still able to manage his post-accident pain through non-surgical means. Moreover, although Dr. Anwar opined that Petitioner would continue to need future radiofrequency ablations twice a year for life, he admitted that his indefinite future recommendation was speculative.

The Commission therefore finds that modification of the permanency award to 20% MAW is warranted, because Petitioner did not require a surgical operation and currently earns a higher wage than he did prior to his accident. Petitioner continues to work full-time and is capable of

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driving an hour to and from work each day. Although he cannot return to a heavy lifting job, Dr. Anwar explained that patients with neurofibromatosis should not be doing heavy lifting regardless.

For the reason stated above, the Commission finds that Petitioner sustained a loss of 20% MAW for the aggravation of his pre-existing lumbar spine condition and modifies the Decision of the Arbitrator accordingly. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated July 3, 2018 is modified as stated herein. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $275.61 per week for a period of 100 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused a 20% loss of use of the person as a whole.

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

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

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

DATED: MAR 16 2020

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/met
O: 1/23/20
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0185

PELTZER, JOHN
Employee/Petitioner

Case# **11WC015758**

DAKKOTA SYSTEMS
Employer/Respondent

On 7/3/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.08% 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:

0293 KATZ FRIEDMAN EAGLE ET AL
JASON CARROLL
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2837 LAW OFFICES JOSEPH MARCINIAK
ROBERT SABETTO
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CHICAGO, IL 60606

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STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JOHN PELTZER,
Employee/Petitioner

v.

DAKKOTA SYSTEMS
Employer/Respondent

Case # **11** WC **15758**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gary Gale**, Arbitrator of the Commission, in the city of **QUINCY**, and decided based on the record by **Charles Watts**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident 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. [ ] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What 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. [x] Other: Prospective Medical – Surgery Approval_____

FINDINGS

On **April 12, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**23,886.20**; the average weekly wage was $**459.35**.

On the date of accident, Petitioner was **21** years of age, single with **0** dependent children.

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $275.61 per 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.

Respondent shall pay reasonable and necessary medical services directly to Petitioner, pursuant to the fee schedule, of $15,827.00 for Illinois Physicians Network; $66,790.39 for Frankfort Surgical Care; $43,200.00 for Pain Management Institute Professional Services; $810.00 for United Rehab Providers; $8,822.96 for Flossmoor Pain Institute & Surgical Care; $22,159.93 for ATI Physical Therapy; $10,682.74 for Summit Pharmacy; and $2,298.33 for Injured worker's Pharmacy; as provided in Sections8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $306.23 per week for 54 4/7 weeks, commencing August 19, 2011 through September 3, 2012, as provided in Section 8(b) 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

April 6, 2018
Date

JUL 3 - 2018

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BEFORE THE ILLINOIS WORKERS'COMPENSATION COMMISSION

JOHN PELTZER	)	
Petitioner	)	
v.	)	11 WC 15758
DAKKOTA SYSTEMS	)	
Respondent	)	

This matter was tried before Arbitrator Gary Gale. This opinion is written by Arbitrator Charles M Watts after a review of the trial transcript and admitted exhibits.

FINDINGS OF FACT

Petitioner, John Peltzer, was diagnosed with neurofibromatosis when he was four years old. (Transcript at 16) Petitioner testified that this condition caused "discomfort" in his middle back. (Transcript at 16) Petitioner's physicians have monitored his neurofibromatosis with physical exams, x-rays, and MRIs of his spine. Petitioner acknowledged consulting with Dr. Gregory Rausch for back pain caused by his neurofibromatosis in 2010. (Transcript at 15-16) Dr. Rausch's February 26, 2010 record documents Petitioner's complaint of moderate and constant low back pain without radiation began months prior to the visit. (PX2 at 7-8) Dr. Rausch also referenced a 2008 MRI that showed neurofibroma in the lumbar spine. (PX2 at 7-8) Petitioner testified that his back pain from neurofibromatosis subsided later in 2010. (Transcript at 18) Petitioner also testified that he underwent occasional diagnostic testing on his back due to his neurofibromatosis but never received any prior treatment for back pain. (Transcript at 17-18)

Petitioner testified that he was working for Respondent, Dakkota Systems, on Tuesday, April 12, 2011, in his usual forklift operator position, and that he felt no back pain when he arrived for his shift. (Transcript at 21) Dakkota Systems supplied headliners (ceilings of automobiles) to Ford Motor Company. (Transcript at 18) Petitioner testified that while lifting a 15-pound headliner from a conveyor belt onto a metal rack he felt a sharp pain in his lower back. (Transcript at 22) Petitioner immediately notified his supervisor. (Transcript at 22) The parties have stipulated that Petitioner sustained an accident that arose out of and in the course of his employment and gave prompt and proper notice to Respondent. (Arb. Ex. 1)

Respondent sent Petitioner to Ingalls Occupational Health the same day as the accident where he was examined by Dr. Amjad Akhtar. (Transcript at 23-24; PX1 at 7) Dr. Akhtar noted that Petitioner was injured while lifting a 15-pound headliner and "developed pain in the posterior right shoulder and the right lower thoracic back area." (PX1 at 7) Dr. Akhtar noted that Petitioner moved briskly without apparent discomfort. (PX1 at 7) On examination, he indicated that Petitioner had tenderness with palpation in the bilateral paraspinal soft tissue at the L2-L3 spine as well as mild tenderness at the right paraspinal at T2-T3. (PX1 at 8) Dr. Akhtar prescribed that Petitioner wear a back brace with activity, begin a home exercise program, and

take ibuprofen. (PX1 at 8) Dr. Akhtar recommended that Petitioner's work status be restricted duty with recommended activity restrictions described on the work status discharge sheet. (PX1 at 8) The work status discharge sheet indicates that Petitioner "may perform full duty without accommodation." (PX1 at 10)

Petitioner testified that he sought additional medical treatment with his primary care physician, Dr. Gregory Rauch, at Orland Primary Care Specialists, on April 15, 2011. (Transcript at 24) Dr. Rauch noted that Petitioner was lifting at work and felt a sharp pain in his lower right back and right shoulder. (PX2 at 11) Dr. Rauch also noted Petitioner's history of neurofibroma, visualized on a prior MRI, and prior chronic back pain. (PX2 at 11) Also noted was that Petitioner "appears to have muscle strain of lumbar spine" and that "[t]his acute pain is reportedly different from his mild chronic intermittent pain." (PX2 at 12) Dr. Rauch advised Petitioner to return to work with the restrictions to avoid lifting over 15 pounds, bending, or squatting. (PX2 at 12)

During this time, Petitioner continued to work and testified that Respondent accommodated the work restrictions. (Transcript at 26)

Petitioner had a follow-up appointment with Dr. Akhtar on April 19, 2011. (Transcript at 26; PX1 at 11) Dr. Akhtar's notes indicate no change in Petitioner's reported condition from the April 12, 2011 initial appointment. (PX1 at 11-12) Dr. Akhtar ordered that Petitioner wear a back brace and start physical therapy. (PX1 at 11-12) Petitioner was to return for re-evaluation by Dr. Akhtar on April 26, 2011, but records and Petitioner's testimony indicate that he never again was evaluated by Dr. Akhter. (Transcript at 26; PX1)

Petitioner saw Dr. Rauch on April 25, 2011. (Transcript at 26-27) The record indicates that Petitioner reported no improvement in his lower back and that his current lower back pain was different in character than his prior chronic back pain. (PX1 at 14) Dr. Rauch prescribed an MRI of the lumbar spine which was completed at open Advanced MRI on April 27, 2011. (PX1 at 14, 16-17) After reviewing the MRI, Dr. Rauch reported in a nursing note that Petitioner was "informed neurofibroma present as already known, also has some degenerative changes" and advised Petitioner to seek treatment with an Orthopedic physician. (PX1 at 19) Specifically, the MRI findings were:

> The overall alignment of the lumbar spine is intact. Vertebral body heights are well-maintained. Degenerative disk disease is present at L1-L2 with disk space narrowing. The conus medullaris terminates at the T11 level and is incompletely evaluated on this examination.
>
> At T12-L1 there is disk bulging resulting in mild compression of the ventral thecal sac without central spinal canal or foraminal stenosis.
>
> At L1-L2 there is disk bulging and degenerative spurring without spinal canal stenosis. There is an intermediate signal intensity rounded lesion suspected within the left L1-L2 neural foramen which could represent a neural origin tumor.

At L2-L3 and L3-L4 there is mild disk bulging without central spinal canal or foraminal stenosis.

At L4-L5 there is a disk bulging and mild degenerative spurring. Degenerative facet changes are notes resulting in mild to moderate central spinal canal stenosis. There is mild left foraminal narrowing.

At L5-S1 there is minimal disk bulging without central spinal canal or foraminal stenosis.

(PX1 at 18)

Dr. Anis Mekhail of Parkview Orthopaedic Group first examined Petitioner on May 16, 2011. PX3 at 9. Dr. Mekhail reviewed the April 27, 2011 MRI and noted the findings of mild degenerative changes to the spine were consistent with neurofibromatosis. Id. He also noted that Petitioner denied back pain prior to his April 12, 2011 accident but had reported having back pain years ago that had gone away. Id. Dr. Mekhail recommended that Petitioner continue to have the same light duty, 50-pound weight restriction and to complete 4 weeks of physical therapy. Id. In an addendum to this report, Dr. Mekhail indicated that "[l]ifting the headliner as patient stated would have caused his lower back pain." Id. at 10. Dr. Mekhail's assessment was "[p]atient with mostly back strain." Id. at 9. On May 26, 2011, Dr. Mekhail again examined Petitioner and advised that he continue on light work duty and switch physical therapy providers so that he could be begin the prescribed 4 weeks of physical therapy. Id. at 13. Dr. Mekhail recorded that Petitioner "has finding on the left L1-L2 of neurofibromatosis which I don't think is related to the condition at all. I don't think it's causing his symptoms." Id.

Petitioner began actual physical therapy treatment on May 23, 2011, transitioned to work hardening on July 5, 2011, and then decided to cancel further work hardening on July 15, 2011. PX7. At Petitioner's May 23, 2011 initial appointment it was noted that Petitioner reported lower back pain on the right side of 8 out of 10. PX7 at 39. Petitioner was assessed as "demonstrating signs/symptoms consistent with lumbar rotation syndrome." Id. at 41. Significant findings were decreased trunk/lumbar active range of motion, decreased lumbar and core strength, decreased lower extremity flexibility, poor posture, and "unable to perform full work duties." Id. The first progress note, covering the period of May 23 through June 10, 2011, indicates that Petitioner was "not progressing" and "has been slow to respond to treatments thus far with little to no reduction in subjective pain complaints, (lower extremity) flexibility has improved moderately as well as strength." Id. at 34. Petitioner's activity tolerance was "60 minutes of core and (lower extremity) strengthening exercises, lifting/squatting training, cardio and manual and self stretching exercises." Id. Range of motion was noted as "major loss of trunk extension, flexion and right side bend moderate loss, minimum loss of left side bending." Id. at 33-34.

At Respondent's request, Petitioner attended a Section 12 examination with Dr. Richard Egwele, an orthopedic surgeon who does not perform back surgeries, on June 13, 2011. (RX3 at 3-6) Dr. Egwele testified that he took a history from Petitioner that included lifting headliners weighing about fifteen to twenty pounds when he moved the wrong way and felt pain in his

lower back. (RX3 at 6-7) Dr. Egwele testified that Petitioner reported his pain at the examination at 7 out of 10. (RX3 at 36) Dr. Egwele never asked for or obtained a history from Petitioner of his level of pain prior to the April 12, 2001 accident. (RX3 at 36)

Dr. Egwele testified that the degenerative changes in Petitioner's spine were the cause of the pain Petitioner reported at the examination. (RX3 at 37) Dr. Egwele agreed that a person can aggravate underlying degenerative changes and that the aggravation can cause pain. (RX3 at 38) Dr. Egwele testified that Petitioner's mechanism of injury did aggravate his underlying degenerative condition but that such an aggravation "usually lasts from four to eight weeks." (RX3 at 50)

Dr. Egwele testified that his review of Petitioner's medical records and his own examination led him to diagnose Petitioner with mild degenerative changes at L1-2, neurofibromatosis, and a resolved back strain. (RX3 at 11) Dr. Egwele testified that Petitioner's back strain was causally connected to his work accident. (RX3 at 11) Dr. Egwele further testified that the mechanism of injury aggravated his underlying degenerative condition. (RX3 at 12) As of the June 13, 2011 examination, Dr. Egwele testified that Petitioner had not yet reached MMI but would do so with one more week of physical therapy. (RX3 at 14)

The next physical therapy progress note, dated June 17, 2011, range of motion had improved to "moderate loss of trunk extension, flexion and right side bend moderate/minimum loss, minimum loss of left side bending." PX7 at 33. Also, "strength in lower extremities and core have improved" and "body mechanics/lifting technique have greatly improved." Petitioner was judged to be "progressing." Id. The final progress note, dated June 30, 2011, also indicates that Petitioner was "progressing" and that 3 out of 3 short-term goals, and 4 of 6 long-term goals had been met. Id. at 27. The plan for Petitioner was to "transition to work conditioning on July 5, 2011." Id. Range of motion, strength and activity tolerance had all improved since June 17, 2011. Id.

Petitioner participated in work conditioning / hardening for a period of 10 days. Id. at 62. The initial progress report, covering the period of July 4, 2011 through July 11, 2011, reported that Petitioner "reported mild lower back soreness and general muscle fatigue as his main complaints." Id. at 56. This report indicated that Petitioner's strength and tolerance to activities increased. Id. Petitioner's functional pain scale was a 3 out of 10 with 1 signifying minimal pain and 10 signifying severe pain. Id. The second progress report, covering the period of July 11, 2011 through July 17, 2011, indicated that Petitioner "reported mild lower back soreness but denied any sharp pain." Id. at 56. This report indicated that Petitioner's strength and tolerance to activities increased. Id. Petitioner's functional pain scale improved to a 2 out of 10. Id. During that time period, Petitioner's physical demand level increased from "light" to "medium." Id. at 55, 62. These two progress reports both noted that Petitioner's goal physical demand level was "medium." Id. On the final report, Petitioner's functional pain scale was noted to have improved to a 1 out of 10 indicating "minimal pain." Id. at 62. Petitioner "called on 7/15/11 to say he is discharging himself from Work Conditioning. He says that he needs to return to work or he will lose his job." Id. at 62. The recommendation indicated on this progress report was "[d]ischarge from program." Id.

Petitioner did not return to work conditioning / hardening after July 15, 2011. PX7.

Petitioner also was examined by Dr. Mekhail on July 18, 2011. PX3 at 18. Dr. Mekhail reported that Petitioner:

> . . . is still having back pain, no radicular symptoms. He is has knee pain which is being treated by another physician who's waiting for x-ray and MRI.
>
> Physical exam: Otherwise for his back it doesn't radiate. He has pain with range of motion of his back. He's neurologically intact.
>
> MRI shows some degenerative changes.
>
> We sent him for work conditioning and work conditioning's last note indicates that he met his job requirement of medium functional demand level. I explained to the patient and his mother that I believe he can do his job. I had already contact him by an Independent Medical Evaluation doctor and asked him to go back to work. I believe he can do his job however he is in pain and he said he is required to lift repetitively over the day. I believe that would aggravate his pain and for his pain I would like to refer him to pain management for possible injections.

Petitioner was examined by Dr. Anas Alzoobi, a pain management specialist, on August 16, 2011 who reported that Petitioner had a disc bulge at L1-L2, degenerative facet changes at L4-L5 resulting in mild to moderate central spinal canal narrowing, and minimal disc bulge at L5-S1 without stenosis. (PX11 at 4) Petitioner reported sharp pain – 7 out of 10 on visual analog score - to the right aspect of the mid and low back area and that the type of work he performed for Respondent worsened his pain. (PX11 at 4) The assessment was discogenic disease at L1-L2 and L4-L5 with facet arthrosis and spondylosis. (PX11 at 4)

Petitioner testified that his last day of work was Monday, August 18, 2011, because Respondent would not accommodate light duty restrictions. (Transcript at 42)

Petitioner received epidural steroid injections from Dr. Alzoobi on August 23, 2011. (PX11 at 5) Petitioner testified that these injections gave him very little pain relief. (Transcript at 31)

Petitioner underwent a functional capacity exam on August 31, 2011 and several tests placed Petitioner in the "light category." (PX13 at 35-37) Testing found Petitioner's occasional lifting capacity (33% of the workday) to be 15 pounds for, frequent lifting capacity(67% of the workday) was 7.5 pounds, and constant lifting capacity was 3 pounds. (PX13 at 35). Petitioner's occasional, frequent, and constant carrying capacity was 10, 5, and 3 pounds respectively. (PX13 at 35) Based on the strength classifications according to the Dictionary of Occupational Titles, Petitioner was in the strength category of light duty. (PX13 at 37) Petitioner's occupation as an assembler is in the medium strength category and therefore Petitioner did not meet the strength requirements for his job. (PX13 at 37) Other job factor restrictions from the testing were that Petitioner could not sit for more than 20 minutes

continuously, walk more than a half mile continuously, push more than 40 pounds, pull more than 55 pounds, engage in any balancing activities requiring crouching, crouch, stoop, or crawl. (PX13 at 37)

Petitioner received a second round of epidural steroid injections from Dr. Alzoobi on September 6, 2011. (PX11 at 6) In addition, Petitioner received facet joint injections of L3-4, L4-5, and L5-S1. PX11 at 6-7) Petitioner reported that the August 23, 2011 injections gave him mild pain relief for one or two days but that he still complained of pain in his lumbar spine. (PX11 at 6) Petitioner testified that these injections gave him a little more pain relief than the first injections. (Transcript at 31) Dr. Alzoobi noted that Petitioner had mild to severe tenderness with pressure over the facet joint at L4-L5 and L5-S1 and a diagnosis of discogenic disease with spurs and facet hypertrophy at those same levels. (PX11 at 6)

Petitioner returned to Dr. Alzoobi on September 20, 2011 and reported that the injections gave him pain relieve for 1 ½ days. (PX11 at 7) Dr. Alzoobi's final diagnosis was discogenic disease at L4-L5 as well as spondylosis and arthritis at L4-L5 and L5-S1 and he recommended that Petitioner receive radiofrequency and he recommended that Petitioner receive radiofrequency ablation of the medial branch block of the L3-4, L4-5, and L5-S1 facet joints. (PX11 at 7)

Petitioner was referred to Dr. Zaki Anwar, another pain management physician in the same practice group as Dr. Alzoobi, who became, and still is, Petitioner's main treating physician, and was examined on October 11, 2001. (PX11 at 8-9) Dr. Anwar testified that his examination was consistent with Petitioner's report of back pain. (PX12 at 15-16) After reviewing Petitioner's history and physical examination findings, Dr. Anwar recommended Petitioner undergo lumbar facet joint injection under fluoroscopy at L4-5 and L5-S1 before proceeding with radiofrequency ablation. (PX11 at 8-9) Dr. Anwar also took Petitioner off work because Petitioner's underlying condition – neurofibromatosis, inflammation around the facet joints, and degenerative changes in his spine – and that he was in pain. (PX12 at 17-18, 20; PX11 at 29)

Petitioner had the recommended injections on October 26, 2011. (PX4 at 16-17) Petitioner testified that these injections gave him little pain relief, but more relief than the two rounds of injections he had received from Dr. Alzoobi (Transcript at 32-33) Dr. Anwar's November 8, 2011 record indicates that Petitioner reported a 40% reduction in pain. (PX4 at 18) Based on these results, Dr. Anwar advised Petitioner to proceed with radiofrequency neurolysis and ablation therapy at L2, L3, L4, and L5 nerves on the right and left sides. (PX4 at 19)

On December 5, 2011, Petitioner underwent his first radiofrequency ablation treatment. (PX4 at 20) Petitioner testified he received 30-40% pain reduction. (Transcript at 34) Dr. Anwar testified that his the goal of this treatment was a 60-80% pain reduction but that this result was sometimes not reached until after a few ablations. (PX12 at 24-26) Dr. Anwar testified that he placed Petitioner on work restrictions of not lifting more than 10 pounds and to avoid bending or twisting to prevent aggravation of Petitioner's joint pain. (PX12 at 26)

In 2012, Petitioner underwent radiofrequency ablations on February 29, May 9, and November 5. (PX10 at 20-21, 23-24, 27-28). At his follow up visits on March 13, May 22, and December 4 of 2012, Petitioner reported a 40-50% reduction in pain and overall improvement of 60%. (PX4 at 25-28; Transcript at 35-36)

Petitioner began working again on September 4, 2012 in a position that paid $14 per hour and required no lifting. (Transcript at 42-43)

Petitioner continued to receive radiofrequency ablations twice per year since 2013. (PX12, exhibit 2 at 23-24; PX4 at 33-34; PX6 at 5-10) Petitioner testified that these treatments gave him 40% pain relief. (Transcript at 36-38) Dr. Anwar's records indicate Petitioner's pain relief was greater – "significant response with radiofrequency denervation with 70% reduction in symptoms of pain for almost up to six months . . ." (PX4 at 37) and up to 80% relief for 6 months in November 2015. (PX12, exhibit 2 at 38)

Dr. Anwar's November 19, 2013 note indicated that Petitioner continued to receive a greater than 70% reduction in pain for up to six months with the ablation treatments. (PX4 at 35) The note also indicates that Petitioner would need to have follow up visits at least 4 times per year for his medication management. (PX4 at 35) This plan continued through the date of trial.

Respondent's IME, Dr. Egwele, examined Petitioner again on October 26, 2015. (RX3 at 17) Following this examination, Dr. Egwele concluded that Petitioner had "multilevel lumbar degenerative disc disease and degenerative lumbar spondylosis and that he had neurofibromatosis Type 1." (RX3 at 22) He further testified that Petitioner's degenerative changes were not caused by a single episode of twisting the back. (RX3 at 22) Dr. Egwele testified that mechanism of injury – twisting motion - would aggravate Petitioner's underlying degenerative condition. (RX3 at 50) Dr. Egwele testified that Petitioner's pain derived from facet arthropathy and not the L2 nerve root tumor. (RX3 at 45) Dr. Egwele also testified that facet arthropathy was not a result of neurofibromatosis but caused by arthritic changes to the joints. (RX3 at 46)

Dr. Anwar testified that Petitioner's low back pain is caused by inflammation of the facet joints. (RX12 at 33) Dr. Anwar testified that Petitioner's neurofibromatosis caused degenerative changes in his spine, which were asymptomatic before the April 12, 2011 injury. (RX12 at 43) He testified that the axial loading from lifting car parts traumatized Petitioner's facet joints – damaged cartilage - causing inflammation and pain. (RX12 at 61, 77, 89) Dr. Anwar testified that radiofrequency ablation treats only Petitioner's facet joint pain which was caused by damage to the cartilage and that neurofibromatosis does not cause cartilage damage. (RX12 at 88-89)

Dr. Anwar testified that Petitioner has a permanent 10-15 pound lifting restriction because "symptomatic pain he has developed after the damage in the facet joints, and facet joints are damaged because of the arthritis he built up in the past." (PX12 at 80, 90) Dr. Anwar testified that Petitioner's neurofibromatosis meant that he was never someone who should engage in heavy duty work. (PX12 at 43) Dr. Anwar testified that Petitioner will need ongoing long term medical care in the form of radiofrequency ablations for the rest of his life. (RX12 at 35-36)

As to his current condition, Petitioner testified that his back is stiff when he wakes up each day. (Transcript at 46) He testified that he is in constant pain for which he takes codeine and Cyclobenzaprine. (Transcript at 44-47) Petitioner testified that he can only sleep on his stomach. (Transcript at 45-46) Petitioner testified that he formerly liked to fish and ride a bicycle but can no longer do so because of the pain. (Transcript at 48). Petitioner testified that he is in pain most of the time. (Transcript at 48)

CONCLUSIONS OF LAW

F. WHETHER PETITIONER'S PRESENT CONDITION OF ILL BEING IS CAUSALLY RELATED TO THE INURY?

The Arbitrator finds that Petitioner's present condition of ill-being, as it relates to his lower back, is causally related to his April 12, 2011 work accident.

Petitioner bears the burden of proving by a preponderance of the evidence all of the elements of his claim. *R & D Thiel v. Workers' Compensation Comm'n,* 398 Ill. App. 3d 858, 867 (2010). Among the elements that the Petitioner must establish is that his condition of ill-being is causally connected to his employment. *Elgin Bd. of Education U-46 v. Workers' Compensation Comm'n,* 409 Ill. App. 3d 943, 948 (2011). 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. Indus. Comm'n*, 128 N.E.2d 718, 720 (Ill. 1955). The workplace injury need not be the sole factor, or even the primary factor of an injury, as long as it is a causative factor. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205 (2003). Thus, if a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Id.*

"A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in a disability may be sufficient circumstantial evidence to prove a causal connection between the accident and the employee's injury." *Int'l Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64 (1982). If a claimant is in a certain condition, an accident occurs, and following the accident, the claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration. *Schroeder v. Ill. Workers' Comp. Comm'n*, 79 N.E.3d 833, 839 (Ill. App. 4th 2017).

Petitioner testified credibly regarding his work accident and resulting medical condition. The transcript indicates that Petitioner was responsive to questions throughout, including on cross examination. His testimony was supported by the medical records which also contain no allegation or intimation of exaggeration of symptoms or malingering. Further, there was no allegation of malingering or exaggeration by Respondent's IME, Dr. Egwele.

Petitioner immediately reported his accident and sought treatment the same day. All physicians, including Dr. Egwele, agree that Petitioner suffers from the preexisting condition of neurofibromatosis which caused degenerative changes in his spine. Dr. Rauch, who had treated Petitioner prior to the injury, noted in the records that Petitioner's new acute pain was differnet from his prior intermittent mild chronic back pain. Petitioner was not taking pain medications

prior to the accident and currently takes prescription Codeine and Cyclobenzaprine. Treating physicians and Dr. Egwele agree that the mechanism of Petitioner's injury – twisting and lifting the headliner - aggravated his underlying degenerative condition.

Although Dr. Egwele agreed that the injury aggravated Petitioner's underlying degenerative condition and agreed that the pain was the result of facet arthopathy, He, nonetheless, concluded that Petitioner's ongoing pain was no longer related to his work accident. On the other hand, Dr. Anwar explained in great detail how the axial loading caused cartilage damage and inflammation of Petitioner's facet joints which caused the pain. The Arbitrator places more weight on Dr. Anwar's testimony than that of Dr. Egwele because Dr. Anwar more credibly explained the cause of Petitioner's pain, pointed out that cartilage damage is not caused by neurofibromatosis, and explained how neurofrequency ablation only treats facet joint pain, fairly successfully in Petitioner's case. That Petitioner's preexisting neurofibromatosis complicates treatment for a discrete injury does not break the chain of causation. Dr. Anwar is a pain management specialist while Dr. Egwele is an orthopedic surgeon who never has operated on the back.

Sisbro holds that if a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. Under *Laclede Steel*, 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." Petitioner's underlying degenerative condition was aggravated by the injury. Petitioner's credible testimony regarding his back pain, both before and after the accident, review of the medical records, and the explanations of Dr. Anwar in contrast to those of Dr. Egwele, fully support finding that Petitioner's current condition of ill being, as it relates to his lower spine facet joint injuries, is causally related to the April 12, 2011 accident.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

The Arbitrator finds that medical services provided to Petitioner have been reasonable and necessary. Respondent has not paid all appropriate charges.

There is no dispute that Petitioner's lifting accident aggravated his underlying degenerative condition. The question is whether the injury resolved. Dr. Egwele predicted in his June 13, 2011 IME report that Petitioner would reach MMI after one additional week of physical therapy. Petitioner completed PT and began a course of work conditioning. Petitioner was seen by Dr. Mekhail on July 18, 2011 who noted that although he though Petitioner could return to work, Petitioner still had significant pain for which Dr. Mekhail recommended further treatment. Petitioner continued to suffer significant pain throughout the rest of 2011 and sought treatment first with Dr. Alzoobi and then with Dr. Anwar. Crucially, and as explained above, Dr. Anwar's testimony was more persuasive that Petitioner's pain was caused by inflammation / cartilage damage which was not a result of Petitioner's underlying degenerative condition than was Dr.

Egwele's explanation that the same pain ceased to be caused by the injury and then, in an instant, was caused by the degenerative condition.

As described above, Petitioner was treated for pain unsuccessfully until he began to receive radiofrequency ablation treatments from Dr. Anwar in late 2011. These ablation treatments continue to be needed, based on credible testimony, twice each year going forward into the future. Petitioner's pain came to be significantly controlled such that he was able to work again full time, albeit with restrictions, which is persuasive that the medical care through the most recent treatment with Dr. Anwar in record (November 18, 2015) was reasonable and necessary.

Respondent shall pay reasonable and necessary medical services directly to Petitioner, pursuant to the fee schedule, of $15,827.00 for Illinois Physicians Network; $66,790.39 for Frankfort Surgical Care; $43,200.00 for Pain Management Institute Professional Services; $810.00 for United Rehab Providers; $8,822.96 for Flossmoor Pain Institute & Surgical Care; $22,159.93 for ATI Physical Therapy; $10,682.74 for Summit Pharmacy; and $2,298.33 for Injured worker's Pharmacy; as provided in Sections8(a) and 8.2 of the Act. The Arbitrator denies any claimed interest by the providers.

K. WHETHER THE PEPTITIONER IS DUE COMPENSATION FOR TEMPORARY TOTAL DISABILITY PAYMENTS?

The Arbitrator finds that Petitioner's proposed TTD benefits on the Request for Hearing to be accurate and awards the same.

To prove entitlement to TTD, a claimant bears the burden of proving not only that he did not work, but also that he was unable to work. *Interstate Scaffolding v. Illinois Workers' Compensation Comm'n,* 236 Ill.2d 132, 148 (2010). An employer's obligation to pay TTD benefits to an injured employee does not necessarily cease because that person's employment has ended. *Id.* at 146. When an injured employee has been discharged, the determinative inquiry for deciding whether that employee is entitled to TTD benefits is whether or not the claimant's condition has stabilized. *Id.* If the injured employee has not reached maximum medical improvement, he or she is entitled to TTD benefits. *Id.*

Respondent's IME, Dr. Egwele opined that he expected Petitioner would be capable of working without restriction one week after his June 13, 2011 examination during which Petitioenr would be undergoing PT. On July 18, 2011, Dr. Mekhail, who reviewed Petitioner's PT and work hardening records, opined that Petitioner met his job requirement for medium function demand level but noted that Petitioner's task of lifting headliners would aggravate his pain so he believed Petitioner should continue at light duty and referred him to a pain management specialist. The PT and work hardening records indicate Petitioner slowly progressed on improving strength and decreasing pain. This is a contrast to Petitioner consistently reported pain of 7 out of 10 to Dr. Egwele, Dr. Mekhail, Dr. Alzoobi and then to Dr. Anwar throughout the rest of 2011 and into 2012. The August 31, 2011 functional capacity test indicated that Petitioner was only suited to light duty work. Dr. Anwar had Petitioner either off work or light duty only going forward to the date of trial. Petitioner testified that his last day of

work was Monday, August 18, 2011, because Respondent would not accommodate light duty restrictions.

The Arbitrator finds that the preponderance of the evidence indicates that Petitioner continued to be in pain through 2011 into 2012 and could only work light duty. Petitioner was therefore not at MMI. Although radiofrequency ablation treatments in 2012 led to a 40% reduction in pain, the Arbitrator finds that Petitioner was not at MMI on September 4, 2012, when he began working at a light duty job.

Therefore, the Arbitrator finds that Respondent shall pay Petitioner temporary total disability benefits of $306.23 per week for 54 4/7 weeks, commencing August 19, 2011 through September 3, 2011, as provided in section 8(b) of the Act.

l. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

The Arbitrator finds that Petitioner sustained 25% loss of the person as a whole, as provided in Section 8(d)2 of the Act. Respondent shall pay Petitioner permanent partial disability benefits of $275.61 per week for 125 weeks.

Petitioner's occupation as a forklift operator was physically demanding and included some heavy lifting. It is noteworthy that Dr. Anwar testified that Petitioner's neurofibromatosis meant that he was never someone who should engage in heavy duty work. His body was not suited for heavy work. Nonetheless, as a result of the injuries sustained on April 12, 2011, Petitioner is restricted from lifting over 15 pounds and unable to resume his former occupation.

There is significant evidence that the injury accelerated in time Petitioner's current and ongoing symptoms by aggravating his underlying neurofibromatosis. There is also evidence that the injury was a discrete injury and that the severity of the symptoms is related to neurofibromatosis. Petitioner was asymptomatic prior to the injury and now cannot ride a bike, fish, or sleep on his back. He wakes up stiff each morning, takes medication for pain, and the plan is for him to receive neurofrequency ablation treatments twice each year for the rest of his life.

While the accident affected the types of occupations Petitioner could perform, there is evidence that Petitioner should never have attempted to work in any occupation that is physically demanding because of his underlying neurodegenerative condition. Although Petitioner was only 21 years old at the time of the accident, the Arbitrator finds that Petitioner's permanent partial disability will be just a bit more extensive than that of an older individual because he preexisting condition also limits the type of physical work Petitioner could perform. The Arbitrator finds that the permanency award in this case should be consistent with a person who undergoes a back surgery given the ongoing restrictions Petitioner now haw which began on the date of the injury and the continued pain.

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

William Crittendon,
Petitioner,
vs.

NO: 15 WC 31369

The American Coal Company,
Respondent.

20IWCC0186

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 disease, temporary disability, medical expenses, sections 1(d)-1(f) and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 18, 2019, 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 16 2020
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BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CRITTENDON, WILLIAM
Employee/Petitioner

Case# **15WC031369**

AMERICAN COAL COMPANY
Employer/Respondent

20IWCC0186

On 6/18/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.13% 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:

5236 CULLEY FEIST KUPPART & JORDAN
ROMAN P KUPPART
3 S MAIN ST SUITE 2
HARRISBURG, IL 62946

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

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

WILLIAM CRITTENDON
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

Case # **15** WC **31369**

Consolidated cases: _____

20IWCC0186

An *Application for Adjustment 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 **March 14, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

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

On this date, Petitioner ***did 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 $**87,849.85**; the average weekly wage was $**1,689.42**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

Petitioner claims no medical.

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

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

ORDER

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that he sustained an occupational disease that arose out of and in the course of his employment by Respondent and that his current condition is causally related to same. All benefits are denied. The Arbitrator makes no conclusions as 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

June 16, 2019
Date

JUN 18 2019

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

WILLIAM CRITTENDON
Employee/Petitioner

v. Case #: **15 WC 31369**

THE AMERICAN COAL COMPANY
Employer/Respondent

20IWCC0186

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner's Testimony

Petitioner testified that he is 61 years old, divorced, and lives in Harrisburg, Illinois. He has an Associate's Degree in Applied Science from Southeastern Illinois College. Petitioner worked in coal mining employment for approximately 36 years, with four years being above ground and the other 32 years being underground. While working in the mines he was regularly exposed to coal and rock dust as well as diesel exhaust emissions. He was a diesel emissions technician underground and tested equipment every day. He would stand in front of a machine while the exhaust was blowing directly back in his face about six feet from him. He did it that way for a little over 10 years.

Petitioner's last day of exposure was August 28, 2015, at Respondent's Galatia mine. He was 58 years old on that date and was considered a safety specialist. He testified that he was exposed to and breathed coal dust on that date. He testified that he took a voluntarily layoff. He testified that he was concerned about his health because it was getting worse, that his breathing was not what it used to be, and that he had been going downhill since his late 40s or early 50s. There were certain things that he had to do in his job that bothered him breathing wise. At the time of his layoff, Respondent was going to change his job position to examining, which would require a lot of walking and a faster pace than what he had been used to. He did not feel he could physically do the examining job.

Petitioner testified that after leaving the mine in August 2015 he drew unemployment for approximately six months. He applied for work at AISIN and General Dynamics and had an interview with both of those employers. He started working for FedEx on September 16, 2016, and was continuing to work for FedEx at the time of arbitration. He testified that he works five days a week, approximately 30 hours per week. He testified that this was the best job he thought

he could get at the time. He has not looked for work since obtaining the job with FedEx. He testified that his job at FedEx is as a courier. When the truck arrives at the station in Marion, he pulls aircraft containers off the 18-wheeler and then they unload the freight from the aircraft containers on to a roller conveyor. After that, he loads his truck with the stuff that was set off to the side for him. Petitioner testified that he has trouble catching his breath when he is pulling aircraft containers off the truck and sometimes when loading freight out of the containers.

Petitioner testified that he graduated from high school in May 1975. He served in the United States Marine Corps from February 1976 to 1979. He started working for Peabody Coal Company on April 1, 1979, and continued there until December 1987, in the surveying department. He went to work for Kerr McGee Coal on February 29, 1988, and Kerr McGee was bought out by Respondent in June 1998. He continued to work for Respondent until he quit on August 28, 2015. He testified that he worked in the safety department for Kerr McGee and continued in that position after Respondent bought out Kerr McGee. He was also a laborer. While working as a laborer, he had to shovel coal, build stoppings and essentially do anything that needed to be done. He also rock-dusted and was a diesel equipment tester.

Petitioner testified that he finally ended up in the safety department full time as a safety specialist. He worked five and a half to seven days week and eleven and a half plus hours per day. As a safety specialist he checked diesel emissions and walked return escape ways, beltlines, and units to make inspections. He traveled with the state and federal mine inspectors and escorted them all over the mine wherever they wanted to go including walking up and down the slope, walking on the surface, and walking up the silos. Sometimes he shoveled on the belt and sometimes carried crib ties or timber to set the prop for a loose roof. Most of the walking he did as a safety specialist was on uneven, hilly, wet, muddy ground with all kinds of obstacles and tripping hazards. It also required him to wade through water that was between ankle and chest deep. As a safety specialist he had to bend, stoop and squat to do his job duties. He testified that his job duties caused him breathing problems.

Petitioner testified that he was currently having breathing problems. He first noticed trouble with his breathing in his late 40s or early 50s, when he was bending over and picking up things or trying to carry certain items such as a crib tie or concrete block. He testified that he was in the fire brigade and had to drag a fire hose, which just wore him down. There were times when he could not catch his breath and he would just have to stop. He testified that he carried 30 to 35 pounds on his safety belt. He testified that as of the date of arbitration, if he were to walk on level ground at a normal pace, he could go an eighth of a mile before he noticed a change in his breathing, and could climb a couple flights of stairs before having trouble with his breathing.

Petitioner testified that from his late 40s and early 50s until the time of arbitration his breathing had gotten worse. He is not taking breathing medication. He testified that his breathing affects his activities of daily life and he has to pick and choose what he does. He has to go slow and take his time. He testified that he does not like the idea of having to pull stuff off containers in the work he has now, but that is part of the job and he just does what he can. He testified that he used to walk four or five miles a day for exercise and is now not able to do that, and believes he does enough walking at work. Petitioner testified that he bow hunts for deer, and walking the terrain back and forth to the stand and climbing up and down the stand causes him to

be out of breath. When walking out of the woods back to his truck he sometimes has to stop and take a break. He noted that his furthest deer stand from the road is probably 50 yards. He testified that his house is in town and sits on four lots. He mows the yard with a riding mower, but trims it with a push mower and weed eater, which causes him some problems. He testified that when he is not at work, he spends his time sitting at home watching TV.

Petitioner testified that his prior family physician was Dr. James Alexander and that he currently sees Dr. Colleen Lawler-Bjornderg at the VA in Harrisburg. He testified that he saw Dr. Alexander for breathing issues, who treated him for bronchitis on numerous occasions and also for pneumonia.

Petitioner testified that he has never smoked. In addition to his breathing issues, he also has high cholesterol, high blood pressure, tinnitus, and neck problems. He testified that while working for Respondent, he completed his job every day, but that it was getting harder to do so at the end of his career.

Prior to his layoff on August 28, 2015, Petitioner received a letter from the Senior Vice President for American Coal advising him of the layoff. He testified that the reason he told the State of Illinois that he left his job with Respondent was layoff, lack of work. He testified that there were many others laid off on that same date.

Petitioner testified that in his job with FedEx there are three to four aircraft containers in the truck and it takes two or three people to pull those out of the truck. The packages inside the containers are then taken out and put on the truck that Petitioner drives. He has a B Class CDL, which means that he can drive anything up to and including a school bus, but he cannot drive an 18-wheeler. When he is finished unloading the containers, he then starts loading packages into his delivery van. He testified that the packages range from documents up to large packages. The weight limit for FedEx is 150 pounds. He has had some items that weighed close to 100 pounds. The number of deliveries in a day varies. He might have 60 or more packages to deliver, and may make three to five stops or 50 to 60 stops. There might be many packages that go to the same address on a particular day. He testified that he is in and out of his van quite a bit during the day. He is required to climb stairs at some of the places where he delivers. He testified that bending over and picking up packages and stacking them in his van causes him breathing problems; carrying and unloading 100-pound packages causes breathing problems for him; and climbing stairs carrying packages on his deliveries causes him breathing problems.

Petitioner testified that he injured his neck while working in the mine on numerous occasions and that he jammed his neck pretty badly. He had not had any surgery, injections or chiropractic care with regard to his neck. He testified that it bothers him to turn his head to the left if he has to look over his shoulder at oncoming traffic. It also bothers him when lifting. He has numbness in his left hand, and his left little finger tingles. He had carpal tunnel surgery performed last year at the VA and, along with that surgery, they relocated his ulnar nerve in the left elbow. He testified that he still has a little trouble from that. He testified that they have done an MRI of his neck and want to perform surgery, but he has not given the OK yet.

Petitioner testified that from time to time while he was employed at the coal mine, he underwent chest x-ray screening by NIOSH to determine whether he had black lung. After each chest x-ray was performed, he would receive a letter telling him what the x-ray revealed. He did not bring any of those letters with him to arbitration. He testified that he saw Dr. Istanbouly one time in December 2015 at the request of his attorney to work him up for this claim. He testified that he would have been honest with Dr. Istanbouly at that time about what his problems were.

Medical Records

Dr. Suhail Istanbouly

Dr. Suhail Istanbouly examined Petitioner on December 29, 2015, at the request of his counsel. He testified by way of deposition on July 5, 2017. Dr. Istanbouly is a physician specializing in pulmonary medicine and critical care medicine. He estimated that about 30% of his patient census deals with the care and treatment of coal miners. He has done black lung examinations in the past for the U.S. Department of Labor. He has been the medical director of the pulmonary department of Herrin Hospital since 2005. He is also the director of the intensive care unit of Carbondale Memorial Hospital. PX1.

Dr. Istanbouly noted that Petitioner was a coal miner for 36 years with most of his jobs being underground. As to past medical history, he noted that Petitioner was diagnosed with asthma during early childhood. He had also been treated for obstructive sleep apnea. He denied a chronic daily cough. He reported intermittent cough with no significant sputum production and denied significant exertional dyspnea. According to Petitioner he was able to walk five miles a day. He mentioned having occasional wheezing. PX1.

Dr. Istanbouly testified that Petitioner's pulmonary function testing was normal. His chest x-ray revealed mild interstitial changes consistent with simple coal workers' pneumoconiosis, which he noted was confirmed by Dr. Henry Smith, B-reader. He testified that Petitioner's physical examination did not show significant abnormality. PX1.

Dr. Istanbouly testified that Petitioner's pulmonary function test results were within normal limits according to the American Thoracic Society Guidelines. He testified that Petitioner's FEV1/FVC of 70% was at the lower limits of the Guidelines. He testified that he would expect someone with category 1 pneumoconiosis to have either normal pulmonary function testing or mild abnormality. He noted that if pneumoconiosis is early stage, it is not unusual for a person to have normal pulmonary function tests. He testified that having pulmonary function tests in the range of normal does not necessarily mean that the lungs have not been damaged but, rather that the damage is early stage. PX1.

Dr. Istanbouly testified that one does not have to be a B-reader to diagnose someone with coal workers' pneumoconiosis. He personally reviewed and interpreted Petitioner's chest x-ray of September 1, 2015, and opined that the findings on the chest x-ray revealed mild interstitial changes bilaterally. He explained that coal workers' pneumoconiosis can cause scarring and a form of emphysema to occur. The scarring and fibrosis of coal workers' pneumoconiosis is permanent and cannot carry on the function of normal healthy lung tissue. He testified that, by

definition, if one has coal workers' pneumoconiosis, he has an impairment of the function of the lungs at least at the site of the scar. He opined that the cause of Petitioner's coal workers' pneumoconiosis was long term coal dust inhalation, based upon his history, chest x-ray, and pulmonary function testing. Dr. Istanbouly testified that there is no cure for coal workers' pneumoconiosis and that it is advisable from a medical standpoint that Petitioner not go back to work in a coal mine and to avoid any further coal dust exposure. PX1.

Dr. Istanbouly performs five to seven examinations in state black lung claims each month. He testified that they are always done for claimant attorneys. Other than the history of childhood asthma, Petitioner related no past history of respiratory disease. He had no chronic cough, no significant sputum, and did not suffer from chronic bronchitis. Petitioner was unable to identify any triggers for his cough. He was not taking any breathing medications, but was taking medications for cholesterol and high blood pressure. Petitioner did not tell Dr. Istanbouly that he left the mine when he did due to respiratory problems, and he did not relate any difficulties in performing his last job duties at the mine. Dr. Istanbouly did not diagnose Petitioner with an obstruction. He testified that there was no indication of restriction from the spirometry that he performed, and that Petitioner's O2 saturation at rest was 98%, which is normal. PX1.

Dr. Istanbouly testified that he is not an A-reader or a B-reader of films. He did not provide a profusion rating for the film he interpreted. He could not say whether the film revealed a profusion of 0/1 or 1/0. He could only tell whether it was mild, moderate or severe. He did not mention in his report whether the film was digital or not, but he assumed it was digital and was of good quality. If it was not of good quality, he would have documented that. He assumes that this was a quality 1 film. The only diagnosis Dr. Istanbouly made for Petitioner was coal workers' pneumoconiosis. PX1.

Dr. Henry K. Smith

Dr. Henry Smith testified by way of deposition on January 29, 2019. He is a diagnostic radiologist and has been board certified in radiology since 1973. He first took the B-reader exam in 1987 and has been continuously certified as a B-reader since that time. Dr. Smith testified that he failed the B-reading recertification exam twice somewhere around 1999. He testified that he failed because of overreading the films, and that he was finding more disease than was present on the standard film. He received his Doctor of Osteopathic Medicine in 1968 from Kirksville College of Osteopathic Medicine. He received a D.O., not an M.D. He did a rotating general internship at Carson City Hospital in Carson City, Michigan, and a radiology residency at Memorial Osteopathic Hospital in York, Pennsylvania. He operated his own private radiology practice from 1988 to 2016. Since closing his practice, he has been doing consulting work in the field of radiology including a lot of B-readings. PX2.

Dr. Smith testified that in performing a B-reading, he starts with determining the quality of the film. The next step is to determine if there are any small opacities present. If opacities are present, he determines if there are enough to be called pneumoconiosis. If so, then he determines whether they are round or linear opacities and categorizes them by size. He testified that with coal workers' pneumoconiosis, the preponderance of small opacities are round. With other kinds

of pneumoconiosis, such as asbestosis related, they are linear or irregular opacities. He explained that opacities occur primarily in the upper to mid lung zones in coal workers' pneumoconiosis, and predominantly occur in the mid to lower lung zones in asbestosis. The next thing the B-reader considers is the profusion, which is the concentration or density of the findings in the lungs. Dr. Smith testified that the profusion tells the reader what degree of involvement is present. The last thing included in completion of the B-reading form are the obligatory findings, which means things that need to be recorded other than the findings of black lung. Dr. Smith described an opacity as a small, abnormal density that one would not see on a normal chest x-ray. It is often seen with people that have occupational lung disease or pneumoconioses. Dr. Smith testified that mottle on a film is a pixely type of look, which may look like there is disease there, but the reader is getting a false sense of there being opacities present because of the mottled appearance. PX2.

Dr. Smith reviewed a chest x-ray of Petitioner dated September 1, 2015, at the request of his counsel. He found the film to be quality 1 and did not record any mottle being present on the film. He interpreted the film as revealing the presence of small opacities size P/P in all lung zones, profusion 1/0. Dr. Smith testified that Petitioner had coal workers' pneumoconiosis, based on his review of the chest x-ray, and that Petitioner had damage to his lung as a result of his coal workers' pneumoconiosis. PX2.

Dr. Smith testified that from 1988 to 2016, Smith Radiology was a diagnostic, walk-in, freestanding medical facility. He testified that Smith Radiology was netting $1.25 million in annual income after expenses, and that about 5% of that income was for medical legal exams or interpretations. He testified that over time he has interpreted chest x-rays for black lung for about 20 different law firms and that 80% of those firms represented claimants. He testified that he was reviewing films for asbestosis for 20 to 25 firms. Of those firms, 50% were handling claimants' cases. Dr. Smith testified that presently he is reviewing films for black lung for five firms that represent claimants, and one of those firms is Petitioner's counsel. He has also reviewed films for Culley & Wissore. He testified that he has read more than 345 films for Culley & Wissore or Petitioner's counsel, Culley, Feist, Kuppart & Jordan. Dr. Smith testified that when he received films from either firm, he would get two or three films at a time on a frequency of twice a month. He might receive a tiny bit more than that from Petitioner's counsel. He testified that at his peak he was interpreting 2,000 films a year for law firms. Presently he is interpreting about 1,500 films a year. PX2.

Dr. Smith testified that he has never sat on any committee with NIOSH. He has not held any office in any capacity with either the College of Osteopathic Medicine or the Osteopathic Board of Radiology. He has not published anything on pulmonary disease or served as a manuscript reviewer for any treatise or journal. Dr. Smith testified that the syllabus he used to study for the B-reading exam he pretty much takes as the gospel. He noted that the panel that puts the syllabus together is made up of the peers that he aspires to be, and that the leaders in the field have been chosen to put that syllabus together. He testified that a new syllabus has been authored for NIOSH and acknowledged that Dr. Cris Meyer was one of the authors of that syllabus. Dr. Smith testified that he agrees with the current B-reading syllabus, that small opacities associated with the exposure to silica and coal dust are usually rounded. He testified that the scarring that is reflected by the opacities on chest imaging are permanent, so profusion

would not regress, and the opacity size would not regress. He agreed with the B-reading syllabus that the small, rounded opacities usually involve the upper lung zones first and as the dust exposure continues, all the lung zones may become involved. He testified that has been his experience. PX2.

Dr. Smith testified that simple pneumoconiosis is unlikely to progress once the exposure ceases. He testified that pulmonary impairment is determined by appropriate valid pulmonary function testing and not by chest x-ray. He testified that, with regard to Petitioner's chest x-ray of September 11, 2015, he did not identify any calcified granuloma. If he had done so, he would have marked same in Section 4(b) of the B-reading form. He testified that he saw opacities in all lung zones. He testified that the progression of small, round opacities from the upper and mid lung zones to the lower lung bases is a process that would take some time to develop, and would take more than a few weeks. He testified that it is not uncommon for B-readers to differ as to quality ratings on a film, as between a 1 and a 2. PX2.

Dr. Smith did not know whether the monitors he uses for interpreting chest x-rays meet the guidelines that are set forth in the Code of Federal Regulations. He did not know whether his equipment complied with the DICOM standard that is set forth in the Code of Federal Regulations. PX2.

Dr. Cristopher Meyer

Dr. Cristopher Meyer testified by way of deposition on August 26, 2016. He reviewed a PA chest radiograph for Petitioner dated September 1, 2015, from Ferrell Hospital. He testified that same was quality 2 due to mottle. He testified that when mottle is present in a film, it typically mimics small rounded opacities, size P, and would actually involve all lung zones, the soft tissues, and any area that is included on the exam. Dr. Meyer testified that there was a calcified granuloma at the left lung base. Otherwise the lungs were clear. There was some degenerative spurring of the mid thoracic spine. Dr. Meyer's impression was no radiographic findings of coal workers' pneumoconiosis. Dr. Meyer testified that the film he reviewed was delivered to him on a CD. He testified that all the data he had on that CD would be on any other CD that was made of that image and disseminated. He testified that there are standards for the digital equipment that have been put out by NIOSH for the Coal Workers' Health Surveillance Program, which requires a high-resolution monitor, use of the full DICOM data set and also periodic quality assurance. Dr. Meyer testified that this is the type of equipment that he uses. He testified that the DICOM data set is just the way that the data is translated from one machine to another. It conforms to a specific radiological standard so that it is reproducible on every machine. RX1.

Dr. Meyer has been board certified in radiology since 1992 and has been a B-reader since 1999. He testified that he was asked to take the B-reading exam by Dr. Jerome Wiot, who was part of the original committee that designed the teaching program which is called the B-reader program. Dr. Meyer has recently been asked to have a more active academic role in the B-reader program. He is on the College of Radiology Pneumoconiosis Task Force, which is engaged in redesigning the course and submitting cases for the B-reader training module and exam. He testified that the faculty for the B-reading course is typically experienced senior level B-readers.

Dr. Meyer testified that to become a B-reader one takes the weekend course which includes a series of lectures describing the B-reading classification system. The teachers of the course go through standard examples of the various components of the B-reading system. The course participants then review a series of practice examples with mentors overseeing the practice examples. At the end of the weekend there is an exam. Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading exam than other specialties. He opined that this was because radiologists have a better sense of what the variation of normal is. He testified that one of the most important parts of the B-reader training and examination is making the distinction between a 0/1 and 1/0 film. RX1.

Dr. Meyer testified that the B-reader looks at the lungs to decide whether there are any small nodular opacities or any linear opacities and, based on the size and appearance of those small opacities, they are given a letter score. He testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described as small round opacities. Diseases that cause pulmonary fibrosis, like asbestosis, will be described as small linear opacities. Distribution of the opacities is also described, because different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper lung zone predominant process. Idiopathic pulmonary fibrosis or asbestosis is a basilar or linear process. The last component of the interpretation is the extent of lung involvement or the so-called profusion. Dr. Meyer testified that the profusion is basically trying to define the density of the small opacities in the lung. RX1.

Dr. James R. Castle

Dr. James Castle testified by way of deposition on August 2, 2017. Dr. Castle reviewed medical records and chest x-ray of Petitioner at the request of Respondent's counsel. He is a pulmonologist and is board certified in internal medicine and the subspecialty of pulmonary disease. Dr. Castle practiced in Roanoke, Virginia for 30 years. His practice was limited to pulmonary disease and chest disease, which encompassed critical care medicine. His practice included treating patients with occupational lung disease. He had some patients in his practice who had coal workers' pneumoconiosis. Dr. Castle was a B-reader from 1985 through June 30, 2017. He testified that he made a personal decision not to recertify as a B-reader as it was not cost effective. Changes in the federal black lung program made it so that he did not get referred as many x-rays as he did four or five years prior. RX2.

Dr. Castle reviewed a chest x-ray dated September 1, 2015. He testified that the film did not have any parenchymal abnormalities consistent with pneumoconiosis, and showed no evidence of emphysema. He testified that none of the B-readers for which he had interpretations found the presence of emphysema. He knows that because the B-reading form has what is called obligatory symbols, including a symbol for emphysema. A radiologist or a B-reader who was looking at the film was supposed to check the box "em" in Section 4-B if there were any radiographic signs of emphysema present. Dr. Castle testified that for a proper reading of a chest x-ray for pneumoconiosis, he first looks at the quality of the film. He then determines whether or not there are any opacities in the parenchyma, and he does that by comparing the film that he is looking at to the standard ILO classification films. If there are opacities present, then they are characterized based on their size and whether they are round and regular or linear and irregular.

The reader then needs to determine what areas of the lung are involved and lists that, and then determines the profusion. The profusion is determined by comparing the film side by side with the standard ILO classification films. The reader then determines whether there are any large opacities and if there is any pleural disease or pleural changes. RX2.

Dr. Castle testified that the ILO system, and in particular the profusion rating, was developed to get away from using such classifications as mild, moderate or severe. It was devised so that readers could have a very explicit way of communicating about what was on a film. He testified that by using the ILO 12-point system, one can certainly determine whether someone has pneumoconiosis or not. In the United States, a 0/1 classification is considered to be a negative film for pneumoconiosis while a 1/0 and above is considered to be a positive film. The system was designed so that a more accurate interpretation could be done. Dr. Castle testified that the distinction between a film rated a 0/1 and 1/0 profusion is a very difficult thing. It is something that the B-reader course spends a very significant period of time on. RX2.

Dr. Castle testified that it is very unlikely for simple pneumoconiosis to progress once the exposure ceases. He agrees with the position of the American Thoracic Society that an older worker with a mild pneumoconiosis may be at low risk for working in currently permissible exposure levels until he reaches retirement age. The Mine Safety Health Administration does not require a miner with pneumoconiosis to cease all exposure to coal dust. Dr. Castle testified that based on his review of medical records, Petitioner did not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to coal mine dust. Petitioner worked in or around the underground coal mining industry for a sufficient amount of time to have developed coal workers' pneumoconiosis, if he were a susceptible host. RX2.

Dr. Castle testified that a risk factor for the development of pulmonary disease is bronchial asthma. Historical information provided by Petitioner's primary care physician as well as that from Dr. Istanbouly indicated that Petitioner had been previously diagnosed with bronchial asthma. His primary care physician had treated him on several occasions for asthmatic bronchitis. Bronchial asthma is an inflammatory disease of the lungs which is unrelated to coal mine dust and coal workers' pneumoconiosis. There was no physiologic evidence of any impairment related to bronchial asthma. Another risk factor for the development of pulmonary disease and symptoms is obesity. Petitioner was significantly obese. At the time of his last physiologic testing at Methodist Hospital on March 22, 2016, he had a BMI of 39.86. This degree of obesity is frequently associated with a number of medical problems including hypertension, diabetes, and coronary artery disease, as well as potential restrictive lung disease, resting hypoxemia and obstructive sleep apnea syndrome. Petitioner had been diagnosed with obstructive sleep apnea syndrome as well as other medical problems related to obesity. Petitioner did not demonstrate any consistent physical findings indicating the presence of an interstitial pulmonary process. He did not have the consistent finding of rales, crackles or crepitations. On most occasions the examination of his lungs was entirely normal. Dr. Castle testified that the physiologic study obtained by Dr. Istanbouly at the time of his examination on December 29, 2015, was a valid study. His study was entirely normal showing no evidence of an obstruction or restriction. The diffusing capacity obtained at Methodist Hospital on March 22, 2016, was also normal. RX2.

Dr. Castle testified that he is familiar with the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition*. He testified that when the results of Petitioner's pulmonary function testing are applied to Table 5-4 of the *Guides*, Petitioner falls under Class 0 impairment. He opined that from a ventilatory standpoint, Petitioner was capable of heavy manual labor. Dr. Castle testified that Table 5-4 of the *Guides* states that an FEV1/FVC ratio of 75% or greater and/or greater than the lower limit of normal was required for Class 0 impairment. He noted that the lower limit of normal for the FEV1/FVC ratio in testing performed by Dr. Istanbouly on Petitioner was 68.22. The actual ratio in the testing performed by Dr. Istanbouly was 70% on the prebronchodilator study. Based upon that, and applying the American Thoracic Society Guidelines for interpretation of spirometry, he opined that Petitioner did not have an obstruction. RX2.

Dr. Castle testified that coal workers' pneumoconiosis is a chronic dust disease brought about by the inhalation of coal mine dust over a period of working in and around the coal mines. He testified that it is manifested by the presence of an abnormal chest x-ray with small, round regular-type opacities primarily in the upper lung zones but, depending on the severity, may involve the middle and occasionally the lower lung zones. The disease may or may not be symptomatic. Dr. Castle testified that coal workers' pneumoconiosis is a type of interstitial lung disease. Along with that disease process there is scarring and fibrosis that can occur in the lungs. He testified that the scar tissue cannot carry on the function of normal healthy lung tissue. The scarring and fibrosis that occurs with coal workers' pneumoconiosis is permanent and irreversible. Dr. Castle testified that Table 5-5 in the *AMA Guides* addresses impairment related to asthma. In the testing that was performed by Dr. Istanbouly, Petitioner had post bronchodilator testing. His post bronchodilator FEV1 was 86% of predicted. He testified that employing Table 5-5 of the *Guides* would place Petitioner in a Class 0 impairment. RX2.

Other Medical Records

Several chest x-ray interpretations by ***NIOSH*** were admitted into evidence.

1. February 25, 1988—interpreted by an A-reader and a B-reader as being completely negative.
2. July 30, 1996—interpreted by an A-reader and a B-reader as being completely negative.
3. June 20, 2000—interpreted by two B-readers as being completely negative.
4. July 5, 2006—interpreted by an A-reader and a B-reader as not having any parenchymal or pleural abnormalities consistent with pneumoconiosis.
5. August 21, 2015—interpreted by an A-reader and two B-readers as not having any classifiable parenchymal abnormalities. RX3.

Medical records of ***Harrisburg Medical Center*** were admitted into evidence. A chest x-ray was taken on March 11, 1995, for complaints of shortness of breath. The impression was no active lung disease. A chest x-ray taken on September 15, 1997, was compared with the study of March 11, 1995. The lung fields were clear. The impression was no active disease or significant interval change. A chest x-ray was taken on August 21, 2015. It was read as showing benign chronic changes, and tiny benign calcified granulomas in both lung bases. RX5.

Medical records of ***Alexander Family Practice*** were admitted into evidence. Pertinent records are noted as follows. On July 1, 1998, Petitioner was seen for evaluation for Respondent. He provided a history of asthma. His lungs were clear to auscultation. The assessment included asthma which was stable. On March 20, 2000, Petitioner was seen for evaluation of cough, congestion, shortness of breath and occasional productive cough. The lungs had inspiratory and expiratory wheezes. Assessment was asthmatic bronchitis. On June 19, 2002, Petitioner had an examination for commercial driver fitness determination. On the health history form he indicated that he had no shortness of breath, lung disease, emphysema, asthma or chronic bronchitis. On July 3, 2002, Petitioner was seen for evaluation of ankle discomfort. He also complained of a bit of a dry cough which had become productive. On examination his lungs were clear. He was diagnosed with bronchitis and prescribed an antibiotic and medication for the cough. RX6.

On May 28, 2004, Petitioner was seen for evaluation of sinus congestion. He reported cough and congestion. His lungs were clear. He was diagnosed with sinusitis and bronchitis. He was advised that it should improve with time. On May 8, 2006, Petitioner was evaluated. He reported no chest pain or shortness of breath. His lungs were clear. RX6.

On November 21, 2007, Petitioner complained of cough and congestion. His lungs were clear on physical examination. Assessment was upper respiratory infection/pharyngitis. On June 3, 2010, he was evaluated and reported no chest pain or shortness of breath. On physical examination his lungs were clear. On May 16, 2011, he was evaluated. His active problems included sleep apnea, hyperlipidemia, hypertension and sepsis. He had no dyspnea or cough on review of systems. His lungs revealed normal breath sounds with no wheezing, rhonchi or rales. On June 22, 2012, he was evaluated. His review of systems pulmonary showed no dyspnea or cough. On physical examination of the lungs there were normal breath sounds with no wheezing, rhonchi or rales. On October 4, 2012, Petitioner was seen for complaint of chapped lips for two weeks. He reported cough without production of sputum in history of present illness. On examination his lungs were clear to auscultation. RX6.

On September 23, 2013, Petitioner was seen for a lab recheck. His review of systems pulmonary showed no dyspnea or cough. On examination he had normal breath sounds with no wheezing, rhonchi or rales/crackles. On December 19, 2014, Petitioner was evaluated. Social history at that time indicated Petitioner was a former smoker. Review of systems pulmonary showed no dyspnea or cough. Petitioner's BMI at that time was 37.6. Physical examination of the lungs revealed normal breath sounds with no wheezing, rhonchi or rales/crackles. The assessment included extrinsic asthma. Petitioner was seen on December 21, 2015, for follow up. He complained of some dyspnea and polyphagia. Review of systems pulmonary included a history of 37 years in mining but no dyspnea and no cough. On physical examination of the lungs he had normal breath sounds with no wheezing, rhonchi or rales/crackles. 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. 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 occupational disease occurred that arose out of and in the course of Petitioner's employment by Respondent, and issue (F), whether Petitioner's current condition is causally related to the injury, the Arbitrator finds the following:

To recover compensation under the Workers' Occupational Diseases Act, a claimant must prove that he suffers from an occupational disease and that a causal connection exists between the disease and his employment. An occupational exposure need not be the sole or principal causative factor, as long as it was a causative factor in the condition of ill-being. *Bernardoni v. Industrial Comm'n*, 362 Ill.App.3d 582, 596 (3rd Dist. 2005).

In this case, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he suffers from coal workers' pneumoconiosis. In so concluding, the Arbitrator relies, in part, upon the findings of the NIOSH A-reader and two B-readers that Petitioner's chest x-ray of August 21, 2015, was negative for pneumoconiosis. No evidence was introduced to counter the negative interpretation of the August 21, 2015, chest x-ray. The Arbitrator further notes that all of the NIOSH B-readers and A-readers found Petitioner's chest x-rays of February 25, 1988, July 30, 1996, June 20, 2000, and July 5, 2006, to be negative for coal workers' pneumoconiosis. The Arbitrator, however, gives less weight to these interpretations due to the temporal remoteness of those x-rays to Petitioner's last date of exposure. The Arbitrator relies upon the opinions of the NIOSH physicians, as NIOSH is the governmental agency responsible for administering the health surveillance program for the benefit of coal miners. NIOSH is not a party to this action, and the x-rays were taken and reviewed for reasons independent of litigation.

Further, the Arbitrator finds the B-reading interpretations and opinions of Dr. Meyer and Dr. Castle to be more persuasive than the B-reading by Dr. Smith. The Arbitrator gives no weight to Dr. Istanbouly's x-ray interpretation, because in his testimony he did not properly describe the findings of the chest x-ray for it to be a useful interpretation.

The only chest x-ray interpreted by the experts retained by the parties to this case was taken on September 1, 2015, which was just 10 days after the last chest x-ray interpreted as negative by NIOSH. Dr. Smith testified that the progression of small round opacities from the upper lung zones to the lower lung bases would take some time to develop and that same would not progress within a few weeks. The Arbitrator finds that it is very unlikely that Petitioner's chest x-ray would progress from being completely negative to having opacities in all lung zones in only 10 days. The B-readings of Dr. Meyer and Dr. Castle of the same September 1, 2015, chest x-ray are consistent with the negative B-readings of the NIOSH chest x-ray taken 10 days earlier, on August 21, 2015.

Dr. Istanbouly's testing as part of his examination of Petitioner on December 29, 2015, was normal. Dr. Castle testified that the study obtained by Dr. Istanbouly showed no evidence of an obstruction or restriction. The diffusing capacity obtained at Methodist Hospital on March 22, 2016, was also normal.

Dr. Castle testified that when he applied the Table 5-4 of the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition*, to Petitioner's testing, Petitioner fell in Class 0 Impairment. Dr. Castle testified that from a ventilatory standpoint, Petitioner would be capable of heavy manual labor.

The Arbitrator notes that there were treatment records for Petitioner which were admitted into evidence. During his treatment at Alexander Family Practice, Petitioner was on occasion treated for asthmatic bronchitis and/or bronchitis. No physician ever related these conditions to Petitioner's coal mine employment. There was nothing in the treatment records indicating that Petitioner suffered from an occupational disease.

The Arbitrator finds that the reverberation of opinions amongst B-readers Dr. Meyer and Dr. Castle, in conjunction with the aforementioned opinions of the NIOSH A-readers and B-readers, to be compelling.

Based upon the foregoing and the record in its entirety, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he suffers from coal workers' pneumoconiosis and/or reduced pulmonary capacity that arose out of and in the course of his exposures in the coal mine, and that his current condition of ill-being is causally related to his employment. All benefits are denied. The remaining issues are moot, and the Arbitrator makes no conclusions as to these issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gena Broner,
Petitioner,

vs. No. 15 WC 03903

Saks Fifth Avenue,
Respondent.

20IWCC0187

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, duration of temporary total disability, medical expenses, prospective medical expenses, and compliance with IWCC Administrative Rule 9110.10 (former Rule 7110.10), 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 including a determination of permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327 (1980).

The Commission notes one portion of the arbitration decision requiring discussion on review. Although neither party included vocational rehabilitation or the implementation of Rule 9110.10 as an issue on the Request for Hearing form, the Arbitrator, as part of his Decision, ordered Respondent to provide a written assessment by a certified rehabilitation counselor of Petitioner's choice. Pursuant to Section 9110.10(a) of the Commission Rules, an employer's vocational rehabilitation counselor shall prepare a vocational rehabilitation written assessment when the period of total incapacity for work exceeds 365 days or when it can be reasonably determined that the injured worker will be unable to resume the regular duties in which she was engaged at the time of her injury. 50 Ill. Admin Code 9110.10(a). The Arbitrator found, and the Commission agrees, that Petitioner was temporarily totally disabled for 187 and 1/7ths weeks, clearly in excess of the 365 days required to trigger the rule's written assessment requirement.

20IWCC0187

The Commission finds that, although the parties did not raise the implementation of the rule as an issue at arbitration, the Arbitrator's findings and conclusions, affirmed here, reaffirm Respondent's duty under the rule. However, the Arbitrator specified that the vocational counselor be of Petitioner's choice. No such proposition is evident from the rule, which requires the contrary. As noted above, the rule specifically provides that the written assessment be prepared by the employer's vocational rehabilitation counselor. For this reason, the Commission modifies the Arbitrator's Decision to provide that Respondent's vocational rehabilitation counselor shall prepare the written assessment in accordance with Section 9110.10(a) of the Commission Rules. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 22, 2018, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent have its vocational rehabilitation counselor prepare a written vocational rehabilitation assessment in compliance with Section 9110.10.

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

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

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 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 16 2020

Marc Parker

Deborah L. Simpson

Barbara N. Flores

mp/dak
o-02/20/20
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRONER, GENA
Employee/Petitioner

Case# **15WC003903**

SAKS FIFTH AVENUE
Employer/Respondent

20IWCC0187

On 8/22/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% 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:

2553 McHARGUE & JONES LLC
MATTHEW C JONES
123 W MADISON ST SUITE 1800
CHICAGO, IL 60602

5001 GAIDO & FINTZEN
GAIL BAMBNISTER
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

GENA BRONER
Employee/Petitioner

v.

SAKS FIFTH AVENUE
Employer/Respondent

Case # 15 WC 3903

Consolidated cases:

20IWCC0187

An *Application for Adjustment 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 **May 15, 2018 & JUNE 18, 2018** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0187

FINDINGS

On **October 14, 2014**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of these accidents 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 **$36,164.70**; the average weekly wage was **$695.48**.

On September 20, 2013, Petitioner was **33** years of age, ***single*** with 0 dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$64,579.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

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

ORDER

Temporary Total Disability

IT IS HEREBY ORDERED Respondent shall pay to Petitioner and her attorney of record the temporary total disability benefits of $417.29/week for 187 1/7 weeks, commencing October 14, 2014 through May 15, 2018, as provided in Section 8(b) of the Act. Respondent is entitled to a credit of $63,164.70 in TTD.

Medical Benefits

IT IS HEREBY ORDERED Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of

ILLINOIS BONE AND JOINT INSTITUTE: $1,283.96, STREETERVILLE OPEN MRI: 5,400.00 , ACHIEVE ORTHOPEDIC REHABILITATION INSTITUTE: $1,525.00, ACCELERATED REHABILITATION CENTERS: $6,180.00, MICHIGAN AVE MEDICAL ASSOCIATES: $226.00, PAIN SPECIALISTS OF GREATER CHICAGO: $8,724.23, UNIVERSITY PAIN PHYSICIANS: $58,540.00, RUSH SURGICENTER: $176,836.00, HINSDALE SURGICAL CENTER: $11,742.00, RUSH UNIVERSITY MEDICAL CENTER: $102,455.87, NORTHSHORE UNIVERSITY HEALTH SYSTEM: $23,659.00.

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

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

#001 Arb. George J. Andros
Signature of Arbitrator

8/21/18
Date

AUG 22 2018

Findings of Facts & Conclusions of Law 15 WC 3903

Gena Broner, (Petitioner) testified that she is currently an employee of Saks Fifth Avenue, (Respondent) and has been employed there since 2005. Tx6. Petitioner was employed as a salesworker, specifically in the fragrance department. Tx7. Petitioner's average work day for Respondent was seven and a half hours a day, during which she would spend the entirety of her shift on her feet. Tx9. Petitioner worked at Respondent's place of business at 700 Michigan Avenue, Chicago IL. Tx9.

Petitioner testified that there is an employee entrance, which she was required to use. Tx11. This entrance is located in the back of her building at the corner of Rush and Superior, and is intended solely for employee use. Tx11-12. There is an alternate entrance on Michigan Avenue, but this entrance is meant for customers, and employees were not allowed to use it. Tx11-12. At the entrance on Rush and Superior, there is a sign that says the entrance is for employees only, and it is Petitioner's, unrebutted understanding from her nearly fourteen years' experience working with Respondent, that employees were only allowed to use that entrance. Tx12.

On October 14, 2014 Petitioner was scheduled to work at 9:30, which was her regular start time. Tx11. Petitioner arrived at work at approximately 9:25 when was dropped off by her boyfriend in front of the employee entrance. Tx11. Petitioner exited the vehicle approximately three feet away from the entrance. Tx13. Petitioner estimated that she took no more than three steps outside before she was inside the Respondent's building.

Petitioner does not recall what the weather was like on this day. Tx15. She testified, however, that after she entered the building that she did not notice any moisture or other substances on her shoes tracked in from outside. Tx15. Megan Bornhauser testified for the Respondent that it had rained earlier that morning, but did not remember if it was raining at the time of Petitioner's accident. Tx97.

Petitioner testified that the normal door she used to access the employee entrance was closed off. Tx14. Alternatively, there was another door a few feet away

propped open by a cone. Tx14-15. This door led to the same entrance as the usual employee door. Tx15-16.

After having walked two or three steps into the building, Petitioner slipped and fell on the ground on her left side. Tx16. When she fell, Petitioner's left shoulder, neck, head and the heel of her left foot hit the ground. Tx17. Petitioner testified that, when she fell, it was due to a slip rather than a trip, and that she slipped backwards. Tx17. After she slipped and was on the ground, Petitioner noticed that the ground was wet. Tx18. Petitioner testified that it felt as if she slipped on a liquid when she fell. Tx18. The area of her shirt and pants that hit the ground were wet where they touched the floor, and Petitioner testified that she smelled something on her body after hitting the ground. Tx18. Specifically, Petitioner's clothes were damp, and she smelled a chemical. Tx19. The parts of her body that did not touch the ground were not damp. Tx19.

After falling, Petitioner experienced immediate pain on her neck, left shoulder, left side, and foot. Tx20. There were construction workers who ran to her and put up a wet floor caution sign. Tx20. The construction workers were working on the inside entrance of the closed employee door. Tx20.

One of the construction workers yelled to Nick Marcolini, security for the Respondent, who came to the scene and filled out a report. Tx21.

Petitioner called her boyfriend to pick her up, who took Petitioner to the doctor. Tx22, 24. It took Petitioner's boyfriend approximately 5-7 minutes to come back to get her, and in that time Petitioner briefly spoke Mr. Marcolini and Ms. Bornhauser. Tx22-23.

Petitioner was brought to her primary care doctor, Dr. Yvette Shannon at North Shore Medical Group, immediately following the accident. Tx24; P1. Petitioner reported to Dr. Shannon that she had fallen entering her building, when she slipped on the wet floor. P1. Dr. Shannon ordered x-rays of Petitioner's body and left heel, and an MRI of Petitioner's left shoulder. Tx24; P1. Dr. Shannon took Petitioner off work. Tx25; P1. During the week following Petitioner's fall, she experienced pain on her left side. Petitioner's heel had hurt immediately following the accident, but on the subsequent fourth day, it developed into excruciating, throbbing pain. Tx25.

On October 23, 2014 Petitioner went to see Dr. Douglas Solway at Illinois Bone and Joint Institute. Tx26; P2. Dr. Solway is a podiatrist. Tx26. Petitioner complained to Dr. Solway that she was unable to apply any weight to her left heel. P2. At this time, Dr. Solway also took Petitioner off work and gave her a CAM boot and crutches. Tx26; P2. Dr. Solway referred Petitioner to Dr. Breslow with Illinois Bone and Joint to treat her neck and left shoulder. Tx26; P2.

On October 30, 2014 Dr. Solway noted that Petitioner was significantly hypersensitive to the pain in her left heel. P2.

Petitioner underwent an MRI of her left foot on November 5th, 2014 and underwent an injection into her left heel on November 7th, performed by Dr. Solway. Tx27, P2. The injection provided Petitioner with temporary and incomplete relief. Tx28. Petitioner also underwent physical therapy with Northshore University for her neck and left shoulder. Tx28, P1.

On December 10, 2014 Petitioner was referred to Dr. Daniel Homer, a neurologist, by Dr. Shannon, for treatment of her neck pain and migraines. Tx28; P1. Petitioner had a history of migraines prior to her accident, but experienced a dramatic increase in their frequency, subsequent. Tx29-30; P1. In addition to the increase in frequency, the Petitioner's migraines following the accident were different in quality and location. They were near occipital, shooting up from the left side of Petitioner's neck, as opposed to the aura based migraines she previously had experienced. Tx29, P1. After approximately a month and a half after beginning treatment with Dr. Homer, Petitioner's migraines dissipated. Tx31, P1.

Petitioner began another course of physical therapy in January of 2015 at Accelerated Rehabilitation Centers, under the care of Dr. Solway and Dr. Breslow, for her left foot, left shoulder, and neck. Tx31, P6. The physical therapy helped Petitioner her neck and left shoulder, but the symptoms in her left foot remained unchanged. Tx32, P6. On January 9th, 2015 Dr. Breslow noted that Petitioner's shoulder pain had resolved, although she continued to experience some neck pain. Tx32; P2.

Petitioner went to Michigan Avenue Medical Associates on January 29th, 2015 for a second opinion. Tx32; P3. Dr. David Shafer recommended a nerve block for

Petitioner's foot and an MRI, due to concerns that Petitioner was suffering from Complex Regional Pain Syndrome. P3. Petitioner underwent this nerve block on February 6th, 2015. Tx33-34; P3. Dr. Shafer and Dr. Jain from Michigan Avenue Medical Associates both opined that Petitioner should remain off of work. Tx34; P3.

Following her treatment with Michigan Avenue Medical Associates, on February 23, 2015 Petitioner discussed her treatment with Dr. Solway. P2. Dr. Solway opined that he also believed Petitioner was suffering from CRPS due to her hypersensitivity and coolness to her skin, and subsequently referred Petitioner to Dr. Goodman with Greater Chicago Pain Specialists on March 9th, 2015. Tx34; P2; P3. Dr. Goodman performed a bone scan, and prescribed aqua therapy. Tx35; P3.

At this point, Petitioner's left foot symptoms included discoloration in her left leg, described at almost albino. Tx36. Petitioner noted hair growth changes, and felt as if the pain in her left heel had started to move up into her leg. Tx36.

Petitioner saw Dr. Goodman on April 10, 2015 where he also diagnosed her with CRPS. P4. Dr. Goodman based this on Petitioner's extreme hypersensitivity, cool skin, and pallor. P4. Dr. Goodman recommended a series of nerve blocks, the first of which Petitioner underwent on June 11, 2015. Tx37-38; P4. This first nerve block provided relief for two days. Tx39. Petitioner underwent her second nerve block on July 2nd, 2015. Tx39. Petitioner's pain returned after the nerve block wore off. Tx40.

Additionally, once the nerve block wore off, Petitioner noted that her left leg again lost color and experienced abnormal hair growth on her lower left extremity. Tx40. Petitioner had not experienced hair growth changes or discoloration prior to her accident. Tx41. Petitioner underwent six nerve blocks while under the care of Dr. Goodman, each provided Petitioner with temporary relief and then a subsequent return to usual pain. Tx41; P4. Petitioner did physical therapy and was off work while treating with Dr. Goodman. Tx41.

Dr. Goodman referred Petitioner to Dr. Timothy Lubenow at Rush University, who she saw on March 30, 2016. Tx42; P5. Petitioner reported to Dr. Lubenow that she slipped and fell on a chemical while at work on October 14, 2014, and had had chronic pain and increased sensitivity in her heel ever since. P5. Dr. Lubenow

recommended another series of nerve blocks, and Petitioner underwent one per week over seven weeks. Tx42; P5. These nerve blocks again provided temporary relief, followed by a return of her symptoms. Tx46. Petitioner was also seen by a psychiatrist at Rush, Dr. Merriman, who Petitioner saw in conjunction with her treatment under Dr. Lubenow. Tx43; P5.

On May 5th, 2016 Petitioner suffered an unrelated accident. Tx43-44. Petitioner was at a restaurant, where a 150 pound painting fell on her head. Tx44. This accident re-injured Petitioner's head and neck, which at this point at recovered fully following her injury on October 14, 2014. Tx45. It did not affect her pain in her left lower extremity. Tx45. At the time of this accident, Petitioner was in middle of a series of nerve blocks prescribed by Dr. Lubenow, which she continued to get on schedule. Tx45; P8. This trauma has no bearing on the case at bar.

Petitioner experienced significant relief following a nerve block. Tx46. During the initial series of nerve blocks performed by Dr. Lubenow, Petitioner was still in a CAM boot. Tx46; P5. The nerve blocks, however, allowed Petitioner to remove the boot and put pressure on her left heel. Tx46. On July 7th, 2016 Petitioner told Dr. Lubenow, that the last nerve block provided her with 100% relief for seven days. P5. Following this nerve block, the extreme pain, left foot coldness, and sweating returned, as it had with all previous injections. P5. At this time, Dr. Lubenow recommend a continuous epidural injection. Tx46-47; P5. This was done on August 16, 2016 during which Petitioner was admitted to Rush Hospital for ten days. Tx47; P8. While on the continuous epidural Petitioner experienced lessened pain and participated in more fully in physical therapy at the hospital. Tx48-49; P8. Petitioner's pain again returned once she was taken off the continuous epidural. Tx49; P8.

On September 1, 2016 Petitioner saw Dr. Lubenow. She felt better overall, but continued to experience temperature changes, and abnormal hair growth in her left lower extremity. P9x42. Dr. Lubenow noted that this lack of hair growth on her left leg was difficult to measure because Petitioner shaved. P9x43.

On October 12, 2016 Petitioner still had persistent of pain. P5, P9x46. Additionally, Petitioner had persistent complaints of discoloration of the left leg and

hypersensitivity. P5, P9x47. She had allodynia in her left heel. P5, P9x48. She also complained of an inability to dorsiflex her left ankle on that particular day. P5; P9x47. Petitioner was unable to completely bear weight on her left extremity, and was using a crutch and CAM boot again. P5, P9x47.

Dr. Lubenow recommended that Petitioner proceed with a trial spinal cord stimulator. Tx49; P5. P9x53-54. For this trial, Petitioner was required to get psychological clearance by Dr. Merriman, which she underwent on October 2016. Tx49; P5. The week before Petitioner underwent the stimulator trail implantation, she continued to experience extreme pain, discoloration in her left lower extremity and hair growth changes. Tx50.

After the trial implantation on November 4th, 2016 Petitioner experienced significant pain reduction. Tx50; P5. She was able to put her foot down, something she had only been able to do previously while on a nerve block. Tx51; P5. After the stimulator trial was removed Petitioner's symptoms returned. Tx51. Petitioner underwent one final injection on November 21st, 2016 following her stimulator trial. Tx51; P5.

On December 12, 2016 Dr. Lubenow permanently implanted the DRG stimulator. Tx51; P5. Petitioner still had the DRG stimulator implanted as of the day of trial, May 15, 2018. Tx52. Petitioner has a portable device that allows her to manually activate the stimulator, so that she can adjust it as needed. Tx53-54.

After the initial implantation of the DRG stimulator, Petitioner experienced incomplete relief of approximately 25-30 percent. Tx54; P5. Dr. Lubenow adjusted the implant, and at Petitioner's appointment a month and a half following implantation, Petitioner was receiving maximum relief. Tx55; P5. Petitioner continued physical therapy and remained off work per Dr. Lubenow. Tx55; P5.

Petitioner's relief while on the DRG stimulator allowed her to put her foot down, and participate more successfully with physical therapy, but did not return Petitioner to pre-accident pain levels. Tx55; P5. On April 19th, 2017 Dr. Lubenow sent Petitioner to physical therapy at Achieve Orthopedic Therapy. Tx56-57; P5. On April 19th, 2017 Dr. Lubenow told Petitioner that she would be able to return to

work in a sedentary position that allowed her the flexibility of sitting and standing as tolerated. P5, P9x67. Respondent did not offer light duty to Petitioner at this time. On June 28, 2017 Dr. Lubenow revised his work restrictions so that they limited the amount of standing, walking or sitting to what Petitioner is able to tolerate, in addition to a 10lb weight restriction. P5. These restrictions remained in place through the date of the trial. Tx58. Petitioner contacted Respondent to return to work with light duty. Tx58. As of the date of trial, Petitioner had not received any offer of work conforming to her current restrictions. Tx58.

Petitioner's most recent date of treatment was with Dr. Lubenow on December 21, 2017, with a follow up in June 2018. Tx59; P5. Petitioner was ordered to continue with physical therapy and stay on the light duty restrictions. Tx59-60; P5. Petitioner has not worked anywhere else since her accident on October 14, 2014. Tx60.

Petitioner continues to require a cane for ambulation. Tx60. Weather changes, especially when cold or wet, increase Petitioner's difficulty with putting weight on her left foot. Tx60.

Cold weather causing throbbing in her foot, although at a significantly reduced level than she had experienced while not medicated by a stimulator or nerve block. Tx61. Petitioner continues to perform home exercises, and expects to start another course of physical therapy. Tx61-62.

Petitioner is able to adjust her stimulator, which she does approximately every 45 minutes in the winter. Tx62-63. Petitioner continues to not stand very often, and limits her walking. Tx63. During the summer, Petitioner does not need her cane as much, and makes less frequent adjustments to her stimulator. As a result of the stimulator, Petitioner has been able to drastically reduce her medication use, including elimination Gabapentin entirely. Tx64. Petitioner continues to take five milligrams of Vicodin occasionally, more frequently in the winter. Tx64. Prior to her stimulator, Petitioner was taking 1600-1900 milligrams of Gabapentin and daily doses of Vicodin. Tx64. Prior to Petitioner's workplace accident on October 14, 2014 she had never had CRPS or any other nerve related issues pertaining to her left foot.

Megan Bornhauser

Ms. Megan Bornhauser testified for the Respondent. Tx91. Although not currently employed by Respondent, she was on October 14, 2014 when she worked as a talent development manager. Tx92.

Ms. Bornhauser testified that the employee entrance was behind Respondent's building on Rush St. Tx93. Although there were technically multiple doors to the employee entrance, there was only one door that was generally used because the other doors didn't have handles. Tx92.

All the doors entered into the same main vestibule. Tx92-93. On the day of the accident there was construction happening on the standard employee door. Tx99-100.

On October 14, 2014 Ms. Bornhauser was called to the employee entrance because Petitioner had fallen. Tx95. Ms. Bornhauser was unable to say how much time had elapsed between the accident and her being told it had happened. Tx109. By the time she arrived, Petitioner was sitting on a step, and Petitioner's boyfriend and Nick Marcolini, a member of Respondent's security team, were there. Tx95-96. Ms. Bornhauser testified that Petitioner told her that she had fallen, and that Petitioner had indicated that her shoulder was hurt and that she had difficulty walking. Tx96. She does not remember if Petitioner told her what she fell on or what caused her to trip.

Ms. Bornhauser testified that it had rained that morning, but that she does not remember if it was raining at the time of Petitioner's accident. Tx97. She further testified that she did not see any liquid on the floor. Tx97-98. However, Ms. Bornhauser also testified that she did not look for any liquid on the ground. Tx98. She was unable to say who was present at the time of the accident or whether or not the floor had been cleaned up. Tx109-110.

When Ms. Bornhauser spoke with Petitioner, they were between five and ten feet apart. Tx98-99. She did not notice one way or the other whether Petitioner was wet or dry. Tx99. It was her understanding that Petitioner's boyfriend would be taking her home to rest. Tx100. Ms. Bornhauser is relying on the statements of Petitioner and that of Mr. Marcolini for her understanding of the accident. Tx110.

Ms. Bornhauser testified that this was the extent of her interaction with Petitioner's accident. Tx102. Although she did see Petitioner in October of 2016 at a bar called Arbella. Ms. Bornhauser spoke with Petitioner, who informed her that she had underwent an epidural injection the day prior. Tx104. She did not see whether Petitioner had a cane. Tx104. However, she admitted that it was possible the cane was somewhere else in the bar with her coat. Tx117, Petitioner was wearing heels at that time, but Ms. Bornhauser could not remember whether they were wedges or not or the height of the heels. Tx105. Petitioner testified that sometimes after having underwent a nerve blocks, she was able to wear wedges. Tx87. The testimony of the witness does not in any way erode the Petitioner's testimony nor impact causation or TTD entitlement.

Nick Marcolini

The parties admitted a written stipulation as to what Nick Marcolini would have testified to, had he been called to testify. R3. Mr. Marcolini was employed by Saks Fifth Ave. as a loss prevention officer on October 14, 2014. R3. He did not see Petitioner fall, but reported to the scene after the accident. R3. He authored Respondent's Form 45. R3; R4. Mr. Marcolini did not report in Respondent's Form 45, that Petitioner had told him there were chemicals on the ground, that he had seen any chemicals, or that there were any additional witnesses to the fall. The Form 45 report indicated that Petitioner slipped and fell while entering the back door on her way to work. R4. It indicated that Petitioner slipped and fell on water inside the back door, and that a wet floor sign was out in the area when Mr. Marcolini created the report. R4.

Dr. Kenneth Candido

Dr. Candido performed, over the course of two and a half years, four independent medical evaluations (IMEs) of the Petitioner for the Respondent. Throughout his examinations, Dr. Candido continuously opined that the propriety of care of Petitioner was largely appropriate. R1. In his reports, and testimony, Dr. Candido consistently supported, and even advocated for, Petitioner's ongoing physical therapy and multiple sympathetic nerve blocks, of which Petitioner went 21. R1x36-37, 46-47, 64-65, 77, 108; P5. The only care Dr. Candido opined that he

did not believe was appropriate was the Petitioner's Botox injection on February 3, 2015, the continuous epidural infusion performed by Dr. Lubenow on August 19, 2016, and the DRG Stimulator implanted by Dr. Lubenow on November 4, 2016. R1x36, 65, 77.

On April 28th, 2015 Dr. Candido opined that while Complex Regional Pain Syndrome was a consideration for Petitioner's diagnosis, that neuritis of the left calcaneal nerve was more fitting. R1, April 28, 2015 IME, x14. Dr. Candido continued to express this opinion, based in part on, the belief that Petitioner did not meet enough of the categories outlined in the Budapest Clinical Diagnostic Criteria sufficient to diagnose Complex Regional Pain Syndrome. R1. Throughout his treatment of Petitioner, Dr. Candido consistently identified several signs of CRPS, but believes that she didn't meet enough qualifications to warrant its diagnosis. R1.

Dr. Candido's assessment of Petitioner's injury on April 28, 2015 was that of a calcaneal nerve injury, which he believed would heal within six to twelve months. R1x109. Petitioner was essentially the same at her next appointment with Dr. Candido on October 6, 2015, where he opined that the recovery may actually take up to 24 months. R1x110. Petitioner saw Dr. Candido for a third time on September 20, 2016, almost two years since her accident, at which point Petitioner was still significantly symptomatic per Dr. Candido. R1x110-112. Dr. Candido testified that at this point petitioner was getting "towards as least on standard deviation" when it came to the bell curve of persons diagnosed with calcaneal nerve injuries. R1x113. Dr. Candido opined that, at this time, he would continue the same treatments Petitioner had been receiving, sympathetic nerve blocks and physical therapy ad infinitum, until she healed. Tx114. Dr. Candido saw Petitioner for the last time on March 14, 2017 where he placed her at MMI because her symptoms had changed considerably. R1x116. Dr. Candido opined that Petitioner's recovery was "100 percent" due to the passage of time. Rx116. This last examination took place four months after Petitioner's DRG stimulator had been implanted. P5.

Dr. Candido placed Petitioner on workplace restrictions for the first time on March 14, 2017, saying that she should be provided an opportunity to sit and elevate her left leg and foot once every two hours for ten minutes, and that she

would have difficulty being on her feet for an eight-hour day. R1x79, 125. At all other points, Dr. Candido opined that Petitioner should be kept off work. R1. Dr. Candido opined that, as of the date of his testimony, despite having declared her to be at MMI, he was unsure as to whether or not Petitioner's injury had healed. R1x120. He recommended that Petitioner continue to undergo physical therapy, possibly unlimited in duration. R1x124. The Arbitrator finds the opinions of Dr. Candido are not persuasive at all compared to the opinions of Dr. Lubenow.

Dr. Timothy Lubenow

Dr. Lubenow initially saw Petitioner on March 30th, 2016. P9x11, P5. Petitioner complained of left heel pain, which resulted from a slip and fall on a chemical while at work on October 14, 2014. P9x11; P5. Dr. Lubenow remarked that Dr. Solway did a bone scan on Petitioner, which, combined with her history, indicated possible CRPS. P9x12.

Petitioner complained of sensitivity in her left heel. P9x12; P5. She also felt that there was a temperature difference, and that she had less hair growth over that left extremity. P9x12; P5. Dr. Lubenow noted that these subjective complaints are potential symptoms of CRPS. P9x14.

Dr. Lubenow's objective testing of Petitioner found that she had a decrease in dorsiflexion of the left foot and ankle, and that there was temperature asymmetry between her left foot and right. P9x14-15; P5. Petitioner also had a diminution of pinprick sensation in the left heel, and diminished ability to perceive cold sensation in the left heel. P9x15; P5. Dr. Lubenow testified that at all times he found allodynia in Petitioner's foot and ankle. P9x17-18. CRPS is detected by looking for a number of historical symptoms complained of by patients combined with physical exam findings, known as the Budapest Clinical Diagnostic Criteria. P9x19-20. Dr. Lubenow used these objective findings, combined with Petitioner's subjective complaints, to diagnosis Petitioner with CRPS. P9x16-17. Dr. Lubenow disagreed with Dr. Candido's findings in regards to the criteria necessary to establish CRPS. P9x28-29.

More importantly, however, he opined that Dr. Candido's assessment that Petitioner was suffering from neuropraxia of the calcaneal does not fit with

Petitioner's response to treatment, or the amount of time it took her to recover. P9x 29, 35. The Arbitrator adopts Dr. Lubenow over Dr.Candido on this point and all other medical conclusions and opinions in this case at bar. Dr. Candido's opinions are rejected herein on all points in the case at bar.

Dr. Lubenow recommended that Petitioner undergo a continuous epidural injection. P9x37. This is essentially a continuous nerve block, which is an intermediate treatment step for this condition, according to Dr. Lubenow in his medical expertise. P9x37-38. Thereafter, she experienced a worsening of her condition. P9x49. Dr. Lubenow opined that this development showed him, as an expert in the care and treatment of CRPS, that regional nerve blocks were not going to be successful. P9x49. At this point. Dr. Lubenow felt Petitioner's condition required a more permanent method of managing her pain. P9x49. He recommended that Petitioner undergo a Dorsal Root Ganglion (DRG) stimulator implantation. P9x50.

Dr. Lubenow testified that the DRG stimulator, was a more narrow and focused treatment as opposed a conventional spinal cord stimulator. P9x50-51. It is used for nerve-related pain that is more focused as opposed to wide spread nerve pain. P9x51. Dr. Lubenow opined that this treatment was appropriate for Petitioner, because Petitioner consistently complained of extreme pain in an isolated area of her body, namely her left heel and ankle. P9x51.

Of the three hundred and fifty physicians who are currently trained in this procedure, Dr. Lubenow was one of the first six. P9x52. Dr. Lubenow has trained other physicians in this procedure, and has performed somewhere between a hundred and two hundred of these procedures. P9x52.

The DRG spinal stimulator has generally has a better success rate than the conventional spinal cord stimulator. P9x52. Dr. Lubenow opined that the regular spinal stimulator gives 50% improvement in pain to 50% of patients. The DRG stimulator, however, gives a greater likelihood of reaching 50% or better pain relief. P9x50. Before receiving this stimulator Petitioner was required to undergo a psychological evaluation to ascertain whether or not there's significant psychological variables that may mitigate the potential for a full functional recovery.

P9x56. Petitioner was determined to be an appropriate candidate for the implantation by Dr. Merriman on October 18th, 2016. P5; P9x56-57.

Following the implantation of the DRG stimulator Dr. Lubenow saw Petitioner on December 15, 2016. P5; P9x61. Petitioner was complaining of increased pain, pale discoloration, swelling, and sweating of the left lower extremity. P9x61. Dr. Lubenow reprogramed her stimulator at this time, in order to recapture the pain relief in her lower left extremity. P9x61. When Petitioner followed up on January 26, 2017 Petitioner was endorsing 75% pain relief following the reprograming of her stimulator. P9x64; P5. Petitioner was able to stand on her left lower extremity, and her other symptoms had decreased or dissipated. P9x64-65.

On April 19th, 2017 Petitioner still felt that she was 75% improved. P5; P9x 66. Dr. Lubenow opined that Petitioner would be able to tolerate seated sedentary position that allowed her the flexibility of sitting and standing as tolerated. P5, P9x 67. On June 28, 2017 Dr. Lubenow revised his work restrictions so that they limited the amount of standing, walking or sitting to what Petitioner is able to tolerate, in addition to a 10lb weight restriction. P5. These restrictions remained in place through the date of the trial. Tx58.

Conclusions of Law

C. Accident

Based upon the totality of the evidence, the Arbitrator finds that the Petitioner sustained an accident on October 14, 2014 arising out of and in the course of her employment for Respondent, as alleged in the case at bar. The Petitioner's testimony is adopted in that conclusion. . The Arbitrator relies on the credible testimony of Petitioner, as well as the consistent history of her medical providers. The Arbitrator perrsonally observed the witness in her testimony and demeanor of the Petitioner at hearing. She was subject to extensive , well focused and prepared cross examination. That examination did not cause any detriment to this extremely articulate and good historian/ Petitioner. As such, I found her testimony to be extremely credible and consistent with records of her doctors.

I. Arising out of

See ." *Sisbro, Inc. V. Industrial Comm'n*, 207 Ill. 2d 203 (2003). *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2013 IL App (4th) 120219WC, ¶ 27. *First Cash Financial Services*, 367 Ill. App. 3d at 106. *First Cash Financial Services* was read by the Appellate court to say that "injuries may be deemed to arise out of the employment if they are caused by defects or slippery *indoor* surfaces at the worksite." *Dukich v. Illinois Workers' Compensation Comm'n*, 2017 IL App (2d), ¶ 41.

Petitioner testified credibly, and was further supported by Respondent's witness Ms. Bornhauser, that she was required to enter through an entrance strictly used by employees only. Tx11-12, 93-94. She was three steps into this entrance when she slipped and fell on the ground. Tx16. Respondent's Form 45, completed by Nicholas Marcolini, also reports that Petitioner slipped and fell on the floor while entering the back door on her way to work. R4.

Petitioner credibly testified that she slipped on a liquid. Tx18. After falling she noticed that the area that hit the floor was damp. Tx19. Petitioner's clothes were not damp prior to falling, and there was nothing on her shoes prior to entering the building. Tx15, 19. After falling Petitioner saw someone put up a wet floor sign. Tx20. This is supported by Respondent's Form 45 where Nicholas Marcolini also reported that there was a wet floor sign, after being called to the scene of the accident. R4. Petitioner slipped on a liquid, after arriving at work and while in Respondent's building, having entered through an employee only entrance in route to beginning her shift. This is based on Petitioner's credible testimony, the supporting documentation of Mr. Marcolini, the testimony of Ms. Bornhauser, and the consistent accident histories of Petitioner's treating doctors. In summary, based upon the totality of the evidence the Arbitrator finds that Petitioner encountered a risk distinctly associated with her employment, which caused Petitioner to suffer an accident arising out of her employment with Respondent.

II. In the course of

As previously noted, on October 14, 2014 Petitioner was entering her place of work, approximately five minutes before her work shift began. Tx11. She had entered her employer's premises by way of the mandated employee entrance. Tx12-

16. Petitioner was approximately two or three steps into the building when she slipped and fell, where she injured her shoulder, neck, head, and left foot. Tx16–17.

It has long been held that accidental injuries sustained on an employer's premises within a reasonable time before and after work are generally deemed to arise in the course of the employment. *Caterpillar Tractor Company v. The Industrial Commission*. 129 Ill. 2d 52, 57, 541 N.E.2d 665 (1989).

Petitioner was on Respondent's premise, having arrived in order to begin her work duties for Respondent, when she slipped and fell. This is undisputed. Based upon the totality of the evidence the Arbitrator finds that Petitioner's injury occurred in the course of her employment with Respondent.

F. Causal Connection

Based upon the totality of the evidence, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to this accident. In doing so, the Arbitrator adopts and relies upon the credible testimony of the Petitioner, and that of her treating doctors. Specifically, the Arbitrator is persuaded by Dr. Lubenow's testimony, and the medical reports of Petitioner's treating doctors, that on October 14th, 2014 Petitioner's accident resulted in injuries to her left shoulder, neck, an increase in migraines, and trauma to the left heel that developed into Complex Regional Pain Syndrome. Additionally, the Arbitrator finds Dr. Lubenow's assessment of Petitioner's condition to be more consistent with the facts in this case. As such, the Arbitrator rejects in total the opinions of Dr. Candido in this case at bar.

The Arbitrator finds that Petitioner suffered a sprain/strain of her neck and left shoulder due to her workplace accident. Petitioner immediately complained of pain in her left shoulder and neck to Dr. Yvette Shannon at North Shore, and treated conservatively with Dr. Marc Breslow until January 5th, 2015 at which point she was placed at MMI.

The Arbitrator also finds that this accident caused Petitioner to suffer migraines from the date of the accident until January 2015. Petitioner testified that she had a history of migraines prior to her workplace accident on December 10, 2014, but had not been treated for them. Following the accident Petitioner's her migraines became much more frequent, and disparate in location and quality. Tx30.

Petitioner experienced near occipital migraines, radiating from her neck on the left side. Tx30. Petitioner was referred to Dr. Homer, a neurologist, on December 10, 2014 for treatment of her migraines. Tx28; P1. Approximately a month and a half after beginning treatment with Dr. Homer, Petitioner's migraines dissipated. Tx31, P1. The Arbitrator finds that Petitioner's migraines through January of 2016 were causally related to her workplace accident.

In regards to the condition of Petitioner's left heel, there are two issues. First, is: what is Petitioner's current condition of ill being? The second: is this condition of ill being causally connected to her workplace accident?

As to the second question. The Arbitrator finds that Petitioner's current condition of ill-being in relation to her left heel is causally related to her workplace injury on October 14th, 2014. Dr. Candido noted that although Petitioner had many more than a dozen sympathetic blocks, that they were all appropriate treatments for Petitioner's condition. R1x102. Dr. Candido never opines that Petitioner's current state of ill being is related to anything other than her injury on October 14, 2014. There is a dispute about what exactly Petitioner is suffering from, but no dispute as to whether or not Petitioner is suffering. Despite having placed Petitioner at MMI, Dr. Candido notes that he isn't even sure that her injury had healed at the time of his examination. R1x120.

As to the first question, based upon the totality of the evidence, the Arbitrator finds, Petitioner's current condition of ill being is that of suffering from CRPS in her left foot. In so finding, the Arbitrator relies on the testimony of Dr. Lubenow, and specifically rejects the opinions of Dr. Candido, whose diagnosis the Arbitrator does not find at all persuasive and in this case not even credible. Dr. Lubenow has been Petitioner's treating doctor for over two years, and has seen her in excess of thirty visits during this time. The Arbitrator finds persuasive that Dr. Lubenow has had the opportunity to get to know, evaluate, and examine Petitioner on many occasions, was able to credibly assess her condition. The symptoms of CRPS are numerous and variable, and the Arbitrator finds that Dr. Lubenow had the best clinical opportunity to access Petitioner's condition.

The Arbitrator also finds Dr. Lubenow to be more persuasive , in part because his diagnosis and treatment plan has established improvement.

Dr. Candido opined that Petitioner's diagnosis is better explained as left calcaneal nerve neuritis or neuropathic pain. Dr. Lubenow disagrees with this diagnosis. P9x26. Significantly, Dr. Lubenow points out that if this were a simple calcaneal neuritis, it would have resolved within the span of a year after the injury. P9x26. This is supported by Dr. Candido's early records, which indicated that Petitioner should have recovered within the first six to twelve months. R1. Dr. Lubenow also opined that if Petitioner was suffering from a calcaneal neuralgia, she wouldn't have any pain relief from the sympathetic nerve blocks. P9x36.

The Arbitrator finds that Petitioner's condition and response to Dr. Lubenow's treatment fits with the diagnosis of CRPS. At the time of her injury, Petitioner developed an acute pain condition of the left foot and ankle. P1. That acute trauma resolved, but left her with ongoing complaints of neuropathic pain, which is the manner in which CRPS forms. P9x75. Generally, CRPS begins within days to weeks to almost three months following a particular event or combination of events. P9x76. In the case of Petitioner, she began to experience excruciating pain several days following her initial injury. Tx25. Petitioner responded favorably to the treatments for complex regional pain syndrome as carried out by Dr. Lubenow, with short term pain relief as seen in patients who have CRPS. P9x75.

In contrast, Petitioner's treatment did not correspond with Dr. Candido's assessment of her injury. Dr. Candido opined in his first IME that the neuro praxia heals virtually 100% of the time. R1 April 28, 2015 IME at 16. He further opines that, while the time frame for recovery is unpredictable, that it should occur within the next 6-12 months at the longest.

The Arbitrator notes that this section 12 examination took place a year and nine months before Petitioner reported last pain relief, and at the time of hearing Petitioner continued to have ongoing complaints.

Petitioner's second section 12 exam occurred on October 6, 2015, six months after Dr. Candido's first evaluation of Petitioner, and almost a year after her initial

injury. At this time, Dr. Candido again opines that the calcaneal nerve injury he diagnosed Petitioner with, could take another 6-12 months. R1 October 6, 2015 IME, at 17.

Dr. Candido places Petitioner at MMI at his March 14, 2017 IME, almost two a half years after her initial accident. R1 March 14, 2017 IME, at 38. Dr. Candido notes at this time that Petitioner's progress was due to time, rather than the neuromodulation she underwent under the care of Dr. Lubenow. R1 March 14, 2017 IME, at 37.

The Arbitrator is not at all persuaded by Dr. Candido or at times his convoluted testimony -avoiding key points in the treatment and diagnosis at Rush Medical Center. Dr. Candido testified that there is no way of knowing whether the DRG implant provided to Petitioner would have affected a calcaneal nerve injury, as he had diagnosed Petitioner. R1x117. Rather, he testified that the timing of Petitioner's recovery with that of the implantation of her stimulator was purely coincidental. R1x 119. Dr. Candido consistently opined that Petitioner would recover naturally, but was also consistently incorrect in regards to the time frame. Petitioner testified that she felt relief immediately following the adjustment of her DRG stimulator. Tx 54.

Dr. Candido would have the Arbitrator believe that this relief was pure coincidence, and that Petitioner's recovery was completely due to the passage of time rather than the treatment she was receiving. T1x 116. The Arbitrator is not persuaded by this opinion, but rather is persuaded by Dr. Lubenow's explanation that Petitioner's relief was due to the implementation of the DRG stimulator. P9x 64.

Dr. Lubenow engaged in a progressive course of treatment, beginning with sympathetic blocks, then moving to a continuous epidural infusion, and then finally the DRG stimulator. P5. When one course of treatment didn't work, he moved on to the next step in his treatment plan. P9x38. Dr. Candido would have had Petitioner continue with the same course of treatment until it got better, even after two and a half years of that treatment not resolving her condition. R1x 114. Dr. Lubenow opined that the DRG stimulator had a greater than fifty percent chance of providing

fifty percent pain relief or more. P9x 50. Which is what happened after Petitioner's stimulator was properly adjusted, when Petitioner endorsed 75 percent pain relief. P9x 64. Based upon the totality of the evidence, the Arbitrator finds that Petitioner is not at a point of medical stability or even maximum medical improvement; She is currently waiting for an additional office visit/treatment with Dr. Lubenow.

J. Reasonableness and Necessity of Medical Treatment

Based upon the totality of the evidence , the Arbitrator finds that Petitioner's medical services were reasonable and necessary.

As previously noted, Respondent's medical examiner, Dr. Candido, only disputes the reasonableness and necessity of Petitioner's medical treatment on a few points. Most notably, was the continuous epidural infusion and DRG stimulator prescribed by Dr. Lubenow. R1x 65, 77. Dr. Candido specifically opined that all 21 of Petitioner's sympathetic nerve blocks, and physical therapy were reasonable and necessary. R1x 36-37, 46-47, 64-65, 77, 108. Dr. Candido does not dispute the reasonableness or necessity of Petitioner's medication, doctor visits, or imaging. Based on Dr. Candido's opinions, the only issues which need to be addressed in regards to the reasonableness and necessity of Petitioner's treatment are that of the continuous epidural infusion, and that of the DRG stimulator.

Dr. Lubenow recommend Petitioner undergo the continuous epidural infusion as an intermitted treatment step for her condition. P9x 38. The continuous epidural infusion is essentially a continuous nerve block, something Dr. Candido repeatedly opined was reasonable and necessary in regards to Petitioner's treatment. P9x 38; R1. Dr. Lubenow explained that the epidural infusion treatment is done to more effectively couple the beneficial effects of the nerve block, with more aggressive physical therapy and exercise. P9x 38. Dr. Candido opined that the support for the continuous epidural infusion is largely anecdotal, and is not considered to be reliable. R1x 65. For Dr. Lubenow, this was the next step in treating CRPS, after not achieving permanent relief from sympathetic nerve blocks. P9x 40. Dr. Candido would have had Petitioner repeat the same modalities over and over, hoping for different response, until she heals. The Arbitrator is not persuaded by this plan.

After Petitioner underwent the continuous epidural infusion, she initially experienced symptom improvement, which then subsequently deteriorated. P9x49. Dr. Lubenow opined that, as an expert in the care and treatment of CRPS, that this deterioration showed him that the nerve block approach was not going to further rehabilitate Petitioner. P9x 49. Rather than continuing to give her nerve blocks and physical therapy, Dr. Lubenow recommended Petitioner proceed with the DRG stimulator. P9x 49-50.

Following the stimulator's implantation Petitioner experience a 68 percent improvement, and was able to tolerate putting pressure on her heel, which she previously was only able to do while on a nerve block. P9x 57-58.

The Arbitrator finds that Petitioner's accident on May 5th, 2016 Petitioner suffered an unrelated accident. Dr. Lubenow opined, and there is no medical evidence to the contrary, that her accident did not affect the condition or diagnosis of her left foot. P9x32-33. The Arbitrator finds that Petitioner's workplace injuries regarding her neck, shoulder, and migraines had all resolved at this point, and any subsequent treatment is unrelated to her accident on October 14, 2014.

Based upon the totality of the evidence , the Arbitrator finds that Petitioner's medical treatment has been reasonable and necessary. IT IS HEREBY ORDERED the Respondent to pay all bills submitted in connection with Petitioner's October 14, 2014 accident.

K. Temporary Total Disability

Based upon the totality of the evidence, the Arbitrator finds that Petitioner is entitled to 187 1/7 weeks of Temporary Total Disability, to be paid by Respondent to Petitioner and her attorney of record.

Every medical provider, including Respondent's Section Twelve Examiner, has opined that Petitioner should be off work completely, or given her working restrictions. Petitioner currently has work restrictions, which Respondent has not accommodated.

The Arbitrator finds the Dr. Lubenow's June 8th, 2017 restrictions to be appropriate and adopts those findings. Dr. Candido has restrictions , too. No work was offered within the adopted restrictions of Dr. Timothy Lubenow.

OTHER ISSUES : Vocational Rehabilitation

The Arbitrator adopts the medical evidence and the lack of tender of a job within the restrictions to order the Respondent to comply with Rule 7110 of the IWCC and to further authorize an initial assessment of petitioner by a certified rehabilitation counsellor (CRC) of the choice of the Petitioner under section 8(a).

STATE OF ILLINOIS)
) SS.
COUNTY OF MC LEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Steven Fears,
Petitioner,

vs. No. 14 WC 24984

20IWCC0188

State of Illinois/Illinois State University,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses 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 25, 2014 he was employed by Illinois State University as a kitchen laborer. His duties included sweeping, mopping and washing dishes. Prior to that day, his left eye and pupil were completely normal. On June 25, 2014, Petitioner was kneeling and using a broom to retrieve silverware which had fallen underneath equipment. In the course of that activity, a fork bounced up off the floor and struck him in his left eye. Petitioner could not see out of that eye and was taken by a co-worker to the emergency room, where he noticed part of his iris was hanging out of his eye.

Petitioner was seen by Dr. Catherine Crockett, who performed surgery on his eye: repair of the ruptured globe, reposting of uveal tissue and reformation of the anterior chamber of the eye.

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After that procedure, Petitioner was required to wear a patch or shield over his left eye for weeks, and use eyedrops or artificial tears. He was also provided with special contact lenses to help block out light, but he was unable to wear them.

Since the surgery, Petitioner still experiences occasional headaches which are precipitated by reading and by bright lights. His left eye is very sensitive to sunlight; he now has to wear tinted prescription eyeglasses and very dark sunglasses. He still uses artificial tears on occasion. At work, he has to wear safety glasses. He has difficulty reading and is unable to read small print. His eye is sometimes painful. When he drives at night, the glare from oncoming traffic is blinding.

The Arbitrator found that Petitioner's injuries caused a 20% loss of the left eye under §8(e) of the Act. In so finding, the Arbitrator noted that following Petitioner's injury and surgery, his symptoms decreased and his visual acuity improved. The Arbitrator went through an analysis of the five factors enumerated in §8.1b(b), and assigned the following weights to them:

(i) **Disability impairment rating:** *no weight,* because no impairment ratings were introduced into evidence.

(ii) **Employee's occupation:** *moderate weight,* because Petitioner is able to perform his job duties and his only work restriction is to wear safety glasses.

(iii) **Employee's age of 35:** *moderate weight,* because Petitioner will have to deal with the adverse effects of his injury for quite some time.

(iv) **Future earning capacity:** *moderate weight,* because his current hourly rate of pay is more than it was at the time of his injury, and his left eye condition has not negatively impacted his earning capacity.

(v) **Evidence of disability corroborated by the treating records:** The Arbitrator did not specify a weight for this factor, although he did discuss Petitioner's disability as corroborated by the treating records. The Arbitrator acknowledged that Dr. Crockett's July 31, 2015 note reported that Petitioner would have ongoing photosensitivity of his eye due to the inability of his pupil to constrict completely. The Arbitrator also noted that Petitioner has residual symptoms from his injury, including reduced visual acuity, photosensitivity, astigmatism, and the possibility of early cataract development.

The Commission finds that in addition to the above-described evidence of disability, Petitioner suffers from other residual effects. Because part of his iris had to be excised, Petitioner was left with an irregularly shaped pupil that cannot completely constrict. His left eye is sometimes painful. He cannot read smaller print. He experiences glare and halos around lights at night, making it difficult for him to drive. For these reasons, the Commission finds that *significant weight* should be placed on factor (v) of §8.1b(b) of the Act. Accordingly, the Commission modifies the Arbitrator's award of 20% loss of use of the left eye, to 35% loss of use of the left eye.

20IWCC0188

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 17, 2018, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of permanent partial disability of 20% loss of use of the left eye is vacated. Respondent shall instead pay to Petitioner the sum of $372.78 per week for a period of 56.7 weeks, as provided in §8(e) of the Act, for the reason that the injury caused the 35% loss of use of the left eye.

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.

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 16 2020

o-02/06/20
mp/mcp
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Marc Parker

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FEARS, STEVEN
Employee/Petitioner

Case# **14WC024984**

SOI/ILLINOIS STATE UNIVERSITY
Employer/Respondent

20IWCC0188

On 4/17/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.94% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
STEVEN R WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 62701

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

0988 ASSISTANT ATTORNEY GENERAL
JORDAN HOMER
500 S SECOND ST
SPRINGFIELD, IL 62706

0903 ILLINOIS STATE UNIVERSITY
1320 ENVIRONMTL HEALTH SAFETY
NORMAL, IL 61790

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

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

APR 17 2018

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

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Steven Fears
Employee/Petitioner

v.

State of Illinois/Illinois State University
Employer/Respondent

Case # **14** WC **024984**

Consolidated cases: ---

20IWCC0188

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Bloomington**, on **March 27, 2018**. By stipulation, the parties agree:

On the date of accident, **June 25, 2014**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**32,307.60**, and the average weekly wage was $**621.30**.

At the time of injury, Petitioner was **35** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of $**1,893.58** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**1,893.58**.

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 $**372.78**/week for a further period of 32.4 weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused 20% **loss of the left eye**.

Respondent shall pay Petitioner Temporary Total Disability benefits of **$416.27**/week for **4 and 4/7 weeks** commencing **06/26/14** through **07/27/14**, pursuant to Section 8(b) of the Act.

Respondent shall receive credit for the payment of Temporary Total Disability benefits totaling $1,893.58.

Respondent shall pay reasonable and necessary services, pursuant to the medical fee schedule, as contained in Petitioner's Exhibit 7, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall receive credit for medical benefits paid through its group insurance, pursuant to Section 8(j) 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.

D. Glenn McEntire

Signature of Arbitrator

4/13/2018
Date

APR 17 2018

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner, Steven Fears, filed an Application for Adjustment of Claim on July 24, 2014, alleging injury to the eyes an d other parts of the body resulting from being struck in the eye by a kitchen utensil on June 25, 2014, while at work for Respondent, Illinois State University ("ISU") (AX2)

Petitioner testified he was a kitchen laborer for ISU on June 25, 2014. (TX p. 9) His job duties included sweeping and mopping in the kitchen. (Id) Petitioner testified on June 25, 2014, he was kneeled down and reaching underneath equipment trying to reach silverware with a broom. (TX pp. 10-11) As he raked the broom under the equipment, a fork bounced up from the floor and struck Petitioner in the left eye. (TX p. 11)

Petitioner testified he immediately noticed that he could not see anything and immediately left work for the ER. (Id)

Petitioner presented to the ER on June 25, where he was diagnosed with a puncture wound to the left eye. (PX 4) On exam, Petitioner was noted to have an asymmetric pupil with puncture wound to scleria at the approximate 1000 o'clock position. (PX 7) He was referred to Dr. Crockett and instructed to follow up with her. (PX 4)

On June 25, Petitioner also saw Dr. Crockett. (PX 5) Dr. Crockett's record indicates the ER found a peaked pupil with a knuckle of its iris prolapsed out of a limbal laceration. (Id) Dr. Crockett's preoperative diagnosis of Petitioner was ruptured globe with prolapse of uveal tissue, left eye. (Id) She performed a repair of ruptured globe with reposting of uveal tissue and reformation of the anterior chamber of the left eye. (Id) The procedure had no complications. (Id)

Petitioner presented on June 26 for a post-operative exam by Dr. Crockett. (PX 8) He reported no pain, but a scratchy feeling and was taking hydrocodone for pain. (Id) Petitioner was diagnosed with scleral/corneal laceration with prolapse and given prescriptions for ofloxacin, prednisolone acetate, and Ilevro eye drops and instructed to wear a shield on the left eve. (Id) Petitioner returned on June 30, denying any issues and stating his vision was slowly improving. (Id) On exam, Petitioner's left eye vision measured 20/150 distance, +2 near, and 20/30 pin hole. (Id) He was instructed to continue eye drops and the eye shield. (Id)

Petitioner then returned to Dr. Crockett on July 3. (PX 8) He stated he experienced some soreness but his vision had been improving since surgery. (Id) He was utilizing a bandage contact lens and wearing the shield occasionally. (Id) On exam, his left visual acuity was 20/60 distance and 20/25 nearness. (Id) The cornea exam noted a tiny pinpoint leak at the base of the sutures. (Id) Dr. Crockett prescribed continuation of the eye drops. (Id)

On July 8, Petitioner returned, and stated that his vision seemed better, the left eye was comfortable most times, and had been wearing the shield 50% of the time. (PX 8) His visual acuity measured at 20/25 at distance, nearness was not measured, and the cornea was clear. (Id) Dr. Crockett noted that there continued to be a small leak at the base of the suture, recommended that he continue with eye drops, and was taken off work until further notice. (Id)

On July 14, Petitioner returned for a recheck with Dr. Crockett. (PX 8) He reported that his vision and comfort was stable. (Id) His visual acuity remained at 20/25 at distance. (Id) The suture leak was reducing and Dr. Crockett recommended against any activity involving strenuous lifting. (Id) He was advised to continue with eye drops and return in one week. (Id) Upon return on July 23, Petitioner advised he had no pain and was experiencing some light sensitivity in the left eye. (Id) His visual acuity measurements were 20/25 at distance, 20/20 nearness, and -1 pin hole. (Id) Petitioner was advised to discontinue medicated eye drops, advised he could return to work on July 28 without restrictions, other than the need to wear safety glasses. (Id)

Petitioner returned to Dr. Crockett on August 20, reported that his vision was "okay" and that he was sensitive to bright lights. (PX 8) On exam, Petitioner's visual acuities measured at 20/25 distance and 20/20 nearness. (Id) Dr. Crockett noted there was no significant refractive error found and advised that the only way to help with light sensitivity was either by stitching the iris, which would require more surgery, or by a specialty contact lens. (Id)

On November 19, Petitioner returned to Dr. Crockett. (PX 8) He reported good vision, the left being slightly more blurred than the right. (Id) He reported trouble only with bright sunlight and has some trouble driving at night. (Id) Dr. Crockett provided Petitioner with a trial contact to block the sun. (Id) On December 3, Petitioner returned and reported the trial contact helped. (Id) He also reported vision in the left eye may be more blurry. (Id) Dr. Crockett ordered a supply of plano contacts for the left eye, elected not to order prescription contacts, and advised that he continue to wear safety glasses at work. (Id)

Petitioner then returned to Dr. Crockett on June 3, 2015. (PX 6) At that time, he advised that he does not wear the contacts, stating the contact does not give him much improvement. (Id) He stated his vision remained stable, that the left eye was a little blurry, complained of a headache when reading and light sensitivity, but not worse than previously experienced. (Id) Dr. Crockett recommended over the counter readers for near vision and recommended possibly removing the right lens of the readers. (Id) On exam, Petitioner's visual acuity for the right eye measured 20/20 distance, 20/20 left eye distance, and 20/15 combined left and right eyes. (Id) Dr. Crockett diagnosed Petitioner with astigmatism, recommending that glasses would help clear the left eye and recommended a trial, tented lens. (Id) She stated that the left eye looked good, and she could not tell how much damage had been done. (Id)

Most recently, Petitioner presented to Dr. Crockett on August 19, 2016. (PX 10) At that time, he stated his vision was good and he wears glasses occasionally for reading or TV, uses artificial tears in both eyes as needed, and denies any pain or discomfort. (Id) On exam, Petitioner's visual acuity in the left eye was 20/25 at a distance. (Id) Regarding previous spectacles, they were a +1.5 on the left eye and described by Dr. Crockett as over the counter "readers." (Id) Petitioner was not currently wearing them. (Id) For the first time, Dr. Crockett prescribed glasses to Petitioner, and it was for +.25 on the right and +1.25 on the left. (Id) Dr. Crockett noted Petitioner's left eye looked "good," that his eyes were "overall healthy," and recommended that Petitioner return in two years. (Id)

Dr. Crockett authored two opinions regarding Petitioner's possible future issues, dated July 31, 2015, and November 6, 2015. (PX 1 and 2) On July 31, Dr. Crocket stated Petitioner has increased light sensitivity and glare/halo lights at night due to pupil constriction issues. (PX 1) She stated these problems are permanent. (Id) Dr. Crockett further opined that Petitioner has some induced astigmatism in the left eye, which is

currently corrected by a glasses prescription. (Id) She stated that the astigmatism and need for glasses could change in the future. (Id) She further opined that Petitioner's injury could induce earlier cataract formation in the eye. (Id)

On November 6, 2015, Dr. Crockett clarified Petitioner's diagnoses. (PX 2) She stated Petitioner's diagnoses would be ruptured globe of the left eye with uveal prolapse and corectopia, an irregular pupil that is not centrally located or irregular pupil of the left eye. (Id)

As to his current condition, Petitioner testified he has blurriness in the left eye, wears safety glasses at work, has occasional headaches, difficulties reading in that he has difficulty seeing small print, wears prescription glasses with a tint and are antiglare, and light sensitivity. (TX pp. 12-14)

Petitioner testified he has returned to his pre-injury position as a kitchen laborer at ISU. (TX p. 9)

Petitioner's contained in Petitioner's Exhibit 9. (PX 9) Dr. Crockett released him to return to work full duty as of July 28, 2015. (PX 8) Respondent paid TTD benefits for 4 and 4/7 weeks, from June 26, 2014, through July 27, 2014, totaling $1,893.58. (AX 1) Petitioner testified he is making $18.12 an hour. (TX p. 18)

THE ARBITRATOR MAKES THE FOLLOWING CONCLUSIONS OF LAW:

With respect to disputed issue *L: What is the nature and extent of the injury*, the Arbitrator makes the following conclusion, pursuant to the factors enumerated in Section 8.1(b) of the Act.

With regard to subsection (i) of 8.1(b), the record contains no impairment rating, and as such this factor is given no weight.

With regard to subsection (ii) of 8.1(b), the Arbitrator notes that Petitioner has returned to his pre-injury job without a demonstrated impact on his ability to complete his job duties. The Arbitrator does also acknowledge that Petitioner's job does not require duties which include symptomatic factors like reading troubles, light sensitivity, or glares while driving at night. Additionally, the only restriction Petitioner is working under is a requirement to wear safety glasses. This is not so much a restriction of Petitioner's physical abilities, but rather a common sense protective device. As such, this factor is given moderate weight in consideration of the nature and extent of his injury.

With regard to subsection (iii) of 8.1(b), the Arbitrator recognizes that Petitioner was 35 years old at the time of his injury. As a younger individual, he will have to deal with the adverse effects of his injury for quite some time. The Arbitrator gives this moderate weight.

With regard to subsection (iv) of 8.1(b), the Arbitrator notes that Petitioner's current hourly rate is more than it was at the time of injury. As such, the condition of his left eye has not demonstratively, negatively impacted his earning capacity. This factor is given moderate weight.

Finally, with regard to subsection (v) of 8.1(b), the Arbitrator notes that Dr. Crocket's report of July 31, 2015 contained her prognosis for the Petitioner. She wrote that he would have ongoing photosensitivity due to the

inability of his pupil to constrict completely. He testified to ongoing issues with bright lights and overhead projectors. She further said that he had developed an astigmatism as a result of the accident. The final office note of August 19, 2016, over a year later, confirms uncorrected vision at 20/25, while his unaffected eye was at 20/20. (PX 10) Finally, she opined that the Petitioner could develop an early cataract in the eye, which from an eye surgeon amounts to more than mere speculation.

This is an unusual injury. The Arbitrator relies on part on the Commission decision in Garibay v. Utility Dynamics Corp., 11 IWCC 736. In Garibay, the Petitioner, like the Petitioner herein, sustained a traumatic tear to the iris with permanent enlargement of the pupil. The best uncorrected vision was 20/50, which is somewhat worse than what was found on Mr. Fears. The award was 25 % loss of the eye.

With the above vision difference, and the other factors refernced above, the Arbitrator finds the Petitioner to have sustained a loss of 20 % of the left eye.

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

SABINO GONZALEZ,

Petitioner,

vs. NO: 16 WC 26660

SCHOLLMEYER LANDSCAPING,

Respondent.

20IWCC0189

DECISION AND OPINION ON REVIEW

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

The Commission corrects the two scrivener's errors in the sentence that comprises the third paragraph of the **Order** section by adding the word "with" and striking the word "a" so that the sentence reads, "Respondent shall authorize and pay for additional reasonable and necessary treatment consistent with the recommendations of Dr. Ross including the L4-5 and L5-S1 transforaminal lumbar interbody and posterolateral fusion, any post-operative treatment, physical therapy or other reasonable and necessary care."

The Commission corrects the scrivener's errors found in the second sentence of the last paragraph of page 4 by adding the word "the" and replacing the word "that" with "than" so that it reads, "After the physical therapy and review of the MRI, which Dr. Ghanayem read as showing

degenerative findings rather than an annular tear at L4-5, Dr. Ghanayem opined that Petitioner exhibits only non-organic findings consistent with symptom magnification."

The Commission corrects the scrivener's error found in the second full sentence on page 5 that misstated the date the discogram was performed. The sentence is corrected to read as follows, "The discogram was performed on December 19, 2017, at L3-4, L4-5 and L5-S1."

The Commission corrects the scrivener's errors found in the last paragraph of page 6 that identify Dr. Rivera as "Dr. Rivero." Those errors are corrected by substituting "Rivero" with "Rivera."

The Commission corrects the scrivener's error found in the first full paragraph on page 9 that identifies Dr. Rivera as "Dr. Rivero." The error is corrected by substituting "Rivero" with "Rivera."

The Commission corrects the scrivener's error found in the sentence that comprises the second paragraph in the section discussing **Prospective Medical** on page 9 by adding the word "with" and striking the word "a" so that the sentence reads, "Respondent shall authorize and pay for additional reasonable and necessary treatment consistent with the recommendations of Dr. Ross including the L4-5 and L5-S1 transforaminal lumbar interbody and posterolateral fusion, any post-operative treatment, physical therapy or other reasonable and necessary care."

The Commission corrects the scrivener's error found in the second sentence of the first paragraph on page 10 by replacing "2017" with "2016."

The Commission corrects the scrivener's error found in the last sentence of the second paragraph by inserting "$" before "10,796.58" so that the sentence reads, "Per the stipulation of the parties, Respondent shall receive credit for $10,796.58."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on November 19, 2018, is hereby affirmed and adopted as modified.

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.

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 $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 16 2020
KAD/mav
O: 01/21/2020
42

Marc Parker

Maria E. Portela

DISSENT

I respectfully dissent from the majority opinion awarding prospective medical treatment.

Petitioner sustained an undisputed work-related accident on August 4, 2016, when he fell off a ladder onto concrete, landing on his back and striking his head. He sought medical attention on August 7, 2016, and underwent a CT scan of the head, cervical, thoracic, and lumbar spine which was negative for hemorrhage, acute fracture or dislocation. A small disc bulge was noted at L4-5. Petitioner was discharged with a diagnosis of back pain and blunt head trauma. (PX8). On August 8, 2016, Petitioner sought care from Dr. Rivera at RNS Physical Therapy where he complained of pain in the low and mid back, neck, headaches, and weakness in all four extremities. (PX1) All neurological testing was normal, and Petitioner was diagnosed with multiple sprains.

Petitioner underwent an MRI scan on August 17, 2016, which was interpreted as showing an annular tear and disc herniation at L4-5 resulting in moderate foraminal stenosis and mild disc desiccation, and disc displacement at L5-S1 with mild to moderate foraminal stenosis. (PX1)

On August 18, 2016, Petitioner was referred to Dr. Novoseletsky for pain management and injections. He complained of sharp middle and low back pain radiating down both legs. His physical examination on that date revealed full range of motion and no neurological deficits which was consistent with Dr. Rivera's findings.

At the request of Respondent, Dr. Jay Levin examined Petitioner on September 14, 2016. (RX1) Petitioner reported low back pain radiating down both legs into his feet, cervical pain and thoracic pain. A physical examination of the lumbar spine revealed midline tenderness and sciatic notch tenderness radiating to his neck without radiation to his legs. He had 4/5 strength on the right and 5/5 strength on the left. Straight leg raising was positive but, when repeated, was negative. Dr. Levin reviewed the MRI scan and found degenerative changes with bilateral facet arthritis, a small left sided disc protrusion at L4-5, and degenerative disc bulging at L5-S1. He found the MRI findings non-correlative on physical examination. He noted non-organic findings and opined no

further medical treatment was necessary, he had reached MMI and could return to regular duty. (RX1)

Upon referral from Dr. Novoseletsky, Petitioner saw Dr. Matthew Ross on November 1, 2016, complaining of continued low back pain with feelings of weakness, and numbness and tingling in both legs. (PX1, PX3) Dr. Ross's physical examination revealed mildly restricted mobility in Petitioner's lumbar spine, with forward flexion and extension. He demonstrated the ability to bend forward to 80 degrees. He had tenderness over his lower lumbar spine, and some tenderness over the sacrum. His straight leg raising was negative to 90 degrees while seated and his motor strength was full. His sensation was perceived as being tingly over the entirety of both legs. His reflexes were diminished but symmetric bilaterally. (PX3)

Dr. Ross testified orthopedic testing was normal, outside of his range of motion, which has a subjective component he pointed out. (PX11, p. 15) At that visit on November 1, 2016, Dr. Ross reviewed the MRI scan of August 17, 2016, noting no significant herniation, disc desiccation, and bulging and annular tear at the L4-5 level, and some disc desiccation at L5-S1. (PX3, PX11, p. 16) Dr. Ross diagnosed Petitioner with low back pain following the work accident that, since he had not responded to conservative treatment, might be discogenic. (PX11. p 19) The November 1, 2016 office note stated, "Petitioner does not have any localizing signs or symptoms that would allow us to say that his pain is originating from the L4-5-disc pathology." In fact, Dr. Ross further stated, "we cannot even say with certainty at this time, whether the disc change at L4-5 represents a new, acute problem or whether it is a coincidental finding." (PX3) He recommended an epidural steroid injection (ESI).

Petitioner underwent an ESI at L4-5 and reported no improvement with pain. He followed up with Dr. Ross on February 6, 2017, who noted no radiation of pain into the legs, but Petitioner does notice occasional tingling which improves with Mobic and Flexeril. Dr. Ross noted Petitioner has not observed any lower extremity weakness. After the ESI, Petitioner was able to flex only 45 degrees, as opposed to 80 degrees, which he demonstrated previously.

Petitioner underwent a discogram performed by Dr. Novoseletsky on December 19, 2017, which revealed no pain at L3-4, concordant pain at L4-5, and non-concordant pain at L5-S1. The CT scan with contrast, post discogram, showed at L3-4, contrast is contained within the annulus with no evidence of herniation or protrusion, at L4-5, contrast is contained within the annulus with no protrusion or extravasation noted, at L5-S1, is not well demonstrated. There was no evidence of posterior protrusion or extravasation. Aside from facet joint degenerative changes there are no abnormalities, it was noted. Despite the lack of findings, Dr. Ross recommended a two-level fusion at L4-5 and L5-S1. (PX3)

At Respondent's request, Petitioner was evaluated by Dr. Alexander Ghanayem, Chairman, Department of Orthopaedic Surgery and Rehabilitation at Loyola University Medical Center, on August 10, 2018. (RX2, p. 5) Examination of his spine revealed small flares of soft tissue tenderness in the mid thoracic all the way to the lower lumbar spine. He was tender to light palpation. His lumbar range of motion was 10 degrees of extension and 10 degrees of flexion; but, Dr. Ghanayem noted, when he moved around the examination room from the chair to the exam table, he could easily flex to 45 degrees. (RX2, pp. 9-10, X2) His lower extremity revealed a

Periodic Table

breakaway weakness. There were no focal motor deficits and distracted leg raise was negative. He noted purposeful results in a delayed response of back pain. His review of the CT scan performed August 2016 was normal, and the lumbar MRI scan of August 2016 revealed mild age-appropriate degenerative changes in the lower lumbar spine. He disagreed with the report of an annular tear at L4-5 which he found was more of a degenerative finding. (RX1, pp. 12-13, X2) Dr. Ghanayem opined Petitioner exhibited non-organic physical exam findings consistent with symptom magnification. (RX2, p. 13, X2)

Dr. Ghanayem also reviewed the December 19, 2017, discogram and found it indicated Petitioner had no pain at L3-4, concordant pain at L4-5 and non-concordant pain at L5-S1. (RX2, pp. 14-15) He opined Petitioner's non-concordant pain makes the recommended surgery not appropriate, stating, "If you have non-concordant pain or you have no control levels, then the results usually come away from the test is that the surgery is not appropriate." (RX2, p. 16)

Dr. Ghanayem further testified:

A: What the discogram did is it raised the red flag behind the curtain and should put the brakes on the surgical recommendation.

Q: What is the nature of the red flag? Is the non-concordant pain akin in your opinion to a non-valid FCE?

A: No. It just tells you if you're thinking of surgery, don't because it's not going to work. That's why I said in the report forget about all the circus behind the whole issue. Taking the discogram on face value, when I give a lecture for the residents and students, I tell them this test, these types of results you should not be operating on the patient. (RX2, pp. 40-41)

The Workers' Compensation Act requires the employer to provide all "necessary first aid, medical and surgical services . . . reasonably required to cure or relieve from the effects of the accidental injury." 820 ILCS 305/8(a). It is within the Commission's province to judge the credibility of the medical experts and resolve conflicting medical opinions. *O'Dette v. Industrial Comm'n*, 79 Ill. 2d 249, 253, 403 N.E.2d 221, 223 (1980); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 1169 (1999); *Hosteny v. Ill. Workers' Comp. Comm'n*, 397 Ill. App. 3d 665, 675 (2009). In this case, the medical opinions concerning Petitioner's condition as it relates to the work accident and Petitioner's need for surgery to cure or relieve the effects of the accidental injury are in conflict.

Based on the evidence presented, I would find the medical opinions of Dr. Ghanayem and Dr. Levin more credible and persuasive than Dr. Ross's opinion. Dr. Ghanayem and Dr. Levin examined Petitioner and found non-organic findings on clinical exam. These findings were consistent with Dr. Ross's finding that Petitioner's objective orthopedic testing was normal. Moreover, Dr. Ghanayem reviewed the MRI and stated it showed mild degenerative changes and no annular tear at L4-5. Dr. Levin likewise reviewed the MRI and found the findings non-correlative on physical examination. Dr. Ghanayem's and Dr. Levin's opinions that Petitioner does

not need further medical treatment are based on a lack of objective findings which is consistent with Dr. Ross's findings.

Dr. Ghanayem also noted evidence of symptom magnification which cannot be ignored. (RX2, p. 13) Petitioner's flexion was limited to 10 degrees when tested but was 45 degrees when Petitioner arose from the examination room chair. (RX2, pp. 9-10) Petitioner's neurological testing revealed breakaway weakness in a leg but without any objective focal motor deficits. (RX2, p. 10) One straight leg raise test resulted in Petitioner voicing a delayed complaint of back pain, but the straight leg raise test performed while Petitioner was distracted was negative. (RX2, p. 10) Dr. Ghanayem's finding of symptom magnification is significant especially in light of the fact that Petitioner's objective exams show no abnormal findings. Dr. Ghanayem's opinion that surgery is not warranted in this case is well supported by the credible evidence.

In contrast, Dr. Ross's surgical recommendation for a two level fusion is not supported by the evidence. Notably, all three physicians found normal exams. Dr. Ross further stated Petitioner does not have any localizing signs or symptoms "that would allow us to say that his pain is originating from the L4-5 disc pathology." In fact, he stated, "we cannot even say with certainty whether the disc change at L4-5 represents a new, acute problem or whether it is a coincidental finding." (PX3, 11/1/16, p.2) Furthermore, Dr. Ross appeared to question the veracity of Petitioner's symptomology. He testified that the tingling and numbness in Petitioner's legs did not sound dermatomal because the symptoms were in both legs. (PX11, p. 13) When asked what the cause would be if it was not dermatomal, Dr. Ross testified, "Let's see. I've seen quite a few patients come in with, you know, perceived motor sensory alteration that may to some extent be a high self-monitor rather than, you know, true symptomology." (PX11, p. 13) Dr. Ross's response to the cause of Petitioner's leg symptoms, "perceived motor sensory alteration...rather than true symptomology," clearly undercuts the basis for his recommendation for surgery.

Finally, Dr. Ross testified as to whether Petitioner's complaints were radicular pain versus referred pain. He testified that radicular pain would be in a dermatomal pattern and referred pain does not have to be in a specific dermatomal pattern. When asked if the Petitioner's complaints would be "referred pain," Dr. Ross remarkably did not testify it was referred "pain." Instead, he testified, Petitioner had referred "symptomology" based on "the *perception* of weakness and numbness, tingling..." (emphasis added) (PX11, p. 14) Despite this paucity of objective findings and correlative symptoms, Dr. Ross recommends a fusion at L4-5 and L5-S1. Dr. Ross's own examination and testimony belie his surgical recommendation for a two level fusion.

Dr. Ghanayem's well-reasoned and substantiated opinion, consistent with Dr. Levin's, is more persuasive than Dr. Ross's opinion. Dr. Ghanayem reviewed the medical records and diagnostic tests, and examined the Petitioner. He noted evidence of symptom magnification. Based on the foregoing, as well as his experience and knowledge in the subject matter, his opinion that surgery was not warranted is more credible. In fact, he testified he lectures residents and students that these types of findings should not lead to an operation on the patient. Dr. Ghanayem's opinion is credible, more persuasive and should be adopted. Therefore, I disagree with the award of prospective medical and respectfully dissent.

Kathryn A. Doerries

Kathryn A. Doerries

20IWCC0189

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

GONZALEZ, SABINO
Employee/Petitioner

Case# **16WC026660**

20IWCC0189
20IWCC0189

SCHOLLMEYER LANDSCAPING
Employer/Respondent

On 11/19/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2553 LAW OFFICE OF JAMES P McHARGUE
MATTHEW C JONES
123 W MADISON ST 18TH FL
CHICAGO, IL 60602

0445 RODDY LAW LTD
CHRISTOPHER TOMCZYK
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Sabino Gonzalez
Employee/Petitioner

v.

Shollmeyer Landscaping
Employer/Respondent

Case # **16** WC **26660**

Consolidated cases: **N/A**

20IWCC0189

An *Application for Adjustment 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 **Wheaton**, on **September 21, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0189

FINDINGS

On the date of accident, **August 4, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$37,310.00**; the average weekly wage was **$717.50**.

On the date of accident, Petitioner was **43** 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 **$10,796.58** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$10,796.58**.

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 $478.33/week for 110 6/7 weeks, commencing August 7, 2016 through September 21, 2018, as provided in Section 8(b) of the Act. Respondent shall be given credit for $10,796.58 for TTD benefits paid under Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $6,567.59 to RNS Physical Therapy, $5,313.00 to Suburban Orthopedics, $121.00 to Midwest Neurosurgery & Spine Specialists, $1,413.00 to RX Compliance Laboratories Inc., $583.85 to Prescription Partners, $1,682.68 to Adco Billing Solutions, $983.00 to Center for Diagnostic Imaging, $38,056.32 to Ashton Surgical Center, and $1,250.00 to Oak Brook Anesthesiologists, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay for additional reasonable and necessary treatment consistent the recommendations of Dr. Ross including a the L4-5 and L5-S1 transforaminal lumbar interbody and posterolateral fusion, any post-operative treatment, physical therapy or other reasonable and necessary care.

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

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

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

Signature of Arbitrator

November 16, 2018
Date

ICArbDec19(b)

NOV 19 2018

Statement of Facts

Petitioner testified in Spanish through an interpreter. Petitioner Sabino Gonzalez testified that he is not currently working. He was employed by Respondent Shollmeyer Landscaping for 4 years. His job was in construction and landscaping. His duties included planting and maintenance of houses and patios. He would put in rocks and concrete, clear debris, carry mulch and plant grass. He would move weights of 150 to 400 pounds. The heavier weight would be moved with equipment. Petitioner testified he had worked landscaping before. He never had a prior back injury or medical care.

Petitioner testified that on August 4, 2016, he was on a ladder painting outside of the shop when he fell 6 to 7 feet onto concrete. Petitioner testified he landed on his back and hit his head on the concrete. He thought his back was broken and it was hard to get his head normal. He reported the accident to his supervisor and completed his shift and went home. He did not work the next day which was Friday. He went to the hospital emergency room on Sunday night.

Petitioner was seen at Rush Copley Medical Center on August 7, 2016 (PX 8). Petitioner reported the accident and complained of upper and lower back pain. He stated he hit the back of his head but did not lose consciousness. He denied neck pain, blurred vision, focal weakness, numbness and tingling, or syncope. CT scans of the head, cervical, thoracic and lumbar spine were negative for hemorrhage, acute fracture or dislocation. There was a small disc bulge noted at L4-5. The discharge diagnosis was back pain and blunt head trauma. Petitioner was provided medication and advised to avoid strenuous activity (PX 8).

Petitioner sought care from Dr. Rivera at RNS Physical Therapy beginning August 8, 2016 (PX 1). He prepared a pain diagram showing pain in the middle of the lower back only. He rated his pain at 9/10. The Initial Evaluation notes complaints in the low back and mid back. He also complained of neck pain and headaches. He reported pain radiating to the back of both thighs and upper extremities. He complained of weakness in all 4 extremities. All neurological testing was normal. Range of motion was reduced due to pain. Dr. Rivera diagnosed multiple sprains. Petitioner was scheduled for 4 weeks of physical therapy and taken off work (PX 1). On August 12, 2016, Petitioner reported improvement in his headaches and neck pain, but his low back pain remains persistent. Petitioner was referred for a lumbar MRI (PX 1). The August 17, 2016 MRI noted an annular tear and disc herniation at L4-5 resulting in moderate foraminal stenosis as well as mild disc desiccation and disc displacement at L5-S1 with mild to moderate foraminal stenosis (PX 1).

Petitioner was referred to Dr. Novoseletsky on August 18, 2016 (PX 2). Petitioner's pain diagram noted symptoms down the back of both legs. He reported sharp middle and low back pain with radiation down both legs. Physical examination noted full lumbar range of motion with no neurological deficits. Dr. Novoseletsky recommended continued physical therapy and SI joint injections and kept Petitioner off work (PX 2). Respondent non-certified the injections and further physical therapy by Utilization Review (PX 2). Petitioner continued therapy at RNS Physical Therapy (PX 1).

Petitioner was examined by Dr. Jay Levin on September 14, 2016 at Respondent's request (RX 1). Petitioner reported low back pain that goes down both legs to the feet. He also reported cervical and thoracic pain. Physical examination of the lumbar spine noted complaints of midline tenderness and sciatic notch tenderness radiating to his neck without radiation to his legs. He recorded loss of lumbar range of motion. Petitioner had 4/5 strength on the right and 5/5 strength on the left. Hoover sign was positive. Straight leg raising was positive at 50 degrees. When repeated it was negative. Reflexes were trace and symmetrical. Dr. Levin's

reading of the MRI found degenerative changes with bilateral facet arthritis and a small left sided disc protrusion at L4-5. There was degenerative disc bulging at L5-S1. Dr. Levin diagnosed a myofascial strain of the cervical, thoracic and lumbar spine. He found the MRI findings non-correlative on physical examination. He found the findings to be consistent with progressive age changes. He notes non-organic findings. Dr. Levin opined that Petitioner was in need of no further treatment, could return to his regular work and had reached maximum medical improvement (RX 1).

On September 15, 2016, Dr. Novoseletsky noted some improvement with therapy. Injections were not certified (PX 2). He reiterated his prior recommendations at that time and at his October 13, 2016 follow up (PX 2). Petitioner continued physical therapy through November 3, 2016. The therapy notes document referral to Dr. Ross as of November 1, 2016 (PX 1).

Dr. Ross saw Petitioner on November 1, 2016 for continued low back pain with feelings of weakness, numbness and tingling in both legs (PX 3). Petitioner reported that his upper back pain had resolved. On physical examination, gait was normal with heel and toe walking performed well. Straight leg raise was negative. Petitioner had tenderness. There was restricted range of motion. Strength was normal. Sensation was perceived as tingling over the entirety of both legs. Reflexes were hypoactive and symmetrical. Dr. Ross reviewed the CT scans and lumbar MRI, noting the disc desiccation, bulging and annular tear at L4-5 without significant herniation and desiccation at L5-S1. He states that Petitioner has no localized signs or symptoms to say that the pain is originating at L4-5. He cannot say with certainty that the disc changes at L4-5 is a new, acute problem or a coincidental finding. Dr. Ross recommended a single lumbar epidural injection followed by a work hardening program. He did not recommend the sacroiliac blocks at this time. He released Petitioner to work with a 25-pound lifting restriction (PX 3).

On December 8, 2016, Dr. Ross noted that the treatment had not been approved. He renewed his recommendations and noted if Petitioner's symptoms did not resolve that he would a candidate for a discogram. He disagreed with Dr. Levin that Petitioner did not need the injection and could return to full duty work. He prescribed Mobic and Flexeril (PX 3). Petitioner underwent the lumbar epidural steroid injection by Dr. Novoseletsky on January 17, 2017. At the February 2, 2017 follow up, Petitioner reported 75% relief, but today feels the same as before the injection (PX 2). On February 6, 2017, Petitioner reported no improvement with the injection. Dr. Ross recommended a discogram (PX 3).

Petitioner saw Dr. Rivera on April 4, 2017. He was pending discogram. Petitioner was released to light duty work (PX 1). Petitioner testified he was offered light work for Respondent, but it was only 20 hours per week. He did return for a few days. He was doing landscaping, but easier tasks. He was sweeping the shop, cutting lawns, cleaning equipment. He testified he felt a lot of pain. He testified he was told by Respondent to go home and come back when he can do full duty.

Petitioner was evaluated by Dr. Ghanayem at Respondent's request on April 10, 2017 (RX 2, Ex. 2). Petitioner reported 10/10 low back pain. After physical examination and review of the MRI, which Dr. Ghanayem read as showing degenerative findings rather that an annular tear at L4-5, Dr. Ghanayem opined that Petitioner exhibits only non-organic findings consistent with symptom magnification. He felt Petitioner may have suffered a back strain which would have required 4-6 weeks of chiropractic or physical therapy. Dr. Ghanayem opined that Petitioner did not need a discogram and was not a surgical candidate. He was at MMI and could return to full duty work (RX 2, Ex. 2).

Petitioner saw Dr. Novoseletsky on August 31, 2017 and November 9, 2017 for prescription refills. Dr. Novoseletsky notes Dr. Ross recommendation for the discogram (PX 2). The discogram was performed on December 17, 2017 at L3-4, L4-5 and L5-S1. L3-4 noted no pain response. L4-5 noted the disc was disrupted and a 9/10 concordant pain response. L5-S1 noted that the disc was internally disrupted and a 7/10 non-concordant pain response (PX 2). The post discogram CT scan noted no evidence of herniation or protrusion at L4-5 or L5-S1 (PX 7). On January 4, 2018, Petitioner saw Dr. Novoseletsky. He noted follow up with Dr. Ross for surgical evaluation or possible SCS (PX 2). On January 5, 2018, Dr. Ross reviewed the discogram and CT scan results and recommended L4-5 and L5-S1 fusion (PX 3). Dr. Ghanayem reviewed the discogram findings on March 16, 2018. He opined that the finding of both concordant and non-concordant pain showed Petitioner was not a surgical candidate (RX 2, Ex. 3).

Dr. Ross testified by evidence deposition taken June 6, 2018 (PX 11). He testified to his credentials as a Board-certified neurosurgeon. He testified to his treatment of the Petitioner beginning November 1, 2016. He noted the Petitioner's subjective complaints and physical examination as documented in his records. He noted the Petitioner's examination did not indicate symptoms in a dermatomal pattern. He noted the diagnostic findings. He testified that Petitioner does not have a herniated disc. He therefore found the negative straight leg raise and negative neurological testing consistent. He testified that a sprain/strain injury would be expected to resolve within 3 months. Petitioner's continued symptoms indicated possible discogenic pain. Based on his examination, he did not feel the sacroiliac joint was the pain generator. He recommended an epidural injection to determine if the pain was caused by inflammation of the nerves. The epidural was ineffective. Dr. Ross therefore ordered a discogram to try and determine where Petitioner's pain was coming from. Dr. Ross testified discogram is not a perfect correlation with surgical outcome (PX 11).

Dr. Ross testified that the discogram noted no pain at L3-4, 9/10 concordant pain at L4-5 and non-concordant pain at L5-S1. Non-concordant pain is pain, but not the exact pain the patient suffers. Based upon the results. he recommended a two-level fusion. The non-concordant pain indicates this level may be contributing to his symptoms. If you were to fuse only L4-5, you mechanically stress L5-S1 which is already indicating a problem. The negative control level and the L4-5 concordant pain support the surgical recommendation. The non-concordant pain does not nullify this conclusion. He disagrees with Dr. Ghanayem's conclusion. Dr. Ross found Petitioner credible. He did not find positive Waddell's signs except non-dermatomal sensory involvement. Dr. Ross testified that the Petitioner's low back condition and his need for surgery were causally related to the accident. Petitioner wishes to undergo the surgery (PX 11).

Dr. Ross testified that the discogram results depend on the patient being truthful. He did not know the order the discs were tested. The radiologic findings may or may not be post-traumatic. The post discogram CT scan is unremarkable (PX 11).

Dr. Ghanayem testified by evidence deposition taken August 22, 2018 (RX 2). He testified to his credentials including being a Board-certified orthopedic surgeon. He testified to his April 10, 2017 examination of Petitioner. He noted multiple non-organic findings including tenderness to light palpation, back pain with axial compression, inconsistent forward flexion and straight leg raise when distracted, break-away weakness with no objective motor deficits. He read the MRI as showing degenerative changes at L4-5. He did not find an acute annular tear. He assessed Petitioner with a soft tissue strain given the mechanism of injury. At the time of the examination, he found non-organic findings consistent with symptom magnification (RX 2).

Dr. Ghanayem testified he reviewed the discogram report. He noted the non-concordant pain at L5-S1. He opined that if you have non-concordant pain or no negative control level, then surgery is not appropriate. It is not predictive of a good outcome. The discogram did not change his prior opinions from his earlier examination (RX 2).

Dr. Ghanayem testified that he identified Waddell's testing of non-organic responses. You could have Waddell's signs and still have an injury. A back sprain would present with symptoms of pain to palpation and with range of motion, usually with negative Waddell's signs. Discogenic pain is a mechanical problem. There is some cross over of symptoms of discogenic pain with sprains. Non-organic symptoms, such as break-away weakness, do not present with discogenic pain. With discogenic pain, you would see disc degeneration, loss of hydration on MRI. An MRI does not show pain. Dr. Ghanayem testified he uses discogram in his practice when subjective complaints, objective physical examination and diagnostic studies point to a potential discogenic pain. He uses the test to determine if he should operate on one versus two discs. With the results showing non-concordant pain, patients do not do well with surgery. He cannot describe the pathophysiologic mechanism. The discogram raised a red flag and should put the brakes on surgery (RX 2).

Petitioner testified he has back pain of 9/10. He feels he has some memory lapses. He has had no treatment for his head since the initial emergency room workup. Petitioner testified he would like to undergo the recommended surgery. Petitioner testified that he would return to work if work within his 25-pound lifting restriction was offered.

Conclusions of Law

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

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *Horath v. Industrial Commission*, 449 N.E.2d 1345, 1348 (Ill. 1983) citing *Rosenbaum v. Industrial Com.* (1982), 93 Ill.2d 381, 386, 67 Ill.Dec. 83, 444 N.E.2d 122). The accident need not be the sole or principal cause, as long as it was a causative factor in a claimant's condition of ill-being. *Lopez v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130355WC-U, P25 (Ill. App. Ct. 3d Dist. 2014)

Petitioner sustained an undisputed accident on August 4, 2016 when he fell from a ladder. He advanced complaints in the head, neck, and back. The medical records note the head, neck and upper back complaints have resolved. Petitioner continues to advance symptoms in the low back and legs. Dr. Ross has diagnosed Petitioner with discogenic back pain and has opined that the condition is causally connected to the accident. Although Dr. Levin and Dr. Ghanayem disagree with the diagnosis and the need for care, they do agree that the mechanism of injury is consistent with a back injury. The dispute in this matter is as to the diagnosis, the current extent of the disability and the need for past and future medical care.

Petitioner initially treated with Dr. Rivero who diagnosed multiple strains. After an MRI noted an annular tear and disc herniation at L4-5 resulting in moderate foraminal stenosis as well as mild disc desiccation and disc displacement at L5-S1 with mild to moderate foraminal stenosis, Dr. Rivero referred Petitioner to Dr. Novoseletsky. Dr. Novoseletsky noted Petitioner's reported sharp middle and low back pain with radiation down both legs. Physical examination noted full lumbar range of motion with no neurological deficits. Dr.

Novoseletsky recommended continued physical therapy and SI joint injections and kept Petitioner off work. Petitioner continued to report 9/10 low back pain with numbness and tingling in his legs. He was referred to Dr. Ross.

Dr. Ross saw Petitioner on November 1, 2016 for continued low back pain with feelings of weakness, numbness and tingling in both legs. On physical examination, gait was normal with heel and toe walking performed well. Straight leg raise was negative. Petitioner had tenderness. There was restricted range of motion. Strength was normal. Sensation was perceived as tingling over the entirety of both legs. Reflexes were hypoactive and symmetrical. Dr. Ross reviewed the CT scans and lumbar MRI, noting the disc desiccation, bulging and annular tear at L4-5 without significant herniation and desiccation at L5-S1. He states that Petitioner has no localized signs or symptoms to say that the pain is originating at L4-5. He cannot say with certainty that the disc changes at L4-5 is a new, acute problem or a coincidental finding. Dr. Ross recommended a single lumbar epidural injection followed by a work hardening program. He did not recommend the sacroiliac blocks at this time. He released Petitioner to work with a 25-pound lifting restriction.

The epidural injection performed on January 17, 2017 was ineffective in relieving Petitioner's symptoms. Dr. Ross thereafter recommended a discogram. The discogram was performed on December 17, 2017 at L3-4, L4-5 and L5-S1. L3-4 noted no pain response. L4-5 noted the disc was disrupted and a 9/10 concordant pain response. L5-S1 noted that the disc was internally disrupted and a 7/10 non-concordant pain response. Based upon his treatment of Petitioner, including the diagnostic studies, the steroid injection and discogram results, Dr. Ross has diagnosed discogenic back pain and recommended a fusion of L4-5 and L5-S1.

On September 14, 2016, Dr. Jay Levin's physical examination of the lumbar spine noted complaints of mid-line tenderness and sciatic notch tenderness radiating to his neck without radiation to his legs. He recorded loss of lumbar range of motion. Petitioner had 4/5 strength on the right and 5/5 strength on the left. Hoover sign was positive. Straight leg raising was positive at 50 degrees. When repeated it was negative. Reflexes were trace and symmetrical. Dr. Levin's reading of the MRI found degenerative changes with bilateral facet arthritis and a small left sided disc protrusion at L4-5. There was degenerative disc bulging at L5-S1. Dr. Levin diagnosed a myofascial strain of the cervical, thoracic and lumbar spine. He found the MRI findings non-correlative on physical examination. He found the findings to be consistent with progressive age changes. He notes non-organic findings. Dr. Levin opined that Petitioner was in need of no further treatment, could return to his regular work and had reached maximum medical improvement. Based upon Dr. Levin's opinions, Respondent non-certified injections and additional therapy.

Dr. Ghanayem testified to his April 10, 2017 examination of Petitioner. He noted multiple non-organic findings including tenderness to light palpation, back pain with axial compression, inconsistent forward flexion and straight leg raise when distracted, break-away weakness with no objective motor deficits. He read the MRI as showing degenerative changes at L4-5. He did not find an acute annular tear. He assessed Petitioner with a soft tissue strain given the mechanism of injury. At the time of the examination, he found non-organic findings consistent with symptom magnification. Dr. Ghanayem testified he reviewed the discogram report. He noted the non-concordant pain at L5-S1. He opined that if you have non-concordant pain or no negative control level, then surgery is not appropriate. It is not predictive of a good outcome.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984);

Hosteny v. Illinois Workers' Compensation Comm'n, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999). 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. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). 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. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). 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. Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 31 Ill.Dec. 789, 394 N.E.2d 1166 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 168 Ill. Dec. 756, 590 N.E. 2d 78 (1992).

Having reviewed the medical evidence and listened to the testimony in this matter, the Arbitrator finds the opinions of Dr. Ross more persuasive than those of Dr. Levin and Dr. Ghanayem. Both Dr. Levin and Dr. Ghanayem note non-organic findings on examination and base their diagnosis on the lack of objective physical findings. Dr. Ross examination also noted a paucity of specific findings, yet his opinions focus on the correlation between the diagnostics, which he admits do not show a disc herniation, the physical examination and the discogram results. The Arbitrator finds Dr. Ross approach in this matter was cautious, conservative and logical. He presents a more reasoned analysis and recommendation as opposed to the blanket rejection of Petitioner's complaints by Respondent's examiners. While the Arbitrator concurs that Petitioner's description of his pain at 9/10 may be above the level of his physical presentation, his presentation and symptoms are consistent throughout his medical care. He admits the resolution of his cervical complaints. Dr. Ross recognized this in releasing Petitioner to restricted work with 25 pounds of lifting. No evidence was presented to demonstrate that Petitioner had performed any activities which are inconsistent with his physical restrictions or to contradict an ongoing problem.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that his current condition of ill being in the low back, being discogenic back pain, is causally related to the accidental injuries sustained on August 4, 2016.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Under section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are necessary to diagnose, relieve, or cure the effects of his injury. *Absolute Cleaning/SVMBL v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 470, 949 N.E.2d 1158, 1165, 351 Ill. Dec. 63 (2011). In weighing the reasonableness and necessity of treatment, the Commission considered the medical opinions presented. In determining the reasonableness and necessity of treatment, the Commission also has considered whether the records demonstrate subjective or objective improvement or whether the treatment failed to provide demonstrable benefit. *Hugo Alvarez v AMI Bearings*, 16 IWCC 0408;

Nelson Centeno v. Minute Men, 13 IWCC 0914, affirmed *Centeno v. Illinois Workers' Compensation Commission*, 2016 IL App (2d) 150575WC-U; 2016 Ill. App. Unpub. LEXIS 1261.

Based upon the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds the opinions of Dr. Ross that Petitioner is suffering discogenic back pain persuasive. Based upon this opinion, the Arbitrator finds the treatment provided by Dr. Rivero, Dr. Novoseletsky and Dr. Ross reasonable, necessary and causally related to the accident. Petitioner submitted the medical bills and records as PX 1-10. The Arbitrator has reviewed the bills submitted and finds the bills supported by the treatment records and reasonable, necessary and causally related. The Arbitrator notes the bills reflect Respondent's payments to Rush-Copley Medical Center, RNS Physical Therapy, Suburban Orthopedics, Midwest Neurosurgery & Spine Specialists, and Oak Brook Anesthesiologists.

Based upon the record as a whole and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $6,567.59 to RNS Physical Therapy, $5,313.00 to Suburban Orthopedics, $121.00 to Midwest Neurosurgery & Spine Specialists, $1,413.00 to RX Compliance Laboratories Inc., $583.85 to Prescription Partners, $1,682.68 to Adco Billing Solutions, $983.00 to Center for Diagnostic Imaging, $38,056.32 to Ashton Surgical Center, and $1,250.00 to Oak Brook Anesthesiologists, as provided in Sections 8(a) and 8.2 of the Act.

In support of the Arbitrator's decision with respect to (K) Prospective Medical, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Causal Connection and Medical, based upon the persuasive opinions of Dr. Ross, the Arbitrator finds his diagnosis and treatment recommendations reasonable. necessary and causally related. The Arbitrator finds Dr. Ross interpretation and analysis of the discogram and his conclusions on the recommended treatment more reasonable that the analysis of Dr. Ghanayem. Dr. Ross has recommended additional treatment including a surgical recommendation for a two-level lumbar fusion at L4-5 and L5-S1.

Based upon the record as a whole and the Arbitrator's finding with respect to Causal Connection and Medical, the Arbitrator finds that Respondent shall authorize and pay for additional reasonable and necessary treatment consistent the recommendations of Dr. Ross including a the L4-5 and L5-S1 transforaminal lumbar interbody and posterolateral fusion, any post-operative treatment, physical therapy or other reasonable and necessary care.

In support of the Arbitrator's decision with respect to (L) Temporary Compensation, the Arbitrator finds as follows:

Temporary compensation is provided for in Section 8(b) of the Workers' Compensation Act, which provides, weekly compensation shall be paid as long as the total temporary incapacity lasts, which has interpreted to mean that an employee is temporarily totally incapacitated from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit. Based upon the Arbitrator's findings with respect to Causal Connection, Medical and Prospective Medical, the Arbitrator finds Petitioner is still in need of medical care and has not yet reached maximum medical improvement.

Petitioner was disabled as of his initial medical care on August 7, 2017. Petitioner has been released to restricted work with a 25-pound lifting restriction. His unrebutted testimony was that Respondent offered him work in April 2017, but after a few days told him not to return until he could do his regular job. No further offer of work within his restrictions was provided.

Based upon the record as a whole and the Arbitrator's findings with respect to Causal Connection, Medical and Prospective Medical, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that he is entitled to temporary total disability from August 7, 2016 through September 21, 2018, being the date of the 19(b) hearing, a period of 110 6/7 weeks. Per the stipulation of the parties, Respondent shall receive credit for 10,796.58 for TTD benefits paid.

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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RENARD REYNOLDS,

Petitioner,

20IWCC0190

vs.

NO: 17 WC 18201

GLOBAL BRASS & COPPER,

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 all issues, and being advised of the facts of 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 thereof.

Petitioner was employed as a DC caster for Respondent. On August 24, 2016, a heavy melt fell onto his left foot and caused the amputation of four of his toes. Petitioner's testimony at the hearing and his treatment records all indicate that Petitioner's injury was to his left foot. However, the Order included in the Decision of the Arbitrator mistakenly awarded 20% loss of use of the right foot instead of the left foot. The Commission therefore modifies the Arbitrator's Order to correctly award Petitioner 20% loss of use of the left foot in addition to the amount that is statutorily due for the amputation of Petitioner's four toes. The Decision of the Arbitrator is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated August 27, 2019 is modified as stated herein. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS FURTHER ORDERED that Respondent pay Petitioner the sum of $775.18 per week for a period of 33.4 weeks, as provided in §8(e) of the Act, for the reasons that the injuries sustained caused a 20% loss of use of the left foot. Respondent has also paid $40,309.36 toward the statutory amputation of Petitioner's four toes and has agreed to pay an additional $13,425.36 for a total

payout of $53,734.72.

20IWCC0190

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.

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 16 2020

Barbara N. Flores

DLS/met
O- 3/5/20
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Marc Parker

DISSENTING IN PART, CONCURRING IN PART

I concur with the majority that the Decision of the Arbitrator must be modified to reflect that Petitioner's injury occurred to his left foot as opposed to his right foot. However, I respectfully dissent from the majority's award of 20% loss of use of the left foot. I would have instead found that Petitioner suffered a 12% loss of use of the left foot based on the §8.1(b) factors in addition to the amount statutorily owed to him for the amputation of his four toes.

Petitioner was placed at maximum medical improvement, returned to work without restrictions, and discharged from Dr. Ricci's care on February 7, 2017. Petitioner was able to return to full duty work in his pre-accident position after being released by Dr. Ricci. Although Petitioner testified that he is no longer able to perform the same amount of overtime work, he is not under any doctor's restrictions regarding overtime. Additionally, although Petitioner expressed concern that he would have difficulty finding a different job with a different employer in the future, Petitioner still worked full duty for Respondent at the time of the hearing and never sought any outside employment. Petitioner testified that he loved working for Respondent, and there was no evidence to suggest that Petitioner's future earning capacity was negatively affected by his work accident.

The above factors, which correlate specifically with criterion (ii) and (iv) of §8.1(b) of the Act, support modifying the permanent partial disability award down to 12% loss of use of the left foot, as Petitioner returned back to work full duty at his pre-accident job and proved no detriment to his future earning capacity. I would therefore have awarded 12% loss of use of the left foot in

addition to the statutorily imposed amounts due for the amputation of Petitioner's four toes.

DLS/met
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Deborah L. Simpson
Deborah L. Simpson

Bibliography

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REYNOLDS, RENARD
Employee/Petitioner

Case# **17WC018201**

GLOBAL BRASS & COPPER
Employer/Respondent

20IWCC0190

On 8/27/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.84% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

6296 JEROME LINDSAY & SALMI LLC
DAVID J JEROME
331 SALEM PL SUITE 260
FAIRVIEW HTS, IL 62208

0299 KEEFE & DePAULI PC
MICHAEL KEEFE
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

20IWCC0190

20IWCC0190

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
NATURE AND EXTENT ONLY

Renard Reynolds
Employee/Petitioner

v.

Global Brass & Copper
Employer/Respondent

Case # **17** WC **18201**

Consolidated cases: **N/A**

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 **Michael Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **7/30/19**. By stipulation, the parties agree:

On the date of accident, **8/24/16**, 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 $**89,581.44**, and the average weekly wage was $**1,722.72**.

At the time of injury, Petitioner was **48** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of $**11,645.69** for TTD, $**0** for TPD, $**0** for maintenance, and $**40,309.36** for other benefits, for a total credit of $**51,955.05**.

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 has paid $40,309.36 towards the statutory amputation of 4 toes and has agreed to pay an additional $13,425.36 for a total payout of $53,734.72.

Respondent has agreed to pay the outstanding medical bills set forth in Petitioner's Exhibit #7, pursuant to the fee schedule.

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 **$775.18**/week for a further period of **33.4** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **20% loss of use of the right foot.**.

Respondent shall pay Petitioner compensation that has accrued from **11/4/16** through **8/22/19**, 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.

Michael K. Nowak, Arbitrator

8/22/19
Date

ICArbDecN&E p.2

AUG 27 2019

FINDINGS OF FACT

Petitioner is a 51-year-old DC Caster at Olin Brass who began working there on July 7, 2000. On August 24, 2016, Petitioner was working in the casting department, adding metal to a melting pot (melt) that he analogized to an enormous soup pot that weighed 15,000 to 20,000 pounds with an additional 30,000 pounds of scrap metal that was added to the pot. Petitioner testified that a co-worker had raised to tilt the melt but did not warn him that the melt was coming back down. Ultimately, the melt came down and crushed the front of Petitioner's right foot which caused the amputation of four toes, leaving only his big toe.

Petitioner was taken by ambulance to Barnes Hospital where remained for 3 days. Medical records from Barnes Hospital confirm the history of a work accident. On August 25, 2016, Dr. Ricci completed surgery that consisted of surgical removal of 4 toes. On September 6, 2016, Petitioner underwent a second surgery that consisted of an irrigation and debridement of the amputated toes.

Thereafter, Petitioner completed physical therapy at Athletico PT. At the time of his release on October 24, 2016, Petitioner was noted to have ongoing throbbing in his foot at the sight of the amputations. He was also noted to have ongoing numbness and tingling in his toes as well as a constant pain that was a 2 out of 10. The therapist noted that Petitioner was having problems with his balance that caused difficulty in performing recreational activities or running.

Petitioner noted that while he was undergoing medical care and physical therapy, he was released to return to work light duty. When Petitioner returned to work, he noted pain at the amputation site and problems with his foot slipping from side to side inside the boot. Additionally, Petitioner developed excruciating pain at the site of the amputations if he tried to work over eight hours. Petitioner also developed a large welt in the top front of his ankle due to his foot slipping in his boot. Petitioner noted that the welt continues to be present to this date.

On February 27, 2017, Dr. Ricci placed Petitioner at maximum medical improvement and released him to return to work full duty. Due to ongoing problems, Petitioner sought a second opinion with Dr. Louis Aquino. Dr. Aquino confirmed the work injury and noted that Petitioner was still having pain at the site of the amputation. The doctor recorded that the pain was constant with activities as well as with wearing shoes. Thereafter, Dr. Aquino prescribed a prosthetic to help Petitioner's foot from sliding around in the shoe. Petitioner noted that it took a few modifications, but they finally were able to create a prosthetic that helped him.

Petitioner presented photographs of the amputated toes as well as the deformity to his foot. (Petitioner's Exhibit #6). Petitioner continues to have constant aching pain at the site of the amputations. Petitioner noted that when he wakes in the morning, the pain is a 2/10 and is located around the toes and ankle area. Petitioner described the pain as being a throbbing pain that has never subsided. Petitioner testified that he has simply learned to deal with the symptoms and not focus on his foot.

By the end of the day, Petitioner's pain level will go up to a 7-8/10. As a result, Petitioner now has to take 8 or 9 breaks during the course of a workday. During the course of the break, Petitioner must sit down on a bench; take off his boot; and sometimes rub his foot. Petitioner will also elevate his foot while on a break or lunch break. Petitioner has noted that during the course of the workday, he develops pain in his foot that causes

him to limp. As soon as he recognizes that he is limping, he tries to correct it because he does not want people to know about his amputated foot.

Petitioner testified that he must now protect his foot. He must always wear a sock and puts one on as soon as he wakes up each morning. Petitioner noted that when he has bumped this foot, it causes a great deal of pain. Petitioner likened bumping his amputated foot to "sticking something in an open wound."

As a result of this work accident, Petitioner now must lead with his right foot even though he is left side dominant. He testified that his right foot is more stable, so he leads with it and brings the left foot up behind it. Similarly, Petitioner climbs the steps by leading with his right foot and then bringing up the left foot in support. Petitioner described how he must slowly go up and down steps while making certain that his left foot is completely on the rail of the step. He noted that he no longer has toes to provide the necessary support for his left foot and therefore he must cautiously think about going up steps.

Petitioner noted that this accident has affected his work activities. Petitioner noted that he used to regularly work overtime, but now he is unable to perform overtime because his foot begins hurting and aching if he tries to work over 8 hours. As a result, Petitioner turns down overtime. Further, Petitioner has turned down jobs that required extensive standing due to the pain in his foot. Petitioner also noted that he has concerns with his ability to continue performing his current work activities on a long-term basis due to his foot injury. Petitioner has not sought alternate employment but also has concerns that a different employer may not accommodate his restrictions.

Petitioner's amputations have also affected his home life. Petitioner is a former athlete who played football, baseball and wrestled in high school. Petitioner also used to enjoy running. However, Petitioner has not been able to run since this accident. Petitioner noted that when he tries to run, he has problems with balance that makes him feel like he is falling. Petitioner has gained over 30 pounds due to his inability to properly exercise.

Additionally, Petitioner is no longer able to play sports with his son. Petitioner's 9 year old son is excelling in both soccer and baseball. Since this injury, Petitioner is no longer able to coach his son as he is unable to keep up with him due to the injury to his foot. Petitioner noted that he is not able to cut from side to side due to missing the amputated toes. Additionally, Petitioner is not able to kick the ball with the front of his foot but must use the side of his foot in order to avoid striking the injured area straight-on.

Petitioner testified that he is self-conscious about the appearance of his foot. When at the beach or pool, he is no longer able to wear flip-flops and ordered special water shoes to hide the missing toes from his foot. Petitioner noted that he wears socks so that people cannot see his foot and ask questions. Similarly, Petitioner testified that prior to this accident, he regularly received pedicures but has not received one since this accident as he did not feel that the pedicurists would understand his injury. Petitioner also noted that he still remains self-conscious when he goes on dates as he feels that he needs to explain his injury.

CONCLUSIONS

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 neither party submitted an impairment rating. 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 Petitioner has returned to his prior occupation following this work injury. However, the Arbitrator notes that Petitioner works in very physical job of metal castings. Although he was released to full duty, Petitioner continues to have problems in standing or walking at work for extended periods. He must take multiple breaks throughout his work day to elevate his foot; remove his boot; and simply sit to rest his injured foot. Petitioner is also unable to work overtime that he had regularly worked prior to this accident. Petitioner noted that Because of the nature of these work duties and ongoing problems in completing them. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner is 51 years old at the time of the accident. Because of his fairly young age and the length of his remaining work life, 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 The Arbitrator notes that Petitioner returned to his pre-employment position. Although Petitioner was released without restrictions, he testified credibly regarding ongoing problems with completing his work activities and removal of overtime hours. Petitioner also testified to concerns regarding his continued employment with Respondent as well as with alternate employers. Therefore, Petitioner testified credibly regarding a reduction in earning capacity as he is no longer able to work overtime hours due to the work injury. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. The Arbitrator notes that Petitioner sustained a severe crush injury to his dominant left foot that led to the amputation of 4 toes when a cast fell onto his foot. Petitioner continues to have significant pain and limitations at the site of the amputations. Further, Petitioner continues to have ongoing limitations with the duration that he can stand which has caused him to turn down overtime that he had previously accepted. Petitioner's injury has also affected his personal life as he is no longer able to coach his son in his athletic endeavors and Petitioner remains self-conscious about he appearance of his foot. 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 20% loss of use of the left foot pursuant to §8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Leslie Graves,

Petitioner,

vs. NO. 19WC 6073

State of Illinois,

Respondent.

20IWCC0191

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 4, 2019 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.

20IWCC0191

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: MAR 16 2020

Stephen J. Mathis

SJM/sj
0-3/3/2020
44

L. Elizabeth Coppoletti

Douglas D. McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GRAVES, LESLIE
Employee/Petitioner

Case# **19WC006073**

STATE OF ILLINOIS
Employer/Respondent

20IWCC0191

On 9/4/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.82% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1189 WOLTER BEEMAN LYNCH ET AL
FRANCIS J LYNCH
1001 S 6TH ST
SPRINGFIELD, IL 62703

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

6140 ASSISTANT ATTORNEY GENERAL
JOSEPH L MOORE
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

SEP - 4 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)SS.

COUNTY OF SANGAMON)

20 IWCC0191

☐ Injured 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

LESLIE GRAVES,
Employee/Petitioner

v.

STATE OF ILLINOIS,
Employer/Respondent

Case # **19** WC **6073**

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 **Springfield**, on **7/30/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5/31/18**, Respondent ***was*** operating under and subject 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 $**198,026.92**; the average weekly wage was $**3,808.21**.

On the date of accident, Petitioner was **55** 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 $**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

Respondent shall pay Petitioner permanent partial disability benefits of $790.64/week for 5 weeks, because the injuries sustained caused the 1% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $790.64/week for 25.3 weeks, because the injuries sustained caused the 10% loss of the petitioner's left arm, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $790.64/week for 25.625 weeks, because the injuries sustained caused the 12.5% loss of the petitioner's left hand, as provided in Section 8(e) of the Act.

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

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

Kaureen Hulia

Signature of Arbitrator

8/14/19
Date

SEP 4 - 2019

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 55 year old Circuit Court Judge, alleges she sustained an accidental injury that arose out of and in the course of her employment by respondent on 5/31/18 when she fell while walking from her assigned parking spot in the parking lot to the employee entrance of the 7th Circuit Court Building. Petitioner alleges that she sustained injuries to her left wrist and elbow, right knee, head/neck, as well as bruises and contusions. The issues in dispute are accident, causal connection as it relates to petitioner's head/neck injury, and the nature and extent of petitioner's injury.

Petitioner is a Circuit Court Judge assigned to the 7th Circuit Court in Sangamon County. She testified that she was unable to park in the metered spots on the street because she was in the courthouse most of the day, and would not be able to exit the courthouse to feed the meter. As a result, she was able to purchase a monthly parking pass at $25/month for parking in the courthouse parking lot. Petitioner was assigned a specific parking spot by her supervisor, Suzanne Maxheimer, Trial Court Administrator, a State employee. The spot petitioner was assigned was in a lot across from the courthouse. Between the courthouse and the parking lot where petitioner parked was a lot that was not used. Petitioner testified that this lot was part concrete, part gravel, and part concrete chunks. Petitioner stated that there were also a few concrete barriers around the lot so cars could not park in it, and construction was set to start at some point in the future. She testified that the lot had been like this for a year and a half. She stated that she was familiar with the condition of the lot, and it was hazardous and uneven. She also stated that the elevation was not different, however, there were just changes in the consistency of the parking lot surface. She stated that she was aware of the hazardous areas of the lot and did her best to navigate around them.

Petitioner testified that the most direct route from the parking lot to the court house was from her parking spot, out of her lot, and across the closed off lot, to the employee entrance. Petitioner testified that if she was to take a route to the left of the direct route she and other employees take from the parking lot to the employee entrance, it would be more dangerous because there is a deep ditch, and "riff raff" concrete along the railroad tracks. Petitioner testified that this route would be more hazardous than the direct route she took. If she was to take a route to the right of the direct route she and other employees take from the parking lot to the employee entrance, that route could take her twice as long to get to the employee entrance and require her to cross the street. Petitioner testified that the lot her assigned parking spot was in was only for employee use.

When petitioner got out of her vehicle she placed a backpack on her back. In this backpack was a case file for her trial that day, briefs, files, and a Civil Bench book she had taken home to review. She testified that everything in the backpack was related to work. She also testified that she was wearing stable flat shoes due to

the uneven terrain she had to walk over to get from her parking lot to the employee entrance, where she had to enter.

After petitioner placed the backpack on her shoulders she began walking from her parking lot across the empty parking lot that consisted of concrete, gravel, crushed gravel, rubble, and concrete chunks, to the employee entrance. She testified that the surface of the parking lot changes throughout the lot. Petitioner was able to walk along part of the concrete section in the empty lot. However, at one point she had to cross over from the concrete section to the gravel, crushed gravel, and concrete chunk section so that she could get to the employee entrance. As she did this she fell very hard on the uneven gravel. Due to her pain in her right knee and left arm, and the weight of the backpack, she could not get up on her own. After sitting there and cussing at herself for awhile because she could not get up, another lady came up to her to help. The lady helped her up and helped walk her to the courthouse. The security guard at the door saw her and knew something was wrong. He called his Lieutenant and took petitioner to her chambers. Petitioner was checked out by the EMT's. Lieutenant Alex took her to the Springfield Clinic Walk-in Clinic. Her daughter met her there.

Petitioner was seen at the Clinic by Dr. Rishi Sharma for evaluation of her left elbow, left wrist, and right knee. She described her pain as constant since she fell and landed on her left elbow and right knee. She reported discomfort. Petitioner underwent various x-rays for her left wrist, left elbow and right knee. She rated her pain as a 7/10. Following an examination and x-rays, Dr. Sharma's assessment was left wrist triquetral fracture, left elbow radial head fracture, and right knee contusion. Petitioner was told to rest, ice, use compression, and elevate the body parts. Her left upper extremity was immobilized in a splint and she was told she would be fitted for a shoulder immobilizer. She denied any pain in her left arm prior to the fall.

On 6/5/18 petitioner presented to Christopher Maender at Orthopedic Center of Illinois. Petitioner gave a history of falling on a concrete surface when she was outside of her work place. She reported that she fell on an extended left hand and caught herself awkwardly. She had an immediate onset of pain in her left hand. She denied numbness and tingling. Dr. Maender examined petitioner and reviewed the x-rays of the left wrist and elbow. He assessed a closed displaced fracture of the head of the left radius, and closed displaced fracture of the triquetrum of the left wrist. He also recommended early range of motion for the radial head fracture. She was shown these exercises. He placed her in a removable wrist splint for her left wrist.

On 6/20/18 petitioner followed-up with Dr. Maender for her left wrist and elbow. She also reported that her headaches had been worse since her fall. Petitioner was tender and had minimal pain. Petitioner showed no swelling or bruising. Her sensation was intact. Dr. Maender took new x-rays of the left wrist and elbow. The x-rays of the left elbow showed her radical neck fracture with mild impaction was in good alignment. The x-rays of the left wrist showed her triquetrum fracture. It was noted that it probably went all the way through the

triquetrum and was not just a dorsal triquetrum fracture. Dr. Maender assessed a closed displaced fracture of the head of the left radius with routine healing, closed displaced fracture of the triquetrum of the left wrist with routine healing, and cervical radiculopathy. Dr. Maender recommended continued non-operative treatment for her left elbow and a CT scan for the left wrist. Due to her neck pain and increased headaches, petitioner asked if she could see a neck physician.

On 6/22/18 petitioner underwent a non-IV contrast CT of the left wrist. The impression was mildly comminuted fracture of the triquetrum dorsally; mild dorsal tilt of the lunate in relation to the capitate without meeting criteria for dorsal intercalated segmental instability; and no CT evidence of a radius fracture.

On 6/26/18 petitioner presented to Dr. Christopher Graves for her neck pain and pain in the back of her head. She reported that her symptoms had been going on for 3 weeks. She reported that her pain radiates into the right and left occipital regions. She described her pain as aching and throbbing. She rated her pain at a 2/10. She stated that her pain was worse with reading, and relieved by lying down. She reported numbness in her hands while driving. She reported trouble with activities involving overhead reach. She also reported significant difficulty with fine motor tasks such as buttoning a shirt or picking a coin off the floor. Dr. Graves performed cervical x-rays that demonstrated normal alignment and range of motion without significant spondylosis or any spondylolisthesis. He also performed an examination. Dr. Graves' assessment was neck pain. Dr. Graves was of the opinion that petitioner had axial neck pain, headaches, and some occasional symptoms radiating down her bilateral upper extremities in about a C7 nerve distribution. He noted that petitioner's biggest problems were neck pain and headaches. Dr. Graves noted that this had been an ongoing issue but was worsened significantly after the fall three weeks prior. Physical therapy was recommended.

On 7/6/18 Dr. Maender discussed the results of the CT scan with petitioner. He noted that it showed a comminuted dorsal triquetrum fracture. He recommended continued splinting and work on her elbow range of motion, as well as gentle work on her wrist motion.

On 7/16/18 petitioner underwent an initial physical therapy examination at PhysioTherapy Professionals for cervical spine pain and headaches after a fall. Petitioner had reduced cervical range of motion and some upper cervical dysfunction. Her problems were listed as left sided headaches, upper cervical spine pain, weak cervical neck flexors, extensors, scapula stabilizers, and reduced range of motion to the right. It was recommended that petitioner undergo therapy 2 times a week for 8 weeks.

On 8/3/18 petitioner followed-up with Dr. Maender for her left elbow and wrist. She reported that the left elbow felt better overall, but was sore at times. She demonstrated good range of motion of the left elbow. No swelling was noted in the left wrist. There was no numbness or tingling noted. She had soreness when making a

fist, and could not quite fully extend her left wrist. She also noted that writing caused her fatigue and weakness. She noted that she was frustrated because she could not play golf. She reported a clicking with mostly flexing motions. Petitioner told Dr. Maender that her headaches were less frequent. An examination revealed that the tenderness over her dorsal triquetrum was better than before. She had a small click at the ulnar side of her wrist and ulnar deviation. She had a mild click at her ECU but it did not fully dislocate. Petitioner was tender over the area as well. Her extension and flexion were 80 degrees on the left, as compared to 90 degrees on the right. She had full pronation and supination. He left elbow had full flexion but lacked 10 degrees of extension. Mild tenderness over the extensor musculature and radial neck was noted. New x-rays of the left elbow showed progressive healing of the radial neck fracture which was mildly impacted. There was good alignment of the joint. X-rays of the left wrist showed her triquetrum fracture. There was mild displacement, but no worse than before. Mild callus was seen through the triquetrum, and there was widening of the scapholunate interval. There was an increased angle of the scapholunate angle in the lateral view. Dr. Maender assessed a closed displaced head of the left radius with routine healing, and closed displaced fracture of the triquetrum of the left wrist with routine healing. Dr. Maender noted that petitioner's fractures were healing as expected, and he would expect her pain to slowly improve, but it may take several months to resolve. He told petitioner to work on her range of motion on her own. He was of the opinion that petitioner could resume light strengthening activities within her pain tolerance, and continue working on getting her full elbow extension. He instructed her to return in 8 weeks for repeat x-rays of left elbow and wrist.

On 9/6/18 petitioner reported no headaches, full range of motion, but some upper cervical stiffness in physical therapy. She reported that she was doing well. On 10/30/18 petitioner was discharged from physical therapy for her cervical spine and headaches. It was noted that her goals were met.

In 2015 and 2016 petitioner underwent physical therapy for her left/right foot plantar fasciitis. In 2016 petitioner underwent physical therapy for her Achilles tendons. In 2016 petitioner was in physical therapy for severe pain in her left cervical spine extending down to her thoracic spine aggravated by walking and running. From 1/26/18-4/17/18 petitioner underwent physical therapy for her right shoulder, and muscle spasm all the way across her back and neck.

The Memorial Health System records were offered into evidence. On 2/2/17 petitioner reported facial pressure and headaches that started 7 days prior. She was assessed with acute frontal sinusitis. On 9/21/17 petitioner reported improvement in back and neck following a motor vehicle accident without air bag deployment. On 1/23/18 petitioner complained of worsening pain in her right shoulder following a strain in her shoulder doing a weight exercise 3 months prior. She had spasms in her neck and back. On 3/2/18 a herniation of an intervertebral disc without myelopathy was noted. It was noted that on 4/5/18 petitioner was diagnosed

with cervical spondylosis without myelopathy, and trigger point of neck. On 5/8/18 petitioner was diagnosed with headaches. On 10/18/18 petitioner complained of sinus pain and headaches with an onset 4 days ago. On 1/17/19 petitioner was diagnosed with migraine variant.

On 1/24/18 petitioner presented to Dr. Karolyn Senica with complaints of right shoulder and neck pain following a pull in her shoulder 3 months ago while doing exercises.

The Illinois Form 45: Employer's First Report of Injury was completed by Erin Leaman, First Notice Associate at Tristar Group, on 2/26/19. She noted that petitioner sustained an injury that occurred on the employer's premises, at 900 S. 9th Street, Springfield, IL. Leaman noted that the accident occurred when "EE was walking from her parking spot to the employee entrance and the walkway went from gravel to broken concrete and she fell". The injury was identified as "right knee pain, left wrist and elbow fractures, headache, neck pain radiating to shoulders".

The Tristar Notification of Injury was also completed on 2/26/19 by E. Leaman. Petitioner's supervisor was identified as Suzanne Maxheimer. The incident date, place, how it occurred, and injuries sustained, were the same as on the Form 45 Leaman completed.

Petitioner offered into evidence photos of the area where she fell (PX6). These pictures were taken by petitioner within a week of the injury. Respondent also offered into evidence photos of the lot where petitioner fell that has since been repaved, and other photos of parking areas restricted to Sangamon County Authorized Vehicles Only. (RX2) No evidence was offered on the record as to when these photos were taken and by whom.

Respondent offered into evidence a medical record from Dr. Chris Wottowa dated 4/4/16 that showed petitioner had active problems that included chronic foot pain. She was being seen for her left wrist. She noted that she woke up 2 days prior with severe pain in her left wrist in the volar aspect. She was tender and had swelling over the pistotriquetral joint. Her wrist motion was full. An x-ray showed sever pisotriquetral arthritis. He recommended a brace and Medrol DosePak. If symptoms continued she was told she may consider an injection.

On 3/25/15 petitioner presented to Dr. Mary Sipes, a podiatrist, for pain in both feet that was increasing. Dr. Sipes noted that when she last saw petitioner in January of 2015 she had significant plantar fasciitis. Petitioner was to have physical therapy but it was not approved by the insurance company. She stated that she found another physical therapy place but had not yet started therapy. Dr. Sipes injected petitioner's feet in January of 2015, and recommended she wear Birkenstocks or Alegria. Petitioner reported that she bought the Birkenstocks and wore them around her house. She also reported that she was icing and stretching. Petitioner's

new complaint was that her feet felt extremely ice cold to her, but not necessarily to the touch. She told Dr. Sipes that she had stopped working out almost entirely. Following an examination Dr. Sipes assessed severe plantar fasciitis. Dr. Sipes was concerned that there could be an underlying neurologic reason, such as possible neuropathy. Dr. Sipes ordered an EMG and sent petitioner for a fasting glucose or A1c test. Petitioner testified that the EMG and A1c tests were normal and she does not have diabetes.

Petitioner testified that she had tension headaches prior to the injury on 5/31/18. However, she testified that she never got headaches looking down and reading her phone or computer before the injury on 5/31/18. She testified that she can only look down to read for about 10 minutes. She stated that it has improved since the injury, since at that time she could not look down for more than 7 minutes.

Petitioner testified that over time her right knee improved and was essentially fine. However, she did mention that it feels different since the injury. She testified that there is a big knot on her right knee that she notices when she does certain positions in yoga, squats or kneels.

Petitioner testified that one year prior to this injury she had torn her calf muscle and had to rest her knee on a scooter. At one point while on the scooter the scooter hit the curb and she fell off the scooter and hurt her right knee. After that healed, her right knee did not hurt again until the injury on 5/31/18. She still has to be careful with her calf muscles.

Petitioner testified that she is an active person who used to water ski, ride a waverunner, and golf prior to the injury on 5/31/18. Since then she has only tried to golf twice and that caused increased pain in her left arm. She also testified that her waverunner is old and trying to turn it causes increased pain in her left wrist.

Petitioner retired as a Circuit Court Judge in December of 2018. She got certified in mediation and is in negotiations with a CPA to start a mediation firm. It may happen sooner than she thought since she has partnered with a CPA.

Petitioner testified that the injury occurred about 8:45 am. She testified that she was not rushing and her court call did not start until 9:30 am. She stated that she was walking at a normal pace. She testified that the injury time of 9:10 am on the reports was not the time of the injury but possibly the time she got to her chambers.

Petitioner testified that she has no knowledge of the State of Illinois owning the lot in which she fell. She thought it may have been owned and operated by SMTD. Petitioner testified that the parking lot where she parks is not open to the general public. Petitioner testified that parking spots were assigned to clerks, coroner staff, court reporters, and judges by her supervisor Suzanne Maxheimer, the Trial Court Administrator and State

employee. Petitioner could not park in metered parking because she is in the courthouse longer than the meter allows.

Petitioner testified that she had been diagnosed with plantar fasciitis 20 years ago when she was pregnant. Since then she has had flare-ups of her plantar fasciitis. The most recent documented flare up was in 2015. She testified that the last time she treated it was with dry needling and that resolved her complaints. Petitioner testified that she has different heels that she changes into in her chambers because she always wore flat shoes to walk from her parking lot to the employee entrance, because of the condition of the lot.

Petitioner testified that her right shoulder, Achilles tendon, calf, and feet conditions, as well as any treatment for these conditions, is not related to the injury on 5/31/18. Petitioner denied any neurological problems with her feet.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner alleges that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 5/31/18 when she slipped and fell while walking from her assigned parking spot to the employee entrance of the courthouse. Respondent disputes this and claims that when petitioner fell she was at no greater risk than the general public.

Petitioner offered the following unrebutted testimony: 1) that she is a Circuit Court Judge who works inside the courthouse most of the day; that the courthouse is surrounded by employee parking lots, as well as metered parking on the streets; that she is unable to park at a metered spot on the street because she is in the courthouse most of the day and cannot run out to feed the meter; that Suzanne Maxheimer, Trial Court Adminstrator, is a State employee and her supervisor; that Maxheimer assigned petitioner a specific parking spot in the employee parking lot; that between the employee entrance to the courthouse and the parking space petitioner was assigned, there is another parking lot that was part concrete, loose gravel, gravel, and concrete chunks with some concrete barriers around it so cars could not park in that lot; that the most direct route to the employee entrance was through the lot with concrete/gravel hazards; that the general public was not allowed to park in the lot petitioner parked in; that petitioner was wearing flat shoes while walking from her parking space to the employee entrance; and, that she was carrying a backpack on her back full of work-related materials including case briefs, files, and a Civil Bench book.

Petitioner also testified that the route she took from her assigned parking space in the employee only parking lot, to the courthouse employee entrance, was the most direct route from her parking spot to the employee entrance. Petitioner further testified this route was hazardous due to the uneven surface of the parking lot which was part concrete, and other areas that consist of gravel, loose gravel and concrete chunks. Petitioner

testified that although there were two alternate routes she could take from her parking spot to the employee entrance, one was more hazardous than the route she took, and the other would take her twice as long to get to the employee entrance. The route to the left would take her through a deep ditch, and "riff raff" concrete along the railroad track. Petitioner testified that this route is even more hazardous than the direct route she took. The route to the right would take twice as long and require her to walk around the block and across different streets.

Respondent also argued that petitioner's fall was due to preexisting problems petitioner had with her feet. However, after reviewing the credible record in its entirety, the arbitrator finds that although petitioner had severe plantar fasciitis for years, after 2015 petitioner has had no documented treatment for this condition.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner sustained an accidental injury that arose out of and in the course of her employment by respondent on 5/31/18. In support of this finding the arbitrator finds the petitioner was clearly at a greater risk than the general public when she fell on her way from her assigned parking space to the employee entrance of the courthouse. The arbitrator finds it unrebutted that petitioner was assigned her parking spot by her supervisor Maxheimer, who was also a State employee; that petitioner was carrying a very heavy backpack full of work related materials on her back when she fell, that was so heavy she could not get back up by herself after she fell; that the most direct route to the employee entrance was across a parking lot that was very hazardous and uneven due to the multiple changes in surface matter ranging from concrete, to gravel and loose gravel, to concrete chunks; that one alternate route to the employee entrance was more hazardous than the route she took, and the other route would have taken petitioner twice as long; that the general public would have no reason to be in the lot where petitioner fell because only certain employees assigned specific parking spaces are allowed to park in that lot; and, that the employee entrance was not an entrance that the general public could enter.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Having found the petitioner sustained an accidental injury that arose out of and in the course of her employment by respondent on 5/31/18 when she fell while walking from her parking space to the employee entrance, the petitioner claims her current condition of ill-being as it relates to her right knee, left arm, head and neck, are causally related to the injury on 5/31/18. However, the respondent claims that even if an accidental injury is found, the petitioner's current condition of ill-being as it relates to her neck and head are not causally related to the injury on 5/31/18. The petitioner claims all treatment for her right shoulder, Achilles tendon, calf problems and feet conditions are not causally related to the injury on 5/31/18.

As such, the only issue in dispute as it relates to causal connection is whether or not petitioner's current condition of ill-being as it relates to her neck and headaches is causally related to the injury she sustained on

5/31/18. It is unrebutted that petitioner had prior neck and headaches issues prior to the injury on 5/31/18. Petitioner testified that she had tension headaches prior to the injury on 5/31/18. However, she testified that she never got headaches looking down and reading her phone or computer prior to the injury on 5/31/18. On 6/20/18 petitioner reported to Dr. Maender that her preexisting headaches had been worse since her fall. Dr. Maender diagnosed cervical radiculopathy. She was referred to Dr. Graves.

On 6/26/18 she told Dr. Graves that her neck pain and pain in the back of her head radiated into the right and left occipital regions. She described this pain as aching and throbbing. She rated her pain at 2/10. X-rays of the cervical spine demonstrated normal alignment and range of motion without significant spondylosis or any spondylolisthesis. Following his review of these x-rays and her examination, Dr. Graves assessed neck pain. He was of the opinion that she had axial neck pain, headaches, and some occasional symptoms radiating down her bilateral upper extremities in about the C7 nerve distribution. He noted that her biggest problems were neck pain and headaches. He noted that although this had been an ongoing issue for petitioner, it worsened significantly after the fall. Respondent offered no credible evidence to rebut Dr. Graves' opinion.

Based on the above, as well as the credible evidence, the arbitrator finds that in addition to a causal connection between the current condition of ill-being between her left upper extremity and right lower extremity and the injury on 5/31/18, the petitioner has proven by a preponderance of the credible evidence that her current condition of ill-being as it relates to her neck/headaches is causally related to the injury on 5/31/18. The arbitrator finds that the petitioner sustained an aggravation of her preexisting neck and headache condition as a result of the injury on 5/31/18. In support of this finding the arbitrator relies on the opinion of Dr. Graves that was not rebutted by any other healthcare provider.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

For injuries that occurred after 9/1/11, according to 820 ILCS 305/8.1B(b) the Commission shall base its determination of permanent partial disability based upon five factors including an AMA report, the occupation of the injured employee, the age of the employee at the time of injury, the employee's future earning capacity and evidence of disability corroborated by treating medical records. Petitioner is alleging injuries to her left upper extremity, right lower extremity, and her person as a whole as it relates to her neck/headaches.

With regard to subsection (i) of §8.1b(b), neither party offered into evidence an AMA impairment report 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 petitioner was a 55 year old Circuit Court Judge. Petitioner did not lose any time from work as a result of this injury. She continued to work full duty until her retirement in December of 2018. Petitioner last treated for her

injuries on 10/30/18. The petitioner testified that she and a CPA are going to begin their own mediation firm. As of the trial date, this firm had not yet opened, but petitioner testified that now that she has a partner it may open sooner than later. For these reasons the arbitrator gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that the petitioner was a 55 year old Circuit Court Judge. She never lost any time from work and ultimately stopped treating as of 10/30/18. Petitioner retired from the Circuit Court in December 2018. Petitioner got her mediation certification and is in the process of opening a mediation firm with a partner that has a CPA. Petitioner testified that it may happen sooner rather than later. Petitioner's primary complaint is that she has pain in her neck and gets headaches when her head is down and she is reading or working on the computer. She testified that she can only read and use the computer while looking down for about 10 minutes. She denied any problems reading or working on the computer prior to the injury on 5/31/19. Petitioner was never given any permanent restrictions. For these reasons the arbitrator gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the arbitrator notes that petitioner was released to full duty work without restrictions. Petitioner testified that 2 months later she retired. She got her mediation certificate and is in the process of opening a mediation firm with a partner who is a CPA. Petitioner offered no evidence regarding her future earning capacity, but it is unrebutted that petitioner continued working after her injury until her voluntary retirement in December of 2018. There is no credible evidence to support a finding that petitioner's future earnings capacity is negatively affected in any way by the injury she sustained on 5/31/18. Therefore, the arbitrator 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 finds the petitioner sustained an injury to her right lower extremity, left upper extremity, and her neck/head that arose out of and in the course of her employment by respondent on 5/31/18.

With respect to her left upper extremity, petitioner was diagnosed with a displaced left wrist triquetral fracture, and displaced left elbow radial head fracture. For her left arm injuries petitioner was initially immobilized. On 6/20/18 Dr. Maender noted that the radial neck fracture with mild impaction was in good alignment, and her triquetrum fracture probably went all the way through the triquetrum and was not just a dorsal triquetrum fracture. He recommended continued non-operative treatment. On 6/22/18 a CT of the left wrist showed a mildly comminuted fracture of the triquetrum dorsally; mild dorsal tilt of the lunate in relation to the capitate without meeting the criteria for dorsal intercalated segmental instability, and no evidence of a radius fracture. Dr. Maender recommended continued splinting and work on her elbow range of motion, as well as gentle work on her wrist motion. By 8/3/18 petitioner reported that her left elbow felt better overall, but was sore at times. She demonstrated good range of motion. With regard to her wrist she had soreness when making

a fist and could not fully extend her left wrist. She also noted that writing caused her fatigue and weakness. She reported a clicking with mostly flexing motions. Her extension and flexion on the left were 10 degrees less than on the right. Her left elbow lacked 10 degrees of extension. She had mild tenderness over the extensor musculature and radial neck. X-rays of the left elbow by this date showed progressive healing of the radial neck fracture which was mildly impacted. There was good alignment of the joint. The left wrist x-rays showed the triquetrum fracture was mildly displaced, but no worse than before. Mild callus was seen through the triquetrum, and there was widening of the scapholunate interval. There was also an increased angle of the scapholunate angle in the lateral view. Dr. Maender noted that both fractures were healing as expected, but it may take several months to resolve. He told her to work on her range of motion.

With respect to her left arm and wrist petitioner reported that playing golf resulted in increased pain in her left arm. She also reported that trying to turn her old waverunner causes increased pain in her left wrist.

With respect to her right knee petitioner was diagnosed with a right knee contusion. Petitioner did not receive any specific treatment for her right knee. At trial, she testified that her right knee improved over time, and is essentially fine. However, she also testified that there is big knot on her right knee that she notices when she does certain yoga positions, squats or kneel. The arbitrator notes that there is no reference to these complaints in the credible medical evidence.

Lastly, with respect to her cervical spine and headaches, petitioner underwent conservative treatment that included x-rays of her cervical spine that demonstrated normal alignment and range of motion without significant spondylosis or any spondylolisthesis. She was assessed with axial neck pain, headaches, and some occasional symptoms radiating down her bilateral upper extremities in about a C7 nerve distribution. Dr. Graves identified her biggest problems were neck and headaches. For this Dr. Graves had petitioner undergo a course of physical therapy 8 weeks long. On 9/6/18 petitioner reported no headaches, full range of motion, and some upper cervical stiffness. She reported that she was doing well. On 10/30/18 she was discharged from physical therapy for her cervical spine and headaches. The therapist noted that petitioner's goals were met. Petitioner sought no further treatment for her neck and headaches after 10/30/18.

At trial petitioner reported that she cannot look down to read or work on her computer for more than 10 minutes before she has pain that prevents her from continuing. Petitioner testified that after the injury she could not look down to read or work on her computer for more than 7 minutes.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner sustained a 12.5% loss of use of her left hand pursuant to Section 8(e), 10% loss of use of her left arm pursuant to Section 8(e);

and 1% loss of use of her person as a whole pursuant to Section 8(d)2 of the Act. The arbitrator finds the petitioner sustained no permanent partial disability to her right leg as a result of her right knee contusion.

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

Gary W. Johnson,

Petitioner,

vs.

NO: 16 WC 15259
16 WC 19045
17 WC 14739

IMEL Pest Control Inc.,

Respondent.

20IWCC0192

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 disability, medical expenses, and prospective medical care, and being advised of the facts and law, affirms with changes 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 disability compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327 (1980).

The Commission observes that the Memorandum of Decision of the Arbitrator finds in part that Respondent paid temporary disability benefits from December 14, 2018 through January 22, 2018. The Commission corrects this finding in Memorandum to reflect an ending date of January 22, 2019 (the hearing date), in order to conform the pleadings to the proofs. The Arbitrator's finding and calculation of the disputed temporary disability benefits, which is completely unaffected by the typographical error, is affirmed and adopted.

20IWCC0192

In addition, the Commission acknowledges the agreed order entered by the Circuit Court of Madison County in Johnson v. Wheeler, No. 16 L 684, which is the civil personal injury action arising out of the April 12, 2016 accident. The order provides in part that Respondent's insurer shall be entitled to a set-off/credit up to the amount of $60,104.09 against any potential future workers' compensation benefits that may be owed in this proceeding.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE FOUND BY THE COMMISSION that Respondent had paid temporary total disability benefits from: April 13, 2016 through August 24, 2016; December 19, 2016 through March 16, 2017; and December 14, 2018, through January 22, 2019. Petitioner shall be given a credit of $16,230.70 for temporary total disability benefits already paid, as well as a credit of $4,123.40 for advance partial permanent disability benefits already paid.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary partial disability benefits of $458.15 per week for 64 and 5/7ths weeks, commencing September 17, 2017 through December 13, 2018, as provided in Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner's reasonable and necessary medical expenses as identified in Petitioner's Exhibit 15, per the Decision of the Arbitrator. Respondent shall pay Petitioner $156.22, representing amounts Petitioner paid to his pharmacy. Respondent also shall pay the remaining expenses identified in Petitioner's Exhibit 15 to Anderson Hospital, Family Physicians of Madison County Ltd., Maryville Radiology, SpineMore Surgical Associates PC, International Pain Institute, Frontenac Surgical & Spine Care Center, St. Louis Orthopedic Surgeons Inc., and Advanced Surgical Center of Sunset Hills pursuant to the fee schedule and Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is liable for Petitioner's prospective medical care, including surgical intervention for Petitioner's neck and right shoulder, as it is causally related to the accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for penalties and attorney's fees is denied.

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

20IWCC0192

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,900.00. 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 16 2020
d: 02/06/20
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

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

JOHNSON, GARY W
Employee/Petitioner

Case# **16WC015259**

16WC019045
17WC014739

IMEL PEST CONTROL INC
Employer/Respondent

20IWCC0192

On 8/5/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5542 WENDLER LAW PC
ANGIE M ZINZILIETA
900 HILLSBORO SUITE 10
EDWARDSVILLE, IL 62025

0000 WIEDNER & McAULIFFE LTD
JAMES A TELTHORST
8000 MARYLAND AVE SUITE 550
ST LOUIS, MO 63105

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)

Gary W. Johnson,
Employee/Petitioner

v.

Imel Pest Control, Inc.,
Employer/Respondent

Case # **16** WC **15259**

Consolidated cases: **16WC19045**
17WC14739

20IWCC0192

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **January 22, 2019**. After reviewing all of the evidence presented, Arbitrator Paul Seal hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0192

FINDINGS

On the date of accident, **April 12, 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 $**35,735.96**; the average weekly wage was $**687.23**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**16,230.70** for TTD, $**0** for TPD, $**0** for maintenance, and $**4,123.40** **(advanced PPD for bilateral carpal tunnel releases)** for other benefits, for a total credit of $**20,354.10**.

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

ORDER

Respondent is ordered to pay Petitioner 64 5/7 weeks of accrued unpaid TTD at the rate of $458.15 weekly for benefits commencing September 17, 2017, through December 13, 2018, in the total amount of $29,648.85.

Based upon the manifest weight of the evidence, the Arbitrator finds that all medical services provided to Petitioner referenced in Petitioner's Exhibit 15 were reasonable and necessary to cure and relieve the effects of Petitioner's injuries resulting from the subject crash. Respondent is ordered to pay for the same in accordance with § 8(a) of the Act and to continue to pay for further medical treatment as necessary and appropriate pursuant to the Act, including surgical intervention for Petitioner's neck and right shoulder.

Penalties and attorneys fees 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

July 29, 2019
Date

AUG 5 - 2019

STATE OF ILLINOIS)
)SS
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

GARY W. JOHNSON,
Employee/Petitioner,

Case Nos. 16-WC-15259
16-WC-19045-C
17-WC-14739-C

v.

IMEL PEST CONTROL, INC.,
Employer/Respondent.

Collinsville, Illinois

20IWCC0192

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties tried this case January 22, 2019, before Arbitrator Michael Nowak. On July 8th and 9th, 2019, the parties stipulated in writing to have another Arbitrator of the Commission write the decision based on review of the Transcript of Proceedings, exhibits, and the parties' proposed findings.

On the date of crash at issue, Gary W. Johnson ("Petitioner") was 58 years of age and had been working as a pest control technician for 11 years. As a pest control technician, his duties consisted of, in relevant part, pushing and pulling with the right arm, lifting 26-50 pounds, carrying 26-50 pounds, driving for extended periods of time, walking and standing for extended periods of time, working in attics and crawl spaces, and lifting a spray wand at, above, and below shoulder level while carrying a 20-pound tank. (Petitioner's Exhibit 16; *see also* Tr. 26-27, 29).

On April 12, 2016, while working for Respondent, Petitioner was traveling eastbound on State Route 140 in Bethalto, Illinois, when Petitioner noticed a vehicle erratically driving westbound on State Route 140. (Respondent's Exhibit 5, *see also* Tr. 15-16). The vehicle then swerved, turned sharply left, and jumped the median entering into oncoming eastbound traffic.

(*Id.*). The vehicle struck the rear driver's side of Petitioner's work vehicle. (*Id.*). Bracing for impact, Petitioner's hands tightly gripped the steering wheel. (Tr. 18-19). The responding officer noted "heavy front-end damage to Unit 1 and heavy rear driver's side and undercarriage damage to [Petitioner's work vehicle]." (Respondent's Exhibit 5). Upon impact, Petitioner immediately felt pain located on the right side of his chest area. (Tr. 19).

Petitioner and the other vehicle's driver were transferred via ambulance to St. Anthony's Health Center Emergency Room. (Petitioner's Exhibit 3; *see also* Petitioner's Exhibit 4). Petitioner complained to the ambulance personnel of chest and shoulder pain, and he was discharged from the emergency room with a chest contusion. (*Id.*; *see also* Tr. 20). Within three days of the crash, Petitioner began experiencing neck pain. (Petitioner's Exhibit 17; *see also* Tr. 21-22). Eight days after the crash, Petitioner followed up with his primary care physician, Dr. Michelle Mulligan, for pain in his neck, back, right elbow, right shoulder, and the right side of his chest. (Petitioner's Exhibit 1). Dr. Mulligan prescribed physical therapy for Petitioner. (*Id.*). On April 26, 2016, Petitioner began physical therapy at Anderson Hospital for a right shoulder muscle sprain and pain in the upper right arm and elbow. (Petitioner's Exhibit 5). The physical therapist noted that Petitioner had a SPADI[1] score of 71%. (*Id.*).

On April 27, 2016, Petitioner followed up with Dr. Mulligan for pain in his left wrist which had been ongoing since the crash. (Petitioner's Exhibit 1). Dr. Mulligan referred Petitioner for an x-ray, which indicated osteoarthritis and a possible fracture. (Petitioner's Exhibit 5). Dr. Mulligan then referred Petitioner to Dr. David Haueisen for his wrist pain.

[1] The SPADI is a 13-item self-report questionnaire. The visual analogue scale is not commonly used. A minimum of 2/3 of items in each subscale must be answered in order to compute a subscale score. Total score is calculated by averaging the pain and disability subscale scores.

(Petitioner's Exhibit 1). On May 5, 2016, Dr. Haueisen examined Petitioner and diagnosed Petitioner with carpal tunnel syndrome. (Petitioner's Exhibit 7).

On May 16, 2016, Dr. Mulligan noted that Petitioner had been going to physical therapy but was still having pain and limited range of motion in his right shoulder. (Petitioner's Exhibit 1). On May 18, 2016, Petitioner was discharged from physical therapy with a home exercise program. (Petitioner's Exhibit 5). However, the physical therapist noted that Plaintiff still had a SPADI score of 23%, significant forward head posture, and rounded shoulders. (*Id.*).

On May 24, 2016, Dr. Haueisen noted that Petitioner was treated for right chest wall and shoulder pain. (Petitioner's Exhibit 7). Dr. Haueisen reviewed Petitioner's physical therapy records and noted that Petitioner's right shoulder was significantly impaired. (*Id.*). He also noted that Petitioner's x-ray indicated arthritic changes which were normal for Petitioner's age. (*Id.*). Petitioner stated that he had difficulty reaching overhead and behind his back. (*Id.*). Petitioner denied any previous shoulder injuries. (*Id.*). Dr. Haueisen recommended a cortisone injection for Petitioner's right shoulder. (*Id.*). On June 7, 2016, Petitioner received an injection in his shoulder but complained of increasing numbness and weakness in his hands. (*Id.*). On June 22, 2016, Dr. Haueisen noted that Petitioner had relief of sharp pains in his right shoulder as a result of the cortisone injection. (*Id.*). On July 5, 2016, Dr. Haueisen recommended a nerve conduction study for Petitioner's carpal tunnel symptomology, and Dr. Haueisen further noted that Petitioner had pain in his right shoulder which should be treated with rest, ice, and elevation. (*Id.*).

On July 19, 2016, Dr. David Brown, Respondent's § 12 examiner, noted that Petitioner complained of neck pain days after the crash. (Petitioner's Exhibit 17). Midwest Occupational Medicine, also hired by Respondent, noted that Petitioner had pain in his right shoulder but was

told that he had a right side chest contusion. (Petitioner's Exhibit 8). Petitioner also had "popping" and soreness in his neck and was unable to reach behind his neck. (*Id.*).

On August 31, 2016, Dr. Boris Khariton noted that Petitioner had an abnormal nerve conduction study indicative of carpal tunnel syndrome. (Petitioner's Exhibit 9). On December 19, 2016, Petitioner underwent left carpal tunnel release surgery. (Petitioner's Exhibit 7). On January 30, 2017, Petitioner underwent right carpal tunnel release surgery. (*Id.*). From February 3 through March 1, 2017, Petitioner followed up with Dr. Haueisen concerning post-operative care and recovery. (*Id.*). On April 26, 2017, Petitioner complained of numbness in his ring and small fingers which radiated to his elbows. (*Id.*). On June 28, 2017, in response to a letter by Petitioner's counsel, Dr. Haueisen wrote that Petitioner's ring and small finger numbness could be associated with cervical radiculopathy. (Petitioner's Exhibit 7). Further, on the same day, Dr. Haueisen noted that Petitioner was positive for back pain. (*Id.*).

On June 15, 2017, Petitioner visited Dr. Mulligan for thoracic back pain. (Petitioner's Exhibit 1). On July 10, 2017, Dr. Christopher O'Boynick referred Petitioner to physical therapy for six weeks for thoracic pain and fatigue in his legs. (Petitioner's Exhibit 7). On July 19, 2017, Petitioner began physical therapy at Anderson Hospital. (Petitioner's Exhibit 6). His physical therapist noted that "with evaluation, cervical issues were also identified," and Petitioner had neck, back, and right shoulder pain. (*Id.*). Further, Petitioner's sleep was disrupted to right shoulder, neck, and back pain. (*Id.*). On July 20, 2017, Petitioner's electromyogram ("EMG") results noted "changes in multiple proximal muscles, such as the biceps and triceps, which are also felt to be consistent with radicular irritability of the C6-T1." (Petitioner's Exhibit 7). On August 16, 2017, Petitioner was discharged from physical therapy

after seven sessions. (Petitioner's Exhibit 6). The physical therapist noted that Petitioner "reported he did not have any pain in his thoracic area, but shoulder pain." (*Id.*).

On September 13, 2017, Petitioner followed up with Dr. Mulligan concerning chronic right shoulder and neck pain. (Petitioner's Exhibit 2). A physical exam of Petitioner's cervical spine indicated "tenderness in the right trapezius muscle, scalene muscle. Foraminal compression tests trigger numbness and tingling in fourth and fifth digits bilateral. There was cervical spine numbness, tingling, and paresthesia. Impression was sprain right AC joint, cubital tunnel syndrome, mild cervical radiculopathy." (Exhibit 2 of Respondent's Exhibit 1; *see also* Petitioner's Exhibit 2). Dr. Mulligan referred Petitioner for an MRI of his neck and right shoulder due to chronic pain. (*Id.*). Dr. Mulligan spoke with Petitioner regarding the MRI results and noted partial rotator cuff tears and right-sided foraminal stenosis at C5-6. (*Id.*). On September 21, 2017, Petitioner followed up with Dr. Mulligan, and she prescribed a home cervical traction device for neck and back pain. (*Id.*). Dr. Mulligan noted severe pain and limited range of motion, referred Petitioner to Dr. Thomas Lee, and excused Petitioner from work until he saw Dr. Lee. (*Id.*).

When Petitioner first visited Dr. Lee on October 10, 2017, he presented with a history of neck and right arm pain which had being ongoing "since a motor vehicle accident about a year and a half prior." (Petitioner's Exhibit 10, 12:11-24). At this visit, Petitioner had asymmetry of his reflexes which is evidence of "some compression of the nerves." (*Id.* at 14:1-4). Dr. Lee also reviewed MRI imaging of Petitioner's right shoulder and neck. (*Id.* at 14:10-19). Based on his review of the imaging, Dr. Lee concluded that Petitioner had "at least a partial tear of his rotator cuff in his shoulder. It was the right shoulder. And then a herniation at C5-6." (*Id.* at 14:20-24). Dr. Lee also testified that there were indications of an annular tear at C6-7. (*Id.* at

15:1-3). Dr. Lee noted that Petitioner's subjective complaints conformed with the objective findings, such as the MRI and physical exam (*Id.* at 15:21-24), and Petitioner's description of the crash at issue was consistent with causing the disc herniation, annular tear, and torn rotator cuff (*Id.* at 16:1-6).

Dr. Lee further testified that Petitioner could not return to work because "he had injuries due to the accident that included neural impingement on the spinal cord nerves. And he also had a shoulder rotator cuff tear that needed to be addressed such that he didn't get further injury to that shoulder." (*Id.* at 19:11-15). Dr. Lee believed that if Petitioner returned to work, he would likely further injure his neck and right shoulder. (*Id.* at 19:16-19). Dr. Lee recommended surgical intervention for Petitioner's neck (*Id.* at 19:20-20:10) and referred Petitioner to Dr. Daniel Schwarze for further evaluation of Petitioner's shoulder (Exhibit 2 of Petitioner's Exhibit 10; *see also* Petitioner's Exhibit 14).

Dr. Lee next saw Petitioner on January 10, 2018. (Petitioner's Exhibit 10, 22:2-4). Dr. Lee noted that the nerve compression in Petitioner's elbows overlapped with his neck symptoms. (*Id.* at 22:16-19). Dr. Lee described "double crush syndrome," which occurs when there are multiple areas of nerve compression, such as in the cervical spine and elbow, and that compression worsens symptomology. (*Id.* at 24:11-20). Dr. Lee also reviewed Dr. Schwarze's medical record and found Dr. Schwarze's findings to be consistent with his own. (*Id.* at 23:15-20). Dr. Lee informed Petitioner that any shoulder surgery should come before neck surgery as injury to the shoulder would more likely occur over time. (*Id.* at 22:22-23:14).

On November 20, 2017, Petitioner had his initial visit with Dr. Gheith. (Petitioner's Exhibit 11). Dr. Gheith noted that Petitioner suffered from chronic, severe neck pain, chronic pain syndrome, and cervical radiculopathy. (*Id.*). Dr. Gheith performed a cervical injection at

C5-6 on the right side. (*Id.*). On December 1, 2017, Dr. Gheith performed another injection at Petitioner's C6-7 paramedian right side. (*Id.*). Dr. Lee reviewed Dr. Gheith's records and noted that Petitioner obtained partial, temporary relief with injections. (Petitioner's Exhibit 10, 25:20-23).

Petitioner followed up with Dr. Gheith for pain management on seven occasions from December 15, 2017, through September 10, 2018, in which Dr. Gheith performed injections and prescribed Petitioner pain medications. (*Id.*). On September 10, 2018, Dr. Gheith noted that Petitioner has chronic intractable, severe neck pain and is at maximum medical improvement subject to surgical intervention. (*Id.*).

On December 4, 2017, Petitioner had his initial visit with Dr. Schwarze. (Petitioner's Exhibit 14). Dr. Schwarze noted that Petitioner had persistent right shoulder pain and a partial rotator cuff tear. (*Id.*). Dr. Schwarze recommended surgery, placed Petitioner off work until surgery was performed, and performed a cortisone injection for Petitioner's right shoulder. (*Id.*).

On October 10, 2018, Petitioner saw Dr. Frank Petkovich for a § 12 examination. (Respondent's Exhibit 2). Dr. Petkovich concluded that Petitioner suffered from degenerative disc disease in C4-5, C5-6, and C6-7. (Respondent's Exhibit 2, 9:22-10:6). Dr. Petkovich found that Petitioner's current condition of ill-being was not related to the crash at issue and was in no way aggravated by the crash. (*Id.*).

On October 23, 2018, Petitioner saw Dr. Michael Nogalski for a § 12 examination. (Respondent's Exhibit 1). During his physical examination of Petitioner, pain, tenderness, and limited range of motion were noted for both the right shoulder and neck. (*Id.* at 13:7-17). Dr. Nogalski concluded: "Mr. Johnson had right shoulder tendinopathy without distinct mechanical findings to support impingement or rotator cuff tear." (*Id.* at 15:12-20). Dr. Nogalski believed

that Petitioner aggravated his AC joint due to the crash, and said issue resolved by June 24, 2016. (*Id.* at 61:10-16).

Petitioner continues to suffer from limited range of motion and pain in his neck and right shoulder. (Tr. 22-23). Since the crash, Petitioner struggles with showering and getting dressed and is unable to do yard work. (Tr. 24). Petitioner struggled with completing tasks related to his job due to shoulder and neck pain and felt that he was unable to do his job due to pain. (Tr. 25, 28). Petitioner testified that he is unable to obtain the surgical intervention recommended by his treating physicians due to his financial situation. (Tr. 59). Petitioner suffers daily with neck and right shoulder pain, and Petitioner's wife confirmed such. (Tr. 30, 67). Petitioner also testified that the conservative treatment described herein did not provide him with significant relief from pain. (Tr. 31).

RESOLUTION OF FACTUAL ISSUES & CONCLUSIONS OF LAW

Disputed Issue F: Is Petitioner's Current Condition Causally Related to the 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 ensuing injuries. *Land and Lakes Co. v. Industrial Comm'n*, 359 Ill.App.3d 582, 592 (2d Dist. 2005). A work-related injury need not be the sole or principal causative factor, as long as it was a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 205 (2003). That is, even if the claimant had a preexisting degenerative condition which made him more vulnerable to injury, recovery for an accidental injury will not be denied as long as he can show that his employment was also a causative factor. *Sisbro, Inc.*, 207 Ill.2d at 205; *see also Swartz v. Industrial Comm'n*, 359 Ill.App.3d 1083, 1086 (3d Dist. 2005).

"Every natural consequence that flows from an injury that arose out of and in the course of the claimant's employment is compensable unless caused by an independent intervening accident that breaks the chain of causation between a work related injury and ensuing disability." *Vogel v. Industrial Comm'n*, 354 Ill.App.3d 780, 786 (2d Dist. 2005); *see also Teska v. Industrial Comm'n*, 266 Ill.App.3d 740, 742 (1st Dist. 2004). "That other incidents, whether work-related or not, may have aggravated the claimant's condition is irrelevant." *Vogel*, 354 Ill.App.3d at 786; *see also Lasley Construciton Co. v. Industrial Comm'n*, 274 Ill.App.3d 890, 893 (5th Dist. 1995).

There is no dispute that Petitioner sustained a work-related injury on April 12, 2016, while in the course of his employment with Respondent when he was involved in a motor vehicle crash. Without anything more, it would not be surprising if a serious injury resulted from such a crash. The evidence amply supports that conclusion. The medical record itself demonstrates a sudden manifestation of symptoms, objective findings, medical restrictions, and significant medical intervention following the injury. The medical opinion testimony of Petitioner's treating orthopedic surgeon, Dr. Lee, is also persuasive and highly probative.

> Well, I base my opinions on his history, his physical findings, his level of function, given his previous occupation, and his potential ability to have done that occupation with his current findings, and the timing of the accident, it all fit that this was an accident-related condition, and the accident was preventing him from returning to work.

(Petitioner's Exhibit 10, 35:12-18).

When asked why Dr. Lee he noted Petitioner's carpal tunnel releases and attempt to return to work, Dr. Lee testified:

> Well, the – I think two things. One is it's consistent with the mechanism of injury of the accident where the patient's hands, particularly on the wheel when the impact occurs. And then – the

> other significance is we really didn't address the neck problem or the shoulder problem until a little bit later on after the accident. And initially the focus was on the hand numbness and the carpal tunnel syndrome that needed to be treated in both wrists. And that's, you know, would explain the delay in treatment.

(*Id.* at 16:17-17:3).

Dr. Lee further testified, "So, yes, it's quite common for one injury initially to overshadow another. And it can then get better, and then the others can surface as sort of the primary problem." (Petitioner's Exhibit 10, 17:18-21). Further, concerning any alleged delay in treatment, Dr. Lee explained: "Well, I think what I see a lot is that is someone's focused on a shoulder, particularly in situations like this, they may just zero in on the shoulder exam, and do more of cursory exam, if any exam at all, on the other body part." (*Id.* at 47:1-5).

i. Testimony of Dr. Michael Nogalski.

Regarding any medical evidence to the contrary, Dr. Nogalski performed an examination pursuant to § 12 of the Act. "Expert opinions must be supported by facts and are only as valid as the facts underlying them." *Gross v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100615WC, ¶ 24; *see also Sunny Hill of Will County v. Illinois Workers' Compensation Comm'n*, 2014 IL App (3d) 130028WC, ¶ 36. The proponent of expert testimony must lay a foundation sufficient to establish reliability of the bases for the expert's opinion." *Id.* If the expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. *Gross*, 2011 IL App (4th) 100615WC, ¶ 24.

Here, the reasons which Dr. Nogalski cited in support of his causation opinions do not appear to support his opinion, and some of the "facts" which Dr. Nogalski relied upon are contradicted by the medical records and other evidence. Furthermore, Dr. Nogalski's opinions do not squarely address or refute the medical basis for the opinions of the radiologist, Dr.

Mulligan, Dr. Lee, and Dr. Schwarze. Nor did he explain why said physicians' opinions were medically unsound or otherwise flawed.

Dr. Nogalski testified that he reviewed all of the documents listed in Respondent's Exhibit 3, which included MRI imaging of Petitioner's shoulder and neck and his medical records. (Respondent's Exhibit 1, 14:15-22; *see also* Exhibit 3 of Respondent's Exhibit 1). Dr. Nogalski testified that he was not aware that Dr. Lee referred Petitioner to Dr. Schwarze for further shoulder treatment despite Dr. Lee and Dr. Schwarze's medical records to the contrary which Dr. Nogalski testified that he had reviewed. (*Id.* at 37:7-13; *see also* Exhibit 2 to Petitioner's Exhibit 10; *see* Petitioner's Exhibit 14).

Dr. Nogalski also testified that he had not reviewed the MRI imaging of Petitioner's right shoulder and would prefer to see the imaging. (*Id.* at 43:3-11). When asked why he did not review the MRI imaging, he responded: "They weren't here. I didn't have them here for review." (*Id.* at 47:2-5). Dr. Nogalski contradicted his prior testimony that he had reviewed the MRI imaging. (*Id.* at 14:15-22). Dr. Nogalski completed an x-ray of Petitioner's right shoulder, but an x-ray does not show soft tissue abnormalities, such as a torn rotator cuff. (*Id.* at 42:7-13). Hence, in coming to his conclusions, Dr. Nogalski relied on the Anderson Hospital MRI radiology report. The radiology report noted partial thickness tears in three of the four rotator cuff tendons: the supraspinatus, infraspinatus, and subscapulari tendons. (Petitioner's Exhibit 2 of Respondent's Exhibit 1). Bursitis was also noted on the radiology report. (*Id.*). Dr. Nogalski testified that bursitis is commonly found with rotator cuff injuries. (Respondent's Exhibit 1, 51:16-18). When asked about the inferiorly direct AC joint osteophytes, Dr. Nogalski testified that such is generally "associated with *subacromial impingement.*" (*Id.* at 52:23-53:5) (emphasis added). When asked about the generalized tenderness over the anterior of the shoulder which

was noted in Petitioner's physical exam, Dr. Nogalski testified that such "would be indicative of a rotator cuff tendon condition." (*Id.* at 53:14-23). Dr. Nogalski further testified that Petitioner had limited range of motion on his right side. (*Id.* at 54:24-55:1). Dr. Nogalski also noted that the results of Petitioner's external rotation at 70 degrees can be indicative of "muscle or tendon conditions." (*Id.* at 55:2-15). Dr. Nogalski noted that he did not find any indications of Petitioner complaining of neck and shoulder pain prior to the subject crash. (*Id.* at 55:21-56:20). Despite the above, Dr. Nogalski testified that there were no findings to support that Petitioner had an impingement issue or torn rotator cuff, and he stated such in his report. (*Id.* at 59:1-4; *see also* Exhibit 2 of Respondent's Exhibit 1). Yet, Dr. Nogalski later testified: "I don't think there's any disagreement that he has what we could say is a *partial thickness rotator cuff tear*." (*Id.* at 59:15-17) (emphasis added). Dr. Nogalski further testified, "I believe that he has findings that a radiologist would consider a *partial thickness rotator cuff tear* by the MRI criteria." (*Id.* at 60:17-19) (emphasis added). Most notably, Dr. Petkovich, Respondent's § 12 examiner, reviewed the MRI image of Petitioner's right shoulder and found a "partial thickness rotator tear in the rotator cuff right shoulder involving the supraspinatus and infraspinatus tendons." (Exhibit 2 to Respondent's Exhibit 2).

As to the mechanism of injury, Dr. Nogalski did not discuss the positioning of Petitioner's hands and arms during the crash nor did he recall asking Petitioner about such. (*Id.* at 39:15-18, 40:23-41:2). When asked whether the position of Petitioner's hands and arms would be "an important factor when determining a shoulder injury occurred," Dr. Nogalski responded: "Assuming that his hands were on the wheel and that he used some force to restrain himself in a seat-belted position, it could be." (*Id.* at 40:4-12).

Additionally, Dr. Nogalski seemingly blames Petitioner's shoulder condition on diabetes. However, Dr. Nogalski did not know whether Petitioner's diabetic condition was well-controlled through the use of diet, whether Petitioner took medication for the diabetic condition, or whether Petitioner's blood sugars were within normal range. (*Id.* at 69:16-71:12). In September of 2015, OPTUM reached out to Dr. Mulligan as Petitioner had not filled his prescription of Metformin, a medication for blood sugar. From September of 2015 and on, Dr. Mulligan's records indicate that Petitioner stopped taking Metformin as the refill amount never changed. (Petitioner's Exhibit 1). As of June of 2017, Metformin was taken off of Petitioner's medication list altogether. (*Id.*). Despite such, Petitioner's diabetic condition was described as "uncomplicated," "controlled," and "well-controlled." (*Id.*). Also, Petitioner's blood work for that time period also indicated that Petitioner's A1C was not consistent with diabetes. (*Id.*).

When asked if he could state what causes frozen shoulder, Dr. Nogalski stated, "Most of the time we can't. It just occurs in and of itself." (Petitioner's Exhibit 1, 72:13-17). Rather many conditions can cause frozen shoulder, such as strains, stresses, trauma, surgical procedures, thyroid disease, kidney disease, bursitis, and rotator cuff injuries. (*Id.* at 72:16-73:7).

Dr. Nogalski also testified that an important factor in determining his opinion that Petitioner did not sustain a rotator cuff injury was the alleged lack of treatment from June 24, 2016, through September 13, 2017. (Respondent's Exhibit 1, 61:20-24). However, Dr. Nogalski's reasoning is flawed. On July 5, 2016, Dr. Haueisen noted pain in Petitioner's right shoulder and told Petitioner to rest, ice, and elevate the shoulder. (Petitioner's Exhibit 7). On August 23, 2016, Midwest Occupation Medicine noted pain in Petitioner's right shoulder, popping and soreness in the neck, and Petitioner was unable to reach behind his neck. (Petitioner's Exhibit 8).

On June 27, 2017, Dr. Mulligan noted that Petitioner had "right upper back pain which is failing to change as expected. . . . ." (Petitioner's Exhibit 1). On June 28, 2017, Dr. Haueisen wrote to Petitioner's counsel that Petitioner had symptoms relative to cervical radiculopathy and that Petitioner was positive for back pain. (Petitioner's Exhibit 7). Dr. Nogalski testified that pain in the neck can oftentimes be due to a shoulder issue and vice versa. (Respondent's Exhibit 1, 62:10-14).

When he was discharged from physical therapy, his physical therapist noted: "[Petitioner] reported that he did not have any pain in his thoracic area, but shoulder pain." (Petitioner's Exhibit 6). Despite the above, Dr. Nogalski held that Petitioner did not seek treatment or make complaints of neck or shoulder pain from June of 2016 through September of 2017.

On July 19, 2017, the physical therapist at Anderson Hospital noted cervical issues, pain in the neck and right shoulder, and difficulty sleeping due to neck and right shoulder pain. (Petitioner's Exhibit 6). On July 20, 2017, Premier Care records indicate that "there are EMG changes in multiple proximal muscles, such as biceps and triceps, which are also felt to be consistent with radicular irritability of the C6-T1," and "[Petitioner] may wish to have further workup for his peripheral neuropathy." (Petitioner's Exhibit 7).

ii. Testimony of Dr. Frank Petkovich.

Similarly, Dr. Petkovich's testimony was contrary to the facts and medical records in this case. Dr. Petkovich testified that "Mr. Johnson did have underlying degenerative cervical disc disease throughout his cervical spine at the C4-5, C5-6 and C6-7 levels. I believe those cervical conditions were obviously chronic conditions that really had no relationship with the motor vehicle accident on April 12, 2016. I did not believe those cervical spine degenerative

conditions were in any way aggravated or accelerated as a result of that motor vehicle accident." (Respondent's Exhibit 2, 9:22-10:6).

As a primary factor in formulating his opinion, Dr. Petkovich testified that the "electrodiagnostic studies did not show any evidence of cervical nerve root compression, and the prior EMG and nerve conduction velocity studies also did not show any evidence of compression of the cervical nerve root areas." (*Id.* at 13:23-14:4; 22:13-15).

However, a letter dated June 28, 2017, and sent to Petitioner's counsel from Dr. Haueisen states that Petitioner's nerve conduction study results and symptoms could also be associated with cervical radiculopathy. (Petitioner's Exhibit 7). Additionally, on July 20, 2017, Dr. Haueisen notes that "there are EMG changes in multiple proximal muscles, such as the biceps and triceps, which are also felt to be consistent with radicular irritability at the C6-T1." (*Id.*). Dr. Petkovich agreed that Dr. Haueisen discusses the EMG and nerve conduction velocity studies done on July 18, 2017, and "Dr. Haueisen in his report and in the electrodiagnostic studies discusses some elements of chronic peripheral neuropathy." (Respondent's Exhibit 2, 43:15-24).

Dr. Petkovich testified, "There was no evidence of disc herniation or nerve root compression or spinal canal compromise." (Respondent's Exhibit 2, 17:18-20). Yet, again, this is contrary to the exams performed by Dr. Mulligan and Dr. Lee as discussed above and outlined in Dr. Nagolski's § 12 report. Dr. Petkovich fails to describe how he reached an opposite conclusion. Furthermore, when asked whether the crash described by Petitioner could cause a disc herniation, Dr. Petkovich agreed that it could. (Respondent's Exhibit 2, 38:19-39:7).

Despite Petitioner's long history of conservative medical treatment for his neck and shoulder pain, Dr. Petkovich testified that Petitioner's complaints were out of proportion to

Petitioner's objective findings. Dr. Petkovish testified that he believes Petitioner suffers from "some pain" in his neck. (*Id.* at 52:13-21). However, Dr. Petkovich was unable to reference any medical record or testimony indicating that Petitioner was malingering or exaggerating his symptoms. (*Id.* at 49:8-50:25). Notably, Dr. Nogalski, Respondent's § 12 examiner, testified, "It appears he gained significant relief from his last epidural steroid injection, *supporting that he had more neck pathology than anything else*." (Exhibit 2 of Respondent's Exhibit 1) (emphasis added).

Also, Dr. Petkovich testified that patients do confuse neck pain with shoulder pain and vice versa. (Respondent's Exhibit 2, 53:13-16). Dr. Petkovich could not recall ever seeing Petitioner treating for his neck and right shoulder prior to the crash. (Respondent's Exhibit 2, 55:8-11).

iii. Testimony of Petitioner and his Wife.

Petitioner testified that he had not received medical treatment, sustained injury, or had issues concerning his neck prior to the crash. (Tr. 33-34). Petitioner also did not suffer any injury to his neck since the crash. (*Id.*). Petitioner testified that he had not received medical treatment, sustained injury, or had issues concerning his right shoulder prior to the crash. Petitioner also did not suffer any injury to his right shoulder since the crash. (*Id.*). Petitioner's wife also testified to such. (Tr. 64-65).

Petitioner's symptoms and complaints remained consistent throughout his treatment. The Arbitrator finds the gaps in treatment to be reasonable and insignificant. The medical evidence does not support the conclusion that Petitioner reached maximum medical improvement for his right shoulder in June of 2016 nor does the evidence support that Petitioner suffered no injury to his neck as a result of the crash. The evidence of surveillance video of Petitioner is insignificant.

The video does not appear to show Petitioner exceeding his restrictions or using his injured shoulder or neck in any significant way. Additionally, the Arbitrator awards greater deference to Petitioner's treating physicians. The Arbitrator finds that after a review of the evidence and testimony presented that Petitioner's current condition of ill-being is causally related to the motor vehicle crash which occurred on April 12, 2016.

Disputed Issue J: Were the Medical Services which were Provided to Petitioner Reasonable and Necessary? Has Respondent Paid All Appropriate Charges for All Reasonable and Necessary Medical Services?

Disputed Issue K: Is Petitioner Entitled to Any Prospective Medical?

The right to be compensated for medical costs associated with work-related injuries is at the very heart of the Workers' Compensation Act. *Hagene v. Derek Polling Center*, 388 Ill.App.3d 390 (5th Dist. 2009). The Act's purpose is to place the burdens of caring for the casualties of industry on industry rather than placing this burden on the public or individuals whose misfortunes arise out of the injury. *Shell Oil v. Indus. Comm'n*, 2 Ill.2d 590 (1954). An employee is entitled to recover reasonable medical expenses that are causally related to the accident and are required to diagnose, relieve, or cure the effects of the injury. *F&B Mfg. Co. v. Indus. Comm'n*, 325 Ill.App.3d 527 (2001).

Here, there is no competent evidence in the record of unreasonable or unnecessary medical treatment. Petitioner went to the emergency room the day of the crash on April 12, 2016. Then, Petitioner followed up with Dr. Mulligan eight days later. Petitioner has dutifully followed a conservative treatment plan, consisting of physical therapy, medication, and injections. After numerous clinical examinations, reviewing MRIs, and conservative treatment, both Dr. Schwarze and Dr. Lee recommended surgical intervention.

On the other hand, Respondent's § 12 examiners, Dr. Nogalski and Dr. Petkovich, dispute Petitioner's need for neck and shoulder surgery. Yet, Dr. Nogalski testified that he

would recommend surgery if conservative treatment failed. (Respondent's Exhibit 1, 76:21-77:11). Further, Dr. Petkovich testified that surgery "would be a consideration if he had some neurologic findings." (Respondent's Exhibit 2, 58:5-14). "If someone had persistent neurologic findings consistent with radiographic findings, putting everything together, and somebody has been through conservative management and still had persistent discomfort, then surgical intervention should be considered." (*Id.* at 59:1-6).

In light of the manifest weight of the record as a whole, including matters discussed previously in this decision, the Arbitrator finds the opinions and testimony of Dr. Lee and Dr. Schwarze, regarding this issue, to be more credible than those of Dr. Nogalski and Dr. Petkovich. Furthermore, the Arbitrator finds the Petitioner to be a credible witness. The Arbitrator rejects the notion, as unfounded in the record, that Petitioner fabricated his symptoms since the crash to the point where multiple reputable physicians would prescribe pain medication, physical therapy, and injections, and recommend surgical intervention. The opposite conclusion has ample support in the record. Respondent does not dispute the amount of medical bills in question nor does it dispute that the bills are the result of medical treatment which Petitioner received for his neck and right shoulder.

With the exception of Dr. Nogalski's opinion, which has already been discussed above, there is virtually no support in the record for the proposition that the medical services provided to Petitioner were unnecessary or unrelated to the accidental injury of April 12, 2016. Based upon the manifest weight of the evidence, the Arbitrator, therefore, finds that all medical services provided to Petitioner referenced in Petitioner's Exhibit 15 were reasonable and necessary to cure and relieve the effects of Petitioner's injuries resulting from the subject crash. Respondent is ordered to pay for the same in accordance with § 8(a) of the Act and continue to pay for

further medical treatment as necessary and appropriate pursuant to the Act, including surgical intervention for Petitioner's neck and right shoulder.

Disputed Issue L: What Temporary Benefits are in Dispute?

Respondent has failed to provide temporary total disability benefits to Petitioner from September 17, 2017, through December 13, 2018. There is a stipulation between the parties that the Respondent is entitled to receive credit for having paid a total of $16,230.70 in TTD. Accordingly, the Arbitrator finds that Respondent has paid TTD from April 13, 2016 through August 24, 2016; December 19, 2016, through March 16, 2017; and December 14, 2018, through January 22, 2018. Therefore, at issue is Petitioner's entitlement for additional TTD commencing for the period of September 17, 2017, through December 13, 2018. The Arbitrator finds that the manifest weight of the record as a whole supports a finding that Petitioner is entitled to TTD benefits for that time period.

The medical records in evidence show that during that period, Petitioner was under the continuous care of his treating physicians to cure and alleviate the effects of his workplace injury. Dr. Mulligan, Dr. Lee, and Dr. Schwarze had either excused Petitioner from work altogether or pending surgical intervention. Consistent with well recognized Illinois law on this issue, it is the holding of the Arbitrator that pending MMI if the employer is unable to accommodate the injured employee's medical restrictions governing a return to work, the employee is entitled to TTD benefits.

Accordingly, Respondent is ordered to pay Petitioner 64 5/7 weeks of accrued unpaid TTD at the rate of $458.15 weekly for benefits commencing September 17, 2017, through December 13, 2018, in the total amount of $29,648.85.

Disputed Issue M: Should Penalties or Fees be Imposed upon Respondent?

Despite the Arbitrator finding Petitioner's treating medical providers more persuasive, the record in its entirety fails to show that Respondent engaged in vexatious or dilatory behavior or acted in bad faith by relying on its rights under section 12 of the Act and the opinion(s) obtained. Therefore, penalties and attorneys fees are denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria Maravilla,
Petitioner,

vs. No. 14 WC 14485

Coleman Cable, Inc.,
Respondent.

20IWCC0193

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of Causal Connection, Medical Expenses, Temporary Total Disability, Prospective Medical Care, and Penalties and Attorney's Fees, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission,* 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

Petitioner, a 47-year-old factory worker, slipped on ice while walking to her car after completing her shift on March 7, 2014. She landed on her buttocks, striking her back and head. Petitioner first treated at Lake Forest Hospital, where she complained of pain in her scalp and low back. She received treatment and was released with restrictions; but when she returned to work the following Monday, she noticed her pain was getting worse. In the subsequent weeks, Petitioner developed neck pain and low back pain radiating down her buttocks and leg.

On May 8, 2014, Petitioner underwent a lumbar MRI, which revealed a broad-based L5-S1 disc herniation. On May 12, 2014 Petitioner saw Dr. Christopher Morgan with complaints of pain in her head, neck, low back and right leg. Dr. Morgan administered injections to Petitioner's neck and low back and recommended a cervical spine MRI. Petitioner's May 20, 2014 cervical spine MRI showed disc herniations at C4-5, C5-6 and C6-7.

Thereafter, Petitioner came under the care of Dr. Dixon. On August 1, 2014 he performed an L5-S1 microdiscectomy and decompression. That surgery provided only limited symptom relief, and the physical therapy which Petitioner underwent thereafter made her pain worse. Dr. Dixon ordered an EMG and another lumbar MRI. When Dr. Dixon left the practice, Petitioner switched her care to Dr. Murtaza.

Dr. Murtaza provided a 3rd injection to Petitioner's lumbar spine on July 16, 2015. Petitioner attempted to do work hardening, but that only increased her pain. She was referred to Dr. Wingate, who on May 3, 2016, performed a second surgery to Petitioner's low back: a bilateral L5-S1 hemilaminectomy, radial L5-S1 discectomy and fusion with hardware. That surgery improved Petitioner's symptoms somewhat, but again, her pain increased during her post-op physical therapy.

On December 7, 2016, Petitioner underwent a lumbar CT, which revealed a diffuse bulge at L4-5. Dr. Wingate gave Petitioner a lumbar epidural steroid injection, but that only provided temporary relief. In July 2017, Dr. Wingate recommended Petitioner undergo a 3rd lumbar surgery in order to relieve her pain. Petitioner now wishes to undergo that procedure.

Dr. Wingate testified via evidence deposition. He first saw Petitioner as a patient on December 21, 2015, following her first lumbar surgery. Then, she complained of a recurrence of leg pain, a progression of her back pain which had begun around the time of her March 7, 2014 work injury, and significant neck pain radiating into her left shoulder and arm.

Dr. Wingate testified that Petitioner developed a significant complication following her first surgery: a recurrent disc herniation. Because not all of the disc material is removed during a discectomy surgery, at least 15% of patients who undergo that procedure develop that problem. Petitioner also developed another complication after her first surgery: recurrent foraminal stenosis at the exiting nerve roots. Regarding Petitioner's cervical pain and hand numbness, Dr. Wingate believed that those symptoms could have been caused by a disc that was herniated when she struck her head in her fall.

Dr. Wingate reviewed Petitioner's scans and records, and testified that her May 8, 2014 lumbar MRI showed a severely degenerated and herniated L5-S1 disc. He concluded that the herniation depicted on the MRI was most likely acute, due to the presence of closely nestled disc material. Petitioner's May 16, 2014 EMG indicated Petitioner had moderate lumbar radiculitis at S1 – a finding which correlated with the findings on her lumbar MRI.

Dr. Wingate further testified that Petitioner's May 20, 2014 cervical MRI showed three herniated discs between C4-C7, with C6-7 being the largest. Petitioner's October 7, 2014 lumbar MRI showed that her L5-S1 disc had reherniated; and also, that a significant part of her L5-S1 facet joint had broken off during, or soon after, her surgery. Petitioner's April 25, 2015 lower extremity EMG suggested she had a lumbosacral radiculopathy. Dr. Wingate testified that Petitioner's third lumbar MRI of June 3, 2015 confirmed her recurrent L5-S1 herniation.

At his deposition, Dr. Wingate provided the following opinions: Petitioner's herniated cervical and L5-S1 discs were most probably caused by her fall at work. That accident caused an exacerbation of her preexisting degenerative condition. Petitioner's work injury was not simply a lumbar strain, because it did not heal in 2-3 months. Petitioner had herniated disc material which compressed her nerve roots. Because radiculopathies are progressive, it is not unusual for them to develop weeks after an injury. Petitioner's pains, which developed or increased in the weeks following her accident, were causally related to her work injury. All of Petitioner's treatment to date had been reasonable and causally related to her work accident. Petitioner requires future treatment for her work injuries, including cervical epidural injections, facet blocks, CT scans and x-rays.

In his April 6, 2018 note, Dr. Wingate reported that Petitioner was pending surgery to remove her hardware at the L5-S1 level, and perform a repeat right L5 hemilaminectomy. Dr. Wingate had first recommended that surgery in December 2017, due to significant bony overgrowth from a combination of L4-5 spondylosis and increased stenosis, which put pressure on the thecal sac.

Dr. Frank Phillips also testified via evidence deposition. He conducted a Section 12 examination of Petitioner on March 12, 2015 at Respondent's request. After examining Petitioner and reviewing her medical records, tests, MRI's and x-rays, Dr. Phillips opined that Petitioner's only injury from her work accident was a temporary lumbar spine sprain/strain. His basis was because Petitioner did not have any convincing radicular complaints to suggest an acute herniated disc. Dr. Phillips interpreted Petitioner's radiographic studies as showing no acute structural injury; only some mild underlying disc degeneration and diffuse bulging at L5-S1. He agreed that Petitioner's bulging lumbar disc impinged upon her nerves, but he did not believe that it compressed them. He acknowledged that compression could cause radicular symptoms. Dr. Phillips did not feel that Petitioner's August 2014 discectomy surgery addressed any of the pathology shown on her May 2014 lumbar MRI, or any symptoms related to her work injury.

Dr. Phillips acknowledged that the treatment Petitioner received (including the August 2014 discectomy) through the date of his IME was reasonable in a general sense. He opined that Petitioner had no objective findings which correlated with her subjective complaints, and that she had no complications or unusual problems after her discectomy surgery. Dr. Phillips found Petitioner to have been at MMI and in need of no further medical treatment as of the date of his March 12, 2015 exam.

The Arbitrator found that Petitioner's condition of ill-being was causally related to her work accident, but only through the date Dr. Phillips' IME exam. The Arbitrator awarded Petitioner TTD and payment of medical care only through that date: March 12, 2015. The Arbitrator believed Dr. Phillips' causation opinion was more persuasive than Dr. Wingate's, because it was, "credible, persuasive and most consistent with the evidence."

The Commission views the evidence differently than the Arbitrator. The Commission finds Dr. Wingate's opinions more persuasive and more supported by the evidence than those of Dr. Phillips.

20IWCC0193

Dr. Phillips' causation opinion, that Petitioner suffered only a lumbar sprain/strain during her work accident, is contradicted by Petitioner's objective diagnostic tests, which documented herniated discs, both cervical and lumbar. Dr. Phillips conceded that Petitioner had objective findings following her accident, including a bulging L5-S1 disc, but he considered them unrelated. He also agreed that bulging discs can cause radiculopathies. Dr. Phillips further conceded that a discectomy surgery would not be performed on a patient with a diagnosis of lumbar sprain/strain, but that it would be performed to address radiculopathies related to herniated discs.

Dr. Phillips' testimony that Petitioner had no complications or unusual problems following her August 2014 discectomy surgery is contradicted not only by Dr. Wingate's opinion and Petitioner's testimony, but also by her contemporaneous medical records and objective evidence therein. Dr. Phillips admitted that if Petitioner's records showed that she did have complaints of radiating pain prior to April 30, 2014, then his causation opinion might change. In fact, the records do show that Petitioner complained of radiating pain prior to April 30, 2014. On April 7, 2014 Petitioner reported to Dr. Edelstein that she was experiencing pain in her left buttock; Dr. Edelstein diagnosed that as, "probable sciatica." And on April 21, 2014, Dr. Edelstein documented that Petitioner complained of radiating pains going down to her right posterior thigh.

The Commission finds Dr. Phillips' opinions less credible than Dr. Wingate's for other reasons as well. Dr. Phillips admitted he had not reviewed Petitioner's records from her initial post-accident medical treatment in the emergency room. He further admitted that cervical injuries could be caused by striking one's head in a fall; but despite knowing this, he failed to perform a cervical examination on Petitioner at his IME. Ultimately, Dr. Phillips opinions are not based on a complete understanding of Petitioner's medical condition and are contradicted by the very types of objective medical evidence he admits could change his opinion.

In contrast, the Commission finds the opinions of Dr. Wingate more credible for several reasons. Dr. Wingate explained how and why he considered Petitioner's post-accident lumbar symptoms to have been causally related to her accident. His opinion that Petitioner's May 8, 2014 lumbar MRI showed Petitioner had not just a bulging disc, but a herniated L5-S1 disc, was corroborated by Dr. Carrion and Dr. Kuritza, each of whom also reviewed that MRI and reported it showed a herniated disc. Objective records confirm Dr. Wingate's opinion that Petitioner suffered significant post-surgical complications following her August 2014 surgery.

For these reasons, the Commission reverses the Arbitrator's decision. The Commission adopts the opinions of Dr. Wingate, and finds Petitioner's current conditions of ill-being in both her cervical and lumbar spines are causally related to her May 7, 2014 work accident.

With regard to Petitioner's petition for penalties and attorney's fees under §16, §19(k) and §19(l) of the Act, the Commission affirms the Arbitrator's decision to deny them. Petitioner presented no arguments in her brief to support an award of penalties and attorney's fees. The Commission finds that Dr. Phillips' opinion that Petitioner attained MMI on March 12, 2015 was not an unreasonable basis for Respondent to rely upon in discontinuing benefits on that date.

20IWCC0193

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 25, 2018, is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $389.90/week for 213-1/7 weeks, commencing on April 30, 2014 through May 30, 2018, as provided by §8(b) of the Act. Respondent is entitled to a credit of $24,062.40 for temporary total disability benefits that have been paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay, pursuant to the fee schedule, the outstanding reasonable and necessary medical expenses incurred for treating Petitioner's cervical and lumbar spine conditions between March 7, 2014 and May 30, 2018, as provided by §8(a) and §8.2 of the Act. Additionally, Respondent shall hold Petitioner harmless with regard to payments made by health insurance.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for prospective reasonable and related medical care prescribed by Dr. Wingate for Petitioner's cervical and lumbar spines, as provided by §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Petition for Penalties and Attorney's Fees, pursuant to §16, §19(k) and §19(l) of the Act, is denied.

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

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

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

Bond for 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 16 2020

Marc Parker

Barbara N. Flores

o-01/23/20
mp/mcp
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20IWCC0193

CONCURRANCE IN PART AND DISSENT IN PART

I respectfully concur in part and dissent in part from the Decision of the majority. The Arbitrator found that Petitioner sustained a work-related accident/injury on March 7, 2014, but that the condition of ill-being resulting from that accident resolved as of March 12, 2015, and he denied benefits incurred after that date. In total, the Arbitrator awarded Petitioner 45&2/7 weeks of TTD and medical expenses of $83,356.69. The Arbitrator also denied Petitioner's Petition for Penalties & Fees.

The majority reversed the Decision of the Arbitrator and found that Petitioner's current conditions of ill-being of her lumbar and cervical spine were still causally related to her work accident. The majority awarded Petitioner 213&1/7 weeks of TTD, all outstanding medical expenses incurred to date, and ordered Respondent to authorize and pay for prospective lumbar/cervical treatment recommended by Dr. Wingate. While the majority reversed the Decision of the Arbitrator on the issue of causation, it affirmed the Arbitrator's denial of penalties and fees. I would have affirmed and adopted the Decision of the Arbitrator. Therefore, I dissent from the decision of the majority on everything except its affirmance of the Arbitrator's denial of penalties and fees.

On March 7, 2014, Petitioner slipped on ice and fell on her buttocks and then struck her head. She went to an Emergency Department where she complained of low back and scalp pain. X-rays showed only mild-to-moderate degenerative changes. Petitioner was diagnosed with back and head contusions and released home with a 10-pound lifting restriction. Petitioner then began treating with Dr. Carrion, D.C. She then started complaining of neck pain more than two months after the accident. An MRI of the neck and head taken on May 18, 2014 was deemed unremarkable. Petitioner then began treating with Dr. Dixon. A lumbar MRI taken on October 1, 2014 showed diffuse bulging/protrusions, with impingement at L5-S1 "likely due to disc herniation and regional granulation tissue." Dr. Dixon performed microdiscectomy on August 1, 2014. Petitioner continued to complain of pain, though the presentation of her pain differed. She came under the treatment of Dr. Wingate, who performed fusion surgery at L5-S1.

Both Dr. Wingate and Respondent's Section 12 medical examiner, Dr. Phillips, testified by deposition. They both opined that the initial surgery was not indicated. Dr. Wingate believed that spinal instability was more of an issue than nerve involvement and therefore a fusion rather than discectomy was called for. Dr. Phillips believed that no surgery was indicated at all because there was no objective pathology which required surgery. He noted that the MRI showed no acute pathology, nothing to corroborate her subjective complaints, and nothing that would require surgery. He opined that Petitioner sustained a lumbar sprain/strain, which temporarily exacerbated her underlying condition. While he did not believe the initial discectomy was necessary or related to her accident, her recovery was uneventful and that surgery did not in any way contribute to any need for the subsequent fusion surgery or her alleged current condition of ill-being.

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The Arbitrator found the opinions of Dr. Phillips more persuasive than those of Dr. Wingate. The Arbitrator noted that when asked to justify his and Dr. Dixon's diagnosis of radiculopathy, which Dr. Phillips did not find, he answered "that would be my political opinion to a reasonable degree of medical and surgical certainty, and so I think it is more of a political difference in what is playing out as a discrepancy or seemingly difference of opinion." I am not certain exactly what Dr. Wingate meant with that explanation. However, his reference of a supposedly scientific medical diagnosis being a "political difference" does not inspire confidence in his opinion. On the other hand, Dr. Phillips limited himself to the medical evidence and convincingly concluded that the objective evidence did not show any acute injury, did not show and structural injury, and did not corroborate her subjective complaints. Therefore, I concur with the opinion of the Arbitrator that the opinions of Dr. Phillips are more persuasive than those of Dr. Wingate.

It is interesting to note that the Arbitrator found that the initial discectomy surgery performed by Dr. Dixon was not medically necessary, as opined by Dr. Wingate and Dr. Phillips. Nevertheless, he awarded medical and temporary disability benefits through recovery from that surgery because it had been authorized by Respondent.

For the reasons stated above, I concur with the majority in affirming the Arbitrator's denial of penalties and fees. However, I dissent from the decision of the majority reversing the Decision of the Arbitrator in finding that Petitioner's alleged current conditions of ill-being of her cervical and lumbar spines were still causally related to her accident on March 7, 2014. Therefore, I respectfully dissent.

Deborah L. Simpson

Deborah L. Simpson

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Roper,

Petitioner,

vs.

NO: 15 WC 12142

William Fox Developmental Center,

Respondent.

20IWCC0194

DECISION AND OPINION ON REVIEW

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

The Commission solely seeks to correct a clerical error. On the Arbitration Decision Form, the Arbitrator mistakenly wrote that in the year preceding the injury, Petitioner earned **$880.92** and had an average weekly wage of **$45,807.84**. This is clearly a scrivener's error. The Commission thus modifies the above-referenced sentence to read as follows:

> In the year preceding the injury, Petitioner earned **$45,807.84**; the average weekly wage was **$880.92**.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 22, 2019, is modified as stated herein.

DATED: MAR 17 2020

d: 3/10/20
DDM/jds
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D. Douglas McCarthy

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROPER, JAMES J
Employee/Petitioner

Case# **15WC012142**

WILLIAM FOX DEVELOPMENTAL CENTER
Employer/Respondent

20IWCC0194

On 5/22/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.34% 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:

1987 RUBIN LAW GROUP LTD
CATHERINE K DOAN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

6197 ASSISTANT ATTORNEY GENERAL
PATRICIA N JJEMBA
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CHICAGO, IL 60601

1745 DEPT OF HUMAN SERVICES
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 62794-9155

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

MAY 22 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

20IWCC0194

STATE OF ILLINOIS)
)SS.
COUNTY OF KANKAKEE)

- [ ] 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

James J. Roper
Employee/Petitioner

v.

William Fox Developmental Center
Employer/Respondent

Case # **15 WC 12142**

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 **Gregory Dollison**, Arbitrator of the Commission, in the city of **Kankakee, Illinois**, on **March 20, 2019**. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of 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. [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 9/19/2014, 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 $880.92; the average weekly wage was $45,807.84.

On the date of accident, Petitioner was 34 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 $88,794.09 for TTD/TPD, $23,242.70 for maintenance, and $-0- for other benefits, for a total credit of $112,036.79.

Respondent is entitled to a credit for payments found to be paid by group insurance under Section 8(j) of the Act. Respondent shall hold Petitioner safe and harmless in connection with those payments.

ORDER

Respondent shall pay Petitioner the sum of $320.61/week for the further period commencing 3/20/2019 and until Petitioner reaches the age of 67 as provided in Section 8(d)1 of the Act, because the injuries sustained by Petitioner caused Petitioner's inability to pursue his usual and customary line of employment.

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

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

5/14/19
Date

MAY 22 2019

20IWCC0194

STATEMENT OF FACTS:

On September 19, 2014, Petitioner was a 34-year-old Mental Health Tech II for Respondent, Fox Developmental Center. Petitioner testified that as a Mental Health Tech II, he was primarily responsible for assisting with the daily living and care of residents. Petitioner testified that this included assisting residents with showering, eating, reading the paper, transporting them into and out of chairs, shower tables, and beds. These duties involved constant bending, squatting, reaching, crouching, twisting, pushing, pulling, restraining of residents, and lifting. Petitioner stated that the heaviest resident he had ever lifted was approximately 300 lbs.

Petitioner testified that he attended high school in Pontiac, Illinois. He graduated high school and attended college at Illinois Central College where he obtained an Associate Degree. Petitioner stated that he served in the military; reached the rank of E-5 and was honorably discharged.

Petitioner testified that on September 19, 2014 he was performing his job duties for Respondent. According to Petitioner he was assisting an individual to a shower table. The person weighed 135 pounds and the individual also had behavioral issues. Petitioner stated he was lifting the person from a seated position to standing by hooking his arms under the individual's arm pits. The person hooked his arms around Petitioner's neck and pulled Petitioner forward. Petitioner stated that he fell forward from a standing position onto his hands and knees. Petitioner indicated that he felt immediate pain in his low back around the belt line. Petitioner testified that prior to September 19, 2014, he had never sustained any accidents or injuries involving his back; he had not received any medical treatment prior to September 19, 2014 nor did he notice anything unusual regarding his back.

As a result of the work accident of September 19, 2014, Petitioner sought medical care. Records submitted show that Petitioner referred for a lumbar MRI study. Petitioner underwent the prescribed MRI on October 10, 2014 at Fort Jess Imaging. (PX 1) The MRI revealed a small central disc herniation at L5-S1 with associated annular tear encroaching on the lateral recess, minimal lateral recess stenosis at L4-L5 and a small renal cyst. (PX 1)

On December 11, 2014, Petitioner was examined by Dr. Stroink. (PX 1) Petitioner complained of low back pain. During examination, Dr. Stroink indicated that other than a positive straight leg test, Petitioner had no obvious back abnormalities. Dr. Stroink felt Petitioner was not a surgical candidate and recommended physiatry with Dr. Jhee for physical therapy. (PX 1)

On December 15, 2014, Petitioner was examined in the emergency room at St. James Hospital. Petitioner presented with recurrent back pain since an injury in September 2014. An examination revealed tenderness and pain. Petitioner was assessed with lumbar strain. He was advised to follow with his previous neurosurgeon and physical therapy referrals. (PX 2, pp. 1-3)

At the recommendation of Dr. Stroink, Petitioner was examined by Dr. Jhee on January 22, 2015. (PX 3) Petitioner complained of low back pain since the accident of September. On physical examination, Petitioner demonstrated tenderness over the SI joint and limited range of motion, positive FABER test and positive Gaenslen's test on the left side. Dr. Jhee assessed recent onset low back pain, lumbosacral strain, lumbar disc disease, rule out left S1 radiculopathy and left sacroiliac joint dysfunction. Dr. Jhee recommended physical therapy and work restrictions. (PX 3) Petitioner engaged in physical therapy at Turning Point Therapies from January 29, 2015 through April 23, 2015. (PX 3)

Petitioner returned to Dr. Jhee on March 5, 2015. Petitioner reported that his low back pain ranges from 4/10 to 8/10. Petitioner reported an episode of his left leg giving out and he experiences radiating pain to the left lower extremity to the knee level. Dr. Jhee recommended ongoing physical therapy and an EMG study. The doctor also recommended that Petitioner return to work in a sedentary position. (PX 3)

Petitioner was examined by Dr. Ghanayem for a second opinion on May 4, 2015. Petitioner reported low back pain and left leg symptoms. After an examination, Dr. Ghanayem assessed sciatica. The doctor recommended an epidural steroid injection with Dr. Carmichael and that Petitioner remain off work. Dr. Ghanayem also noted that he wanted to see the MRI previously taken. (PX 4)

On June 2, 2015, Petitioner underwent the EMG prescribed by Dr. Jhee. The doctor reviewed the study that same day indicating same was compatible with mild L5 radiculopathy which could be chronic in nature and residuals for previously bilateral S1 nerve root compromise. Dr. Jhee recommended an epidural steroid injection and that Petitioner work at a sedentary level. (PX 3)

Petitioner was evaluated by Dr. Carmichael for pain management on July 31, 2015. Dr. Carmichael performed a left L5 and S1 transforaminal ESI on September 4, 2015 at the Center for Outpatient Medicine. Repeat injections were carried out on October 13, 2015. At his follow-up appointment with Dr. Carmichael on October 29, 2015, Petitioner reported only mild temporary relief from the injections. Dr. Carmichael referred Petitioner back to Dr. Ghanayem and recommended continued work restrictions. (PX 5, PX 6)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Patrick T. O'Leary on November 19, 2015. According to Dr. O'Leary, Petitioner reported with complaints of back pain and lower extremity pain. After performing an examination and reviewing Petitioner's medical records, Dr. O'Leary assessed Petitioner with a central disk herniation at L5-S1 with predominantly left lower extremity pain and S1 distribution. The doctor opined that Petitioner did not have any significant pre-existing conditions or health conditions that contributed to his condition. He stated that Petitioner had back pain with left lower extremity pain consistent with a positive straight leg raise. Dr. O'Leary noted that he did not find any evidence of symptom magnification or Waddell's signs. Dr. O'Leary opined that Petitioner's current condition of ill-being was causally related to the work-related accident and that the treatment provided was reasonable and necessary. (PX 8). Dr. O'Leary stated that "[g]iven the degree of back pain that he has in addition to the leg pain, it may be appropriate to perform an interbody fusion at L5-S1." The doctor opined that an evaluation with a surgeon would be reasonable. Dr. O'Leary recommended work restrictions no lifting more than 25 pounds, frequent breaks to sit, stand, and adjust position. No excessive bending, stooping, or twisting from the waist. (PX 8)

Dr. Ghanayem evaluated Petitioner on February 22, 2016. Petitioner reported unmanageable ongoing mechanical low back pain. On examination, Petitioner demonstrated increased back pain with lumbar range of motion. He also had tenderness at the base of his spine. Dr. Ghanayem recommended a repeat MRI. (PX 4)

Petitioner returned to Dr. Ghanayem on June 6, 2016. According to the doctor, the MRI revealed disc degeneration, but no collapse at L5-S1. Dr. Ghanayem did not feel surgical intervention "...would make [Petitioner] feel better." Dr. Ghanayem recommended Petitioner continue with his exercise program and physical therapy. He felt Petitioner had reached maximum medical improvement. Dr. Ghanayem returned Petitioner to work with the permanent restriction that "...he cannot be in a situation where he has to potentially physically restrain or control somebody physically. The doctor also restricted Petitioner to lifting in the 20lb. to 30lb. range. (PX 4)

Petitioner testified that Respondent did not accommodate the restrictions. Petitioner indicated that he was provided with vocational rehabilitation services and worked with Ms. Amy Portz. Petitioner stated that he initially met with Ms. Portz on March 3, 2017. Petitioner testified that he participated in a job search.

Petitioner indicated that he contacted employers on his own and also followed up on job leads provided by Ms. Portz. Petitioner testified that he conducted the job search by driving to employers, asking for the hiring manager and filling out an application. He provided confirmation of the job search to Ms. Portz.

Petitioner testified that during his work with Ms. Portz, he experienced computer issues. Petitioner provided that he had an old computer which was not compatible with the programs that Ms. Portz required that he use. Petitioner stated that he was not able to send his resume to Ms. Portz and had difficulty forwarding confirmations. Petitioner stated that he communicated the computer issue to Ms. Portz who recommended that he purchase a new computer. Despite the computer problems, Petitioner eventually provided Ms. Portz with a copy of his resume. Petitioner conduced a job search from March 2017 through July 2017. Petitioner testified that he complied with the requests of Ms. Portz. The confirmations from the jobs found by Ms. Portz were admitted into evidence. (PX 12)

Petitioner testified that he did not bring his resume to the first meeting with Ms. Portz. He explained that he was not told to bring anything to that meeting. Petitioner testified that he applied for the management job in Bloomington and Pontiac. He did not receive an offer of employment. He tried to apply to ATS, but the link for the job did not work. He advised Ms. Portz that the link did not work. Petitioner also applied for the job at CVS as a pharmacy technician. He did not receive a job offer. He testified that he reapplied for the CVS position in 2019. Petitioner confirmed that the jobs listed by Ms. Portz began at $8.50 per hour. Petitioner testified that he did not receive any interviews from the job leads provided by Ms. Portz.

Petitioner testified that he ultimately obtained employment as a medical office assistant with Dr. Rinker. Petitioner stated that he discussed the job with Ms. Portz and she recommended that he accept the job. Petitioner stated that he in fact accepted the position based on her recommendation. Petitioner testified that he assisted patients in the office. He took down their basic information and entered same into the computer for the doctor. Petitioner testified that the job was within his restrictions. He earned $10 per hour and worked on an as needed basis. The pay stubs from Dr. Rinker's office which were admitted into evidence show Petitioner began earning a salary for the period of July 21, 2017 through August 3, 3017. They show that Petitioner earned $10 per hour in his employment as a medical office assistant. (PX 9) Petitioner testified that he continues to work for Dr. Rinker on an as needed basis.

Petitioner testified that he obtained a second position as a pizza delivery person for Marchelloni's. Petitioner earned $8.50 per hour. He worked approximately 12 hours per week. Petitioner discussed the position with Ms. Portz who recommended that he accept the position. Accordingly, Petitioner accepted the position. Petitioner testified that his position with Marchelloni's ended in August of 2018. He indicated however that Marchelloni's is currently under new management and that the new managers indicated they will re-hired him once the restaurant is remodeled. Petitioner will earn $8.50 per hour. The paystubs from Marchelloni's were admitted into evidence. The earliest stub dated August 13, 2017 show Petitioner was earning $8.50 per hour. (PX 10)

Respondent paid Petitioner temporary total disability benefits, temporary partial disability benefits and maintenance benefits. The payment history was admitted into evidence. (RX 1)

As noted above, Petitioner participated in vocational rehabilitation with Amy Portz at the request of Respondent. She prepared a transferable skills analysis/Labor Market Survey dated March 27, 2017. The Labor Market Survey indicated Petitioner could earn between $8.25 and $16.80 per hour. The targeted jobs were for medical clerk/customer service, customer service clerk, customer service/sales, security and driver. (RX 2)

Ms. Portz prepared an additional Labor Market Survey dated July 30, 2018. (RX 3). According to Ms. Portz, she identified twenty-five (25) potentially appropriate jobs during the week of July 23, 2018. The jobs were both full and part-time positions in the Pontiac area and ranged from $8.00 to $16.35 per hour. (RX 3)

On February 28, 2019, Ms. Portz prepared an R-Individual Written Rehab Plan. (RX 4). The plan set forth that Petitioner would engage in job search. (RX 4) On March 1, 2019, Ms. Portz prepared a Vocational Initial Report (Re-Open). The purpose of the meeting was to begin job placement. (RX 5)

The evidence deposition of Ms. Portz was completed on March 6, 2019. (RX 6). Ms. Portz testified that she currently has two clients. She works part time as a vocational counselor. (RX 6 at 6) Ms. Portz was originally certified as a vocational counselor in 1994 until 1999 and recertified in 2008. (RX 6 at 10-11) Ms. Portz testified that she identified jobs for Petitioner with earnings ranging from $8.25 to $16.80 per hour. (RX 6 at 16) Ms. Portz testified that she did not recall receiving a resume from Petitioner. (RX 6 at 17) Ms. Portz testified that Petitioner had transferable skills for jobs such as medical clerk/customer service, customer service clerk, customer service/sales, security and driver. (RX 6 at 21)

Ms. Portz testified that she completed another labor market survey on July 30, 2018. (RX 6 at 22) Ms. Portz testified that full time work would have been available for Petitioner. (RX 6 at 24) Ms. Portz testified that she was asked to re-open vocational services in 2019. (RX 6 at 28) Ms. Portz explained that Petitioner did not always follow through on tasks assigned to him and cancelled appointments. (RX 6 at 31) Ms. Portz stated that Petitioner did not always provide her with job search logs. (RX 6 at 32) Ms. Portz testified that she met with Petitioner on February 28, 2019 and that Petitioner has not provided her with information about his start date for work or with job contacts. (RX 6 at 36)

Ms. Portz testified that the job search was an appropriate vocational plan for Petitioner. She acknowledged that the earnings for a job and the mileages were significant in determining whether the job was suitable. She stated that Petitioner could earn between $8 and $16 per hour. She also acknowledged that $10 per hour falls within her projected range of earnings. Ms. Portz stated that a medical clerk or medical assistant position would be appropriate employment for Petitioner. She stated that the medium earnings for a medical clerk was $30,000 per year; however, appropriate wages may fall below that number. (RX 6 at 43-46)

Ms. Portz described how she conducted the labor market survey. She stated that she contacted employers that she found online that were hiring. She did not specifically contact each employer to determine whether they could accommodate Petitioner's restrictions. Ms. Portz testified that she looked to verify whether Petitioner was qualified for the job but did not document the qualification for each job. (RX 6 at 46-48). Ms. Portz testified that the most recent labor market survey performed was an overview of the job market, and she did not determine whether each employer could accommodate Petitioner or whether they were hiring. (RX 6 at 59)

Ms. Portz confirmed that Petitioner attended meetings with her. He dressed appropriately and was friendly, personable and communicated with her. Ms. Portz confirmed that Petitioner reported that he was having technical problems with his computer. Ultimately, Ms. Portz received Petitioner's resume. Ms. Portz also acknowledged that Petitioner provided her with a job search log and confirmations that he applied to jobs. Petitioner performed some aspects of the job search but he was also confused by the process. Ms. Portz acknowledged that vocational placement can be new to people and it is reasonable to be confused with the jobs search. Ms. Portz also acknowledged that Petitioner was motivated and had a lot of ideas for his job search. Further, Petitioner showed an intent to return to work. (RX 6 at 49-56)

Ms. Portz noted that Petitioner obtained employment as a medical assistant and a delivery driver. She testified that a job as a medical assistant earning $10 an hour on a full-time basis would constitute suitable employment. She based her opinion on the labor market survey. She stated that obtaining employment was the

goal of vocational rehabilitation and Petitioner was able to obtain employment. She stated that after Petitioner obtained employment as a driver, she was asked to discontinue vocational services. (RX 6 at 56-58)

An Employability Study was conducted by Mr. Edward Pagella at the request of Petitioner's attorney on September 8, 2017. Mr. Pagella prepared a report dated October 20, 2017. Mr. Pagella opined that Petitioner would not be able to return to work as a mental health technician based on the restrictions of Dr. Ghanayem. (PX 7) He stated that the job Petitioner obtained as a medical assistant was suitable and viable occupation for Petitioner. He stated that there is an excellent labor market for him in this position. Mr. Pagella also noted that Petitioner was motivated to find alternative work and actually found two jobs. (PX 7)

The evidence deposition of Mr. Pagella was completed on December 19, 2018. (PX 11) Mr. Pagella noted that Petitioner had a history of working in the medical field. He stated that Petitioner obtained employment as a medical office assistant, which is in the medical field, and utilizes some of the transferable skills that he obtained from his work with Respondent. Mr. Pagella testified that Petitioner could not return to his pre-injury employment since he would not be able to lift and assist patients. Mr. Pagella agreed that Petitioner required vocational rehabilitation services. He noted that Petitioner did as he was asked and looked for and actual secured employment. Mr. Pagella set forth that Petitioner could work a 40-hour work week. (PX 11 at 16-19)

Mr. Pagella testified that Petitioner performed a diligent job search. He noted that Petitioner was able to secure employment and as a result, the job search was a success. Mr. Pagella also noted that Creative Case Management discontinued vocational rehabilitation once Petitioner secured employment. (PX 11 at 20-22)

Mr. Pagella opined that $10 an hour was a suitable compensation for the position. Mr. Pagella testified that office assistants would earn $12.51 to $13.35 per hour after two years in the field. He provided that a starting salary $10 is the average salary and normal. (PX 11 at 24) Mr. Pagella testified that suitable employment for Petitioner would be the medical assistant position earning $10 per hour over a 40-hour work week. The basis for his opinion was his experience, information from the United States Department of Labor, the fact that Creative Case Management discontinued service after Petitioner obtained employment and that Petitioner was able to obtain the employment. (PX 11 at 25, 39) Mr. Pagella also testified that he did not perform a labor market survey since Petitioner obtained suitable employment. (PX 11 at 35)

Petitioner testified regarding his current subjective complaints. Petitioner testified that there are days that are worse than others. He experiences pain in his low back and down his left leg. Petitioner also experiences weakness in his left leg. Petitioner testified that he takes over the counter medication for the pain. He takes the medication when he experiences pain. Petitioner testified that he experiences pain in his back at work. He experiences pain if he twists his back the wrong way. Petitioner testified that since the accident, his wife performs most of the chores around the house. He provided that his wife has to now load the children into the car. He is not able to play catch with his sons or work on the bike with them. He stated that he had to sell his dirt bike due the accident. Lastly, Petitioner testified that his doctors recommended that he lose weight. Prior to the work accident of September 19, 2014, Petitioner weighed 235 pounds. Currently he weighs 175 pounds.

In support of the Arbitrator's decision relating to "L," nature and extent of the injury, the Arbitrator finds as follows:

Petitioner seeks an award under Section 8(d)1 of the Act. The Arbitrator finds that Petitioner is entitled to wage differential benefits under Section 8(d)1 of the Act in the amount of $320.61 per week effective March 20, 2019, the date of the arbitration hearing. In support of his finding, the Arbitrator relies on the credible and unrebutted testimony of Petitioner, the medical records, the work restrictions of Dr. Ghanayem, the paystubs admitted into evidence and the vocational opinions of Mr. Edward Pagella. The Arbitrator notes that Ms. Amy Portz, Respondent's vocational rehabilitation counselor, agreed that Petitioner could not return to his pre-injury

employment based on his work restrictions, sustained an impairment of earnings and that suitable employment was earning $10 per hour over a 40 hours per week as a medical assistant.

The Arbitrator notes that a wage differential award is the preferred method of compensation in workers' compensation claims. *See Gallianetti v. Industrial Commission*, 315 Ill.App.3d 721, 734 N.E.2d 482 (3d Dist. 2000).

To qualify for a wage differential award, a Petitioner must establish: 1) that he is partially incapacitated from pursuing his usual and customary line of employment; and 2) an impairment of earnings. *Copperweld Tubing Products, Co. v. Workers' Compensation Com'n*, 402 Ill.App.3d 630, 931 N.E.2d 762 (1st Dist. 2010). To establish an impairment of earnings, the Commission considers the amount that the claimant "is earning or is able to earn in some suitable employment or business after the accident." *Id.*

In the instant case, the Arbitrator finds that Petitioner has established that he is partially incapacitated from pursing his usual and customary line of employment. Petitioner's usual and customary line of employment was a mental health technician. The job of a mental health technician is physically demanding and requires bending, squatting, crouching, twisting, lifting people weighing up to 300 pounds and restraining people. As a result of the work-related accident of September 19, 2014, Petitioner was given permanent work restrictions by Dr. Ghanayem. The doctor set forth that Petitioner could not restrain people and could not lift more than 20 to 30 pounds. Dr. Ghanayem's work restrictions were undisputed. Both Mr. Pagella and Ms. Portz testified that based on the work restrictions, Petitioner would be unable to return to his pre-injury employment. Based on the work restrictions of Dr. Ghanayem and the vocational opinions, Petitioner was unable to perform his job duties as a mental health technician. Accordingly, the Arbitrator finds that Petitioner is partially incapacitated from pursing his usual and customary line of employment as a mental health technician.

The Arbitrator finds that Petitioner has also established an impairment of earnings. The Arbitrator finds that Petitioner would be earning $880.92 in his pre-injury employment. The Arbitrator relies on the Section 10 wages to establish what Petitioner would be earning in his pre-injury employment. *Franklin v. Peabody Coal Company*, 7 IWCC 1402, 2007 WL 4099250 (IWCC Oct. 9, 2007) (holding that the claimant can establish earnings in his pre-injury employment through the Section 10 average weekly wage).

The Arbitrator also finds that the employment Petitioner obtained as a medical office assistant constitutes suitable employment. The Arbitrator relies on a 40-hour work week in finding that the job as a medical office assistant constitutes suitable employment. The Arbitrator finds that Petitioner could earn $10 per hour over a 40-hour work week, or $400 per week, in his job as a medical office assistant.

Suitable employment is any work which takes into consideration both the attributes and limitations that the disabled worker presents to the marketplace. *Lavery v. United Airlines*, 04 IIC 0038, 2004 WL 384160 (IWCC Jan. 15, 2004). The Commission has found that Petitioner obtained suitable employment where Respondent's vocational rehabilitation counselor advised the employee to accept the job offer. *Lehman v. Halliburton*, 05 IWCC 0285, 2005 WL 1325016 (IWCC April 11, 2005). Where Respondent's vocational rehabilitation counselor advises that an employee accept a job offer and closes the vocational rehabilitation file, it can be assumed that the employer was satisfied with the job and that the employment was suitable. *Id.*

The Arbitrator's finding that Petitioner's position as a medical office assistant, assuming a 40-hour week, is suitable employment is supported by Petitioner's credible and unrebutted testimony and the vocational opinions of Mr. Pagella who specifically testified that the job of medical office assistant earning $10 per hour over a 40-hour work week constituted suitable employment. Further, Respondent's vocational rehabilitation counselor, Ms. Portz, testified that a job of medical office assistant earning $10 per hour over a 40-hour work week constituted suitable employment. She noted that the salary fell within the range set forth in the labor market

survey. Further, Ms. Portz closed the case file after Petitioner obtained employment as a medical office assistant and pizza delivery person supports the Arbitrator's finding. Accordingly, Petitioner has established that the position as a medical office assistant earning $10 per hour over 40 hours per week, or $400 per week, constitutes suitable employment and that Petitioner sustained an impairment of earnings.

Respondent argues that Petitioner could have earned more in suitable employment. Respondent argues that the labor market survey included wages that were higher than $10 per hour. The labor market survey contained a range of wages from $8.25 to $16.80 per hour. It is significant that earnings of $10 per hours falls within the range of wages that Ms. Portz stated that Petitioner could earn. Further, many of the jobs on the labor market survey fall below the $10 per hour that Petitioner is earning as a medical office assistant. Additionally, Petitioner applied for the jobs in the labor market survey which documented earnings of $16.80 per hour. Petitioner did not receive any interviews or offers of employment from any of the employers which set forth earnings of $16.80 per hour. Ms. Portz could not state that the employers were hiring, whether they could accommodate Petitioner's restrictions and whether Petitioner was qualified for the position. Lastly, Petitioner was able to obtain employment earning $10 per hour. Ms. Portz admitted that the job as medical office assistant earning $10 per hour over a 40-hour work week was suitable employment.

Respondent also argued that since Petitioner was not compliant in vocational rehabilitation, he could be earning more than $10 per hour. While Ms. Portz testified that Petitioner did not follow through on the tasks she assigned, she admitted that he participated in a job search, vocational services, attended vocational meetings and obtained employment. Accordingly, Petitioner participated in vocational rehabilitation and obtained employment. It is most significant that Ms. Portz testified that the job of medical office assistant earning $10 per hour, 40 hours per week, constituted suitable employment. Mr. Pagella also testified that Petitioner was complaint in vocational services and obtained employment. The Arbitrator rejects Respondent's argument based on the testimony of its own vocational counselor.

Accordingly, Petitioner is entitled to a wage differential award based on 2/3 of the difference between what he could have been earning in his pre-injury employment as a mental health technical ($880.92 per week) and what he is capable of earning in suitable employment as a medical office assistant ($400 per week). Therefore, Petitioner is entitled to a wage differential benefit in the amount of $320.61 per week until he reaches the age of 67 effective March 20, 2019.

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lino Remedi

Petitioner,

vs. NO: 18 WC 29881

Illinois Dept. of Transportation,

Respondent.

20IWCC0195

DECISION AND OPINION ON REVIEW

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

The Commission affirms the Arbitrator's determination that Petitioner sustained the loss of use of 15% of the left arm relative to his left elbow injury pursuant to §8(e)10 of the Act. However, the Commission modifies the Arbitrator's decision to find that Petitioner suffered the permanent partial loss of use of 30% person-as-a-whole pursuant to §8(d)2 relative to his left shoulder injury, based on the the five (5) factors outlined in §8.1b of the Act.

With respect to (i) the reported level of impairment, the Commission notes that no AMA impairment report and/or opinion was submitted into evidence by either party. As a result, the Arbitrator accords no weight to this factor.

With respect to (ii) the occupation of the injured employee, the Commission notes that Petitioner was employed as a seasonal highway maintainer at the time of the incident and did not return to that job thereafter. The evidence also shows that the third and last FCE performed at ATI Physical Therapy on 10/30/18, as amended on 4/2/19, found that Petitioner job as a highway maintenance worker was at a MEDIUM occupational physical demand level while Mr. Remedi only demonstrated a LIGHT physical demand level capability. (RX7). The Commission

disagrees with the Arbitrator's attempt to discount the significance of this factor based on what he termed "a great deal of inconsistency in Petitioner's physical capacity and the physical demands required of his job." (Arb.Dec., p.9). Along these lines, the Commission is not persuaded that the first two FCEs were somehow more credible than the last, especially given that the FCE performed on 9/21/17 was done after the elbow surgery but before the shoulder surgery and in light of the fact that Petitioner was still treating and not at MMI at the time of the second FCE performed on 7/9/18. Indeed, with the corrected information as to Petitioner's job title, and given the validity of the FCE performed on 10/30/18, the Commission is inclined to view the final addendum report of 4/2/19 to be the most recent and relevant of the three FCEs undertaken. The Commission also notes that the permanent restrictions imposed by Dr. Poepping – including, maximum above-the-shoulder, two-handed lifting of 19 lbs., maximum below-the-shoulder lifting of 23 lbs., maximum pushing/pulling of 86 lbs., maximum carrying of 27 lbs., and maximum left-handed lifting of 10 lbs. – are well below the requirements of the highway maintenance worker position in which Petitioner once toiled and is no longer able to perform. As a result, the Commission accords this factor greater weight.

With respect to (iii) the age of the employee at the time of the injury, the Commission notes that Petitioner was 59 years old at the time of the accident and as an older worker will presumably have a more difficult time dealing with the limiting factors associated with his injury, both on the job and during the course of his activities of daily living, and may in fact limit his potential employment opportunities as a result. Therefore, the Commission disagrees with the Arbitrator's assessment of lesser weight and would instead accord at least moderate weight to this factor.

With respect to (iv) the employee's future earning capacity, the Commission notes that while Petitioner is clearly not unemployable, the third and most recent FCE and addendum shows that he demonstrated a LIGHT physical demand level capability while his job as a highway maintenance worker was at a MEDIUM occupational physical demand level. Furthermore, while the evidence does in fact show that Petitioner has applied for and is receiving SSDI benefits, and that he also suffers from unrelated back, neck and leg injuries, the record supports a finding that his current inability to return to work as a highway maintainer is at least partially due to the work injury on 1/27/16, and his left shoulder in particular. As a result, the Commission chooses to place moderate weight on this factor.

Finally, with respect to (v) evidence of disability corroborated by the treating medical records, the Commission finds that this factor is entitled to greater weight. Along these lines, the record shows that an MRI of the left shoulder performed on 3/9/16 revealed "1. Small collection in the subacromiodeltoid bursa. 2. Type II acromion process with acromioclavicular joint arthropathy results in mild subacromial impingement of the rotator cuff. 3. Supraspinatus tendinosis without evidence of tear. The rest of the rotator cuff is normal. 4. Small tear in the anterosuperior margin of the glenoid labrum, at 2 O'clock position. 5. Tiny cystic changes on the posterolateral aspect of the humeral head." (PX2). In addition, an MR of the left elbow performed on 3/9/16 revealed "1. Small elbow joint effusion. 2. Partial-thickness tear at the undersurface of the common extensor tendon near its origin from the lateral epicondyle." (PX2).

The record also shows that on 10/18/16, Petitioner underwent surgery at the hands of Dr.

Bibliography

Poepping in the form of left elbow extensor carpi radialis brevis debridement and lateral epicondyle debridement. (PX1). The post-operative diagnosis was left elbow lateral epicondylitis. (PX1). Petitioner also underwent surgery at the hands of Dr. Poepping on 1/23/18 in the form of left shoulder arthroscopic subacromial decompression, distal clavicle excision, extensive debridement. (PX1). The post-operative diagnosis was 1. Left shoulder acromioclavicular arthrosis, 2. Left shoulder partial-thickness rotator cuff tear, 3. Left shoulder impingement, and 4. Left shoulder extensive synovitis. (PX1). In addition, Petitioner underwent extensive physical therapy and work conditioning as well as numerous injections to his shoulder.

Petitioner last saw Dr. Poepping for his left shoulder on 11/16/18 at which time he recorded that the patient presented for follow up "... to review the FCE for his left shoulder and elbow. He overall is about the same as last time I saw him." (PX2). Upon physical exam of the left shoulder Dr. Poepping noted full active and passive range of motion, cuff strength in elevation of 4+/5 and 4+/5 in external rotation, with tenderness over the AC joint and greater tuberosity. (PX2). Dr. Poepping indicated that the patient was neurovascularly intact. (PX2). Dr. Poepping's impression was 1. Status post left shoulder arthroscopic subacromial decompression, distal clavicle excision, and debridement, and 2. Status post left elbow extensor carpi radialis brevis debridement. (PX2). Dr. Poepping noted that the FCE was valid and that "I formulated permanent restriction recommendations based on these findings. I will see him back on an as-needed basis. I do consider him an [sic] MMI at this point." (PX2).

In a "Medical Excuse/Appointment Verification" note dated 11/16/18, Dr. Poepping noted Petitioner should return to work as of that date with the following limitations: "max above shoulder 2 hand lift 19 lbs., max below shoulder lift 23 lbs[.], max push/pull 86 lbs[.], max carry 27 lbs[.], max left hand lift 10 lbs. Restrictions are permanent and based on valid FCE." (PX7).

Currently, Petitioner notices that his left shoulder hurts and that he can't use it like he used to before. (T.50). He noted that "... the popping is still there; and I do get pain, you know, on and off with it." (T.50). He indicated that the pain is in the front of the shoulder on top of the chest, "... right here where the armpit is..." (T.50). The Arbitrator described what Petitioner was indicating as "[a]cross the top of the joint along towards the neck." (T.51). Petitioner noted that he constantly feels this and that he does not have the same movement or range of motion in his shoulder. (T.51). He stated that before the injury he could reach with his left arm "[a]s far as it goes, to the top." (T.51). He indicated that now it doesn't go all the way, and that he can only get it to the eleven o'clock position. (T.52). In addition, he claimed that he cannot lift the same amount of weight as before, when he could lift items weighing maybe 40 or 50 pounds on a regular basis. (T.52-53). When asked how much he can lift now, Petitioner responded: "[i]t depends. A gallon of milk. Sometimes if I have more than a gallon of milk it will start hurting. And sometimes to place something on the table I have to like swing it... [f]rom the down position to swing it on the table." (T.53).

Based on the above, and the record taken as a whole, including the fact Petitioner is unable to return to his usual and customary line of employment at least in part due to his left shoulder injury, the Commission modifies the decision of the Arbitrator to find Petitioner sustained the permanent partial loss of use of 30% person-as-a-whole pursuant to §8(d)2.

20IWCC0195

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 7/29/19 is modified as described herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $673.07 per week for a period of 146-2/7 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 reasonable and necessary medical expenses in the amount of $1,725,00 for G&T Orthopedics, $564.00 for Elmhurst Hospital, $102.00 for Elmhurst Radiology, and $3,121.00 for ATI Physical Therapy, pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $605.77 per week for 187.95 weeks, because the injuries sustained caused the loss of use of 15% of the left arm, as provided in §8(e)10 of the Act, for the injury to the left elbow, and 30% loss of use of the person-as-a-whole, as provide in §8(d)2 of the Act, for the injury to the left shoulder.

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; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

Pursuant to Section 19(f)(l), this decision is not subject to judicial review.

DATED: MAR 17 2020
o:3/10/20
DM/pmo
52

D. Douglas McCarthy

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REMEDI, LINO
Employee/Petitioner

Case# **18WC029881**

ILLINOIS DEPT OF TRANSPORTATON
Employer/Respondent

20IWCC0195

On 7/29/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0311 KOSIN LAW OFFICE LTD
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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

JUL 29 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

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

Lino Remedi
Employee/Petitioner

v.

Illinois Department of Transportation
Employer/Respondent

Case # **18** WC **29881**

Consolidated cases: **N/A**

20IWCC0195

An *Application for Adjustment 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 **Wheaton**, on **June 25, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0195

FINDINGS

On **January 27, 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 **$52,500.00**; the average weekly wage was **$1,009.61**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$90,389.16** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$667.59** for other benefits, for a total credit of **$91,056.75**.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $1,725.00 to G&T Orthopedics, $564.00 to Elmhurst Hospital, $102.00 to Elmhurst Radiology, and $3,121.00 to ATI Physical Therapy, as provided in Sections 8(a) and 8.2 of the Act. By stipulation of the Parties, Respondent shall pay directly to the providers. Respondent shall have additional credit upon proof of any additional payment pursuant to the Act. Respondent shall further pay $215.52 to Petitioner for the out-of-pocket prescription payments.

Respondent shall pay Petitioner temporary total disability benefits of $673.07/week for 146 2/7 weeks, commencing January 28, 2016 through November 16, 2018, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $91,056.75 for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of $605.77/week for 162.95 weeks, because the injuries sustained caused the 15% loss of the Left Arm, as provided in Section 8(e)10 of the Act for the injury to the left elbow, and 25% loss of the Person as a Whole, as provided in Section 8(d)2 of the Act for the injury to the left shoulder.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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, 2019
Date

JUL 29 2019

Statement of Facts

Petitioner Lino Remedi testified that on January 27, 2016, he was employed by Respondent Illinois Department of Transportation as a highway maintainer. He had been employed in that position for 6 years. He testified that this was a seasonal position. His duties included plowing snow, picking up litter and large debris along the roadways such as refrigerators, tires and dead animals. He would lift weights from 50 to 150 pounds. Larger items would require co-worker assistance. He would need to lift from the ground to above shoulder level. He would also set up for snowstorms. This required putting on the plow, getting salt and checking the vehicle. Prior to January 27, 2016, he had no problems, symptoms or medical treatment for his left shoulder or elbow. He had a back or neck injury in 1980. He testified he is righthanded.

Petitioner testified that on January 27, 2016, he worked from 6:00 AM to 3:00 PM. At 2:30 PM, he was attaching a salt spreader to the rear of an IDOT truck with the assistance of a co-worker, Keith Sutton, in anticipation of an upcoming storm. The spreader was approximately two to two and a half feet long and three feet wide and weighed approximately 60 to 70 pounds. It had two rails which slide into channels on the rear of the truck and lock down. If one side slid into the channel unevenly, it would jam and need to be removed. Petitioner and his co-worker each held one side and lifted the device into place. The box became jammed. While pulling it loose, the box came free and the other employee fell to the ground and lost his grip placing the entire weight on Petitioner's left side. Petitioner testified that he could not free his left hand from the box and was pulled downward, although he did not fall. Petitioner testified that he immediately felt pain at the front of his left shoulder and along the top of his shoulder. The pain extended down his arm. His arm felt weak. He had difficulty raising his arm or grasping with his left hand. Petitioner finished his work shift, approximately another half hour.

Petitioner testified that evening the pain became worse. The next day, Petitioner called off work due to the pain but did not seek medical attention. His condition did not improve. He began to feel numbness into the middle fingers of his left hand. On January 29, 2016, Petitioner returned to work and advised his supervisor of his injury and prepared an accident report (RX 1). Petitioner was sent to Elmhurst Occupational Health.

Petitioner was seen at Elmhurst Occupational Health on January 29, 2016 (PX 1). He provided a consistent history of accident and advanced complaints in the left elbow and shoulder. Examination noted full range of motion in the shoulder with mild pain and pain in the elbow with motion. There was full strength. X-rays of the elbow noted minimal spurring of the radial head with no dislocations or significant fractures. Left shoulder x-rays were negative for fracture or dislocation. Mild degenerative changes were noted in the AC joint. Petitioner was diagnosed with a left arm strain and restricted to right-handed work only (PX 1, p 277-289). On February 8, 2016, Petitioner noted no improvement and was referred to Dr. Poepping (PX 1, p 292-297).

On February 12, 2016, Petitioner was examined by Dr. Poepping. Petitioner complained of left elbow pain greater than his left shoulder pain and pain radiating into the two middle fingers of his left hand. On physical examination, he had limited elevation of his arm with positive Neer and Hawkins' tests with tenderness and 4/5 infraspinatus strength. He had tenderness over the lateral epicondyle of the left elbow and severe pain with resisted wrist extension. There was mild swelling laterally over the elbow. Dr. Poepping ordered an MRI of the left shoulder and elbow and started physical therapy (PX 2, p 34). The impression of the March 9, 2016 left shoulder MRI was a small collection in the subacromiodeltoid bursa; type II acromion process with acromioclavicular joint arthropathy resulting in mild subacromial impingement of the rotator cuff; supraspinatus tendinosis without evidence of tear; small tear in the anterosuperior margin of the glenoid labrum; and tiny

cystic changes on the posterolateral aspect of the humeral head. A left elbow MRI showed small joint effusion and a partial-thickness tear at the undersurface of the common extensor tendon (PX 2, p 408-412).

On March 18, 2016, Petitioner noted his shoulder was better, but the left elbow was still very painful. Dr. Poepping diagnosed left shoulder rotator cuff tendinosis, left shoulder AC arthrosis and left elbow partial tear of the common extensor tendon. He offered an injection, but Petitioner was interested in just starting physical therapy (PX 2, p 33). Petitioner began therapy at Chicago Rehabilitation Services on April 4, 2016 (PX 3). On April 22, 2016, Petitioner returned to Dr. Poepping with continuing complaints to his elbow and shoulder. His left elbow was injected (PX 2, p 32). On May 20, 2016, Petitioner noted only 2 weeks improvement from the injection. He complained of pain with gripping and lifting. A wrist brace was provided, physical therapy was continued, and the Petitioner was advised to consider surgery to his elbow (PX 2, p 31). Petitioner continued therapy and follow up with Dr. Poepping for his left elbow and shoulder. On July 22, 2016, Petitioner expressed interest in surgery. Dr. Poepping noted conservative care has failed to provide lasting relief and felt Petitioner was an excellent candidate for ECRB debridement (PX 2, p 29). Petitioner's therapy ended on August 10, 2016 (PX 3). On October 18, 2016, Petitioner underwent an extensor carpi radialis brevis debridement and lateral epicondyle debridement at Elmhurst Hospital (PX 1, p 44-45).

Petitioner had post-operative follow up with Dr. Poepping (PX 2). He resumed physical therapy beginning November 11, 2016 (PX 3). Dr. Poepping noted improvement in the left elbow but continued complaints in the left shoulder including pain and crepitus. Petitioner had a subacromial steroid injection on January 6, 2017 without lasting relief. On February 3, 2017, Dr. Poepping suggested shoulder surgery. Petitioner requested additional therapy to avoid more surgery (PX 2, p 24-27). Physical therapy ended on March 6, 2017; Petitioner having reached a plateau (PX 3). Petitioner began a home exercise program on March 10, 2017, with Dr. Poepping still stating that he is a surgical candidate. Petitioner reported neck treatment from an automobile accident on April 8, 2017 (PX 2, p 23). Petitioner testified that he has filed a personal injury claim for that matter claiming his back and neck. The claim is still pending. On May 19, 2017, Petitioner reported his elbow felt well. He was scheduled for an evaluation with Dr. Cole (PX 2, p 21-22).

On May 22, 2017, Petitioner was examined by Dr. Brian Cole at Respondent's request pursuant to Section 12 (RX 4). With respect to Petitioner's left elbow, physical examination was normal with full range of motion and 5/5 strength. Dr. Cole opined Petitioner was post lateral epicondylectomy as a result of his work-related injury. He opined that he had a fair to good outcome and could return to full duty with no restrictions based upon the left elbow alone. Dr. Cole stated that he may have discomfort in his elbow upon return to work but that it would not be orthopedically unsafe. With regard to Petitioner's left shoulder, Dr. Cole opined Petitioner continued to experience persistent rotator cuff tendinitis versus a possible tear as a result of the work injury and that he had yet to attain MMI. These findings were causally related to the January 27, 2016 work accident. Dr. Cole suggested further treatment depending upon where Petitioner's principle pain was located in his shoulder. These additional modes of treatment included further cortisone injections and/or arthroscopy (RX 4).

On June 30, 2017, Petitioner returned to Dr. Poepping. He was still apprehensive of surgery and was scheduled for an FCE to formulate permanent restrictions as suggested by Dr. Cole (PX 2, p 19). The September 21, 2017 FCE performed at Chicago Rehabilitation Service was determined to be valid. Petitioner performed in the Medium Physical Demand level with lifting and carrying of 26 to 35 pounds (PX 3, p 305-319). On October 13, 2017, Petitioner returned to Dr. Poepping with continued shoulder pain. On examination, the pain was noted superiorly, anteriorly and laterally. The pain was not periscapular, but in the

region of the rotator cuff and AC joint and biceps tendon. Crepitus was noted in the joint as well as positive Neer and Hawkins' tests. Dr. Poepping again advised arthroscopic surgery and Petitioner agreed (PX 2, p 18).

On January 23, 2018, Petitioner underwent a left shoulder arthroscopic subacromial decompression, distal clavicle resection and extensive debridement (PX 1, p 120-121). Petitioner sustained a urinary retention issue post-surgery which was treated on an emergency basis at Elmhurst Memorial Hospital on January 28, 2018 (PX 1, p 124).

Post-operative care with Dr. Poepping began February 2, 2018. Petitioner was scheduled to return to physical therapy (PX 2, p 16). Petitioner began physical therapy at Team Rehabilitation Services on February 7, 2018 (PX 4). On April 6, 2018, Petitioner noted slight improvement in his left shoulder. He was still getting a popping in his shoulder joint with anteriorly based pain. Dr. Poepping noted point tenderness over the AC joint with some crepitus and a palpable gap in the AC joint. He administered an injection into the shoulder for pain relief (PX 2, p 15). On May 4, 2018, Petitioner reported improvement with pain after the injection. He noted discomfort superiorly and clicking in the shoulder joint. Dr. Poepping ordered the last four weeks of physical therapy to be followed by two weeks of work conditioning and then either a trial of work or an FCE (PX 2, p 14). On June 1, 2018, physical examination noted full range of motion with no gross abnormalities. There was clicking in the region of the AC joint and tenderness. Strength was 4+/5. Petitioner received another injection to the shoulder. On June 22, 2018, Petitioner reported the injection provided transitory benefit. Examination noted mildly positive Neer and Hawkins' tests, mild positive Spurling's test and tenderness to palpation to the left trapezius in the suprascapular notch region. Work conditioning was started (PX 2, p 13).

On July 9, 2018, Petitioner underwent a Work Hardening/Conditioning Evaluation at Team Rehabilitation (PX 4, RX 6). The test noted Petitioner to be able to perform 87.9% of the physical demands of his job as a highway Maintenance Worker. He was unable to successfully achieve Occasional Squat Lifting, Occasional Power Lifting, Occasional Shoulder Lifting, Occasional Overhead Lifting, Occasional Unilateral Lifting, Occasional Bilateral Carrying, Occasional Unilateral Carrying and Above Shoulder Reaching. Petitioner was found to be at the Medium Physical Demand Category with lifting and carrying from 40 to 65 pounds. Highway Maintenance Worker was classified in the Heavy Physical Demand Category (RX 6). Petitioner participated in work conditioning through his discharge on July 23, 2018. The Discharge summary notes his physical capacity was essentially unchanged. It also notes that the physical demands of the job were provided by Petitioner (PX 4, p 170-172). On August 3, 2018, Dr. Poepping noted Petitioner complained of continued discomfort and weakness in his left shoulder and arm, particularly with overhead activities. Physical examination noted full range of motion. There was tenderness and some crepitus in the AC joint. Petitioner was neurovascularly intact. He had 4/5 strength on elevation and 4+/5 strength in external rotation. Dr. Poepping stated he has maximized conservative care and rehabilitation. He recommended an FCE to formulate permanent restrictions (PX 2, p 11).

On August 6, 2018, Dr. Cole prepared an addendum report based upon review of additional treating records (RX 5). Dr. Cole reviewed various medical records to date, including Dr. Poepping's records, the Chicago Rehabilitation Service FCE, records of Team Rehabilitation including the July 13 work conditioning progress report. Dr. Cole opined that the left shoulder treatment to date was reasonable and necessary. Dr. Cole opined that the shoulder condition was guarded for any further improvement. Further treatment would not elevate his work capacity to any large degree. Dr. Cole opined that Petitioner was at Maximum Medical Improvement but could not say with conviction that he could return to regular work full duty without restriction. He stated that Petitioner could attempt a full duty return to work and deal with his subjective complaints of pain knowing it

would be orthopedically safe for him to do so. If Petitioner adamantly denies he is capable of doing so, Dr. Cole opined that a job specific FCE could be obtained with a validity test (RX 5). Respondent terminated temporary compensation benefits as of August 31, 2018.

Petitioner had follow-up appointments on September 7, 2018 and October 19, 2018 waiting for an FCE (PX 2, p 9-10). Dr. Poepping kept Petitioner on restrictions (PX 2, p 92-94). On October 30, 2018, an FCE with validity testing was performed at ATI (PX 5, RX 7). The FCE report notes that the results were valid. Petitioner performed at a Light Physical Demand Level with above shoulder lifting of 19.2 pounds occasionally, desk to chair lifting of 23.6 pounds occasionally, chair to floor lifting of 14.8 pounds occasionally and carrying (Right/Left) was limited to 27.0 pounds/27.0 pounds occasionally. ATI notes a job description for a Dept. of Transportation Laborer was received and was classified as Light. Petitioner described lifting up to 60 pounds. They noted Petitioner could perform within the job description but not his self-reported description (PX 5). An amendment to the FCE report, dated April 2, 2019, utilized a job description of a Highway Maintenance Worker as well as DOT number finding that job's physical demand level is Medium (RX 7, p 2).

On November 16, 2018, Dr. Poepping reviewed FCE results. His examination noted full range of motion, 4+/5 strength. There was some tenderness. His impression was post left shoulder arthroscopic subacromial decompression and distal clavicle excision, and post left elbow extensor carpi radialis brevis debridement. Petitioner was found at MMI and discharged from care, to return as necessary. (PX 2, p 8). Dr. Poepping provided permanent restrictions of max above shoulder two hand lift of 19 pounds; max below shoulder lift of 23 pounds; max push/pull 86 pounds; max carry 27 pounds; and max left-hand lift 10 pounds (PX 7). Petitioner testified that he brought these written restrictions to Respondent's Schaumberg office and presented them to Respondent's workers' compensation liaison, Gayle Carone. Present was George Khoury. Petitioner testified that he was informed that the Respondent could not provide work within the restrictions. Notice of Respondent's response to the restrictions was sent to Respondent's counsel dated November 19, 2018 (PX 7).

Petitioner testified that he elected to apply for SSDI benefits and is receiving same. He has not sought other employment. He sustained an unrelated injury to his right ankle on February 13, 2019 for which he has undergone surgery and for which he is currently treating (PX 2, p 6-7). Petitioner testified that he continues to have pain in his left shoulder whenever he reaches away from his body. He has difficulty picking up items heavier than a gallon of milk. He cannot reach straight above his head with his left arm. He continues to have constant shoulder discomfort. If he sleeps on the shoulder the pain will wake him up. He takes medication to control the pain. Petitioner testified that his left elbow is no longer painful. He has weakness with grip in his left hand and feels a pulling sensation when reaching away from his body.

Conclusions of Law

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

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *Horath v. Industrial Commission*, 449 N.E.2d 1345, 1348 (Ill. 1983) citing *Rosenbaum v. Industrial Com.* (1982), 93 Ill.2d 381, 386, 67 Ill.Dec. 83, 444 N.E.2d 122). The Commission may find a causal relationship based on a medical expert's opinion that the injury "could have" or "might have" been caused by an accident. *Mason & Dixon Lines, Inc. v.*

Industrial Comm'n, 99 Ill. 2d 174, 182, 457 N.E.2d 1222, 1226, 75 Ill. Dec. 663 (1983). However, expert medical evidence is not essential to support the Commission's conclusion that a causal relationship exists between a claimant's work duties and his condition of ill-being. *International Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63, 442 N.E.2d 908, 911, 66 Ill. Dec. 347 (1982). A chain of events suggesting a causal connection may suffice to prove causation. *Consolidation Coal Co. v. Industrial Comm'n*, 265 Ill. App. 3d 830, 839, 639 N.E.2d 886, 892, 203 Ill. Dec. 327 (1994). Prior good health followed by a change immediately following an accident allows an inference that a subsequent condition of ill-being is the result of the accident. *Navistar International Transportation Co. v. Industrial Comm'n*, 315 Ill. App. 3d 1197, 1205 (2000). Petitioner has established causation by both theories.

Petitioner's unrebutted testimony is that he had no injuries or issues with the left shoulder or elbow before the accident on January 26, 2016. He reported immediate onset of complaints, provided a consistent history of the injury, and initiated a course of medical care within days to the left elbow and shoulder. He continues with treatment including surgery to the elbow and thereafter to the shoulder up until his release from care.

The initial treatment at Elmhurst Occupational Health provided treatment based upon the accident history. Dr. Poepping's records address the condition of Petitioner's left elbow and shoulder in the context of the accident history reported. Dr. Cole's reports provide specific causal connection opinions for both the left elbow and shoulder.

Base upon the record as a whole, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that his conditions of ill-being in the left elbow and left shoulder are causally connected to the accidental injury sustained on January 26, 2016.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Under §8(a) of the Act, a claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of a claimant's injury. The claimant has the burden of proving that the medical services were necessary, and the expenses incurred were reasonable. *City of Chicago v. Illinois Workers ' Compensation Commission*, 409 Ill. App. 3d 258, 267 (1st Dist., 2011).

Petitioner submitted PX 6 consisting of medical bills claimed outstanding, and listed the claimed balances as Attachment A to Arb. Ex.1. [The Arbitrator notes the PX 6 includes cover pages for the bills listing them as individual exhibits, some duplicative of the other exhibits already admitted. To avoid confusion, the Arbitrator will refer to the bills as PX 6 and the page numbers of that exhibit that correspond to the billing rather than the internal exhibit numbers]. Respondent admitted a payment ledger as RX 3. The Arbitrator has reviewed the bills claimed and the medical records offered and finds the bills correspond to the treatment rendered by the treating physicians for causally related conditions of ill-being to the left elbow and shoulder. The unpaid balances claimed are:

1. G&T Orthopaedic (PX 6, p 11-15: $1,725.00) for services rendered June 22, 2018, August 3, 2018, September 7, 2018, October 19, 2018 and November 16, 2018.

2. Elmhurst Hospital (PX 6, p 34: $564.00) for a left shoulder x-ray ordered by Dr. Poepping on February 2, 2018. The Arbitrator notes that the provider has indicated an adjustment leaving a balance of $185.59.
3. Elmhurst Radiologists (PX 6, p 38-44: $102.00) for radiological assessment on January 29, 2016 and March 2, 2018.
4. ATI Physical Therapy (PX 6, p 78-80: $3,121.00), for the FCE performed on October 30, 2018.
5. Out-of-pocket prescriptions (PX 6, p 98-124: $215.52) for medications prescribed by Petitioner's treating physicians.

The Arbitrator finds that the Elmhurst Hospital and Elmhurst Radiology bills and the out-of-pocket prescription payments are for undisputed treatment and are reasonable and necessary charges. On August 6, 2018, Dr. Cole opined that the left shoulder treatment to date was reasonable and necessary. Respondent has disputed the remaining visits with Dr. Poepping and the ATI FCE, suggesting that Petitioner was at MMI as of the date of the Team Rehabilitation FCE on July 9, 2018 and Dr. Cole's August 6, 2018 addendum report rather than upon his final release by Dr. Poepping on November 16, 2018.

Although Petitioner physical capacity did not improve following the July 9, 2018 functional assessment, Dr. Poepping recommended additional work conditioning which was undertaken until July 23, 2018. On August 3, 2018, although Dr. Poepping stated Petitioner has maximized conservative care and rehabilitation. He recommended an FCE to formulate permanent restrictions. Dr. Cole opined that further treatment would not elevate his work capacity to any large degree. Dr. Cole opined that Petitioner was at Maximum Medical Improvement but could not say with conviction that he could return to regular work full duty without restriction. He stated that Petitioner could attempt a full duty return to work and deal with his subjective complaints of pain knowing it would be orthopedically safe for him to do so. If Petitioner adamantly denies he is capable of doing so, Dr. Cole opined that a job specific FCE could be obtained with a validity test. While Dr. Poepping found Petitioner essentially at MMI on September 7, 2018, he noted that he was not able to return to his regular job and sought the FCE to establish his safe work level. The office notes of Dr. Poepping Dr. Cole's opinion, ordering, reviewing and assessing an FCE with validity testing from ATI. On November 16, 2018, Dr. Poepping documented Petitioner's permanent restrictions as suggested by Dr. Cole in his record review of August 6, 2018.

Based upon the medical records and reports, the Arbitrator finds that Petitioner did not reach maximum medical improvement until after the ATI FCE and November 16, 2018 follow up appointment with Dr. Poepping at which time he was provided permanent restrictions and was released from care. The treatment through that date was reasonable and necessary.

Based upon the record as a whole, the Arbitrator finds that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $1,725.00 to G&T Orthopedics, $564.00 to Elmhurst Hospital, $102.00 to Elmhurst Radiology, and $3,121.00 to ATI Physical Therapy, as provided in Sections 8(a) and 8.2 of the Act. The parties have stipulated that, should these bills be awarded, Respondent shall pay directly to the providers pursuant to the applicable fee schedule. The parties have also stipulated that, should additional payments have been made, not noted on RX 3, Respondent shall have additional credit upon proof of payment pursuant to the Act. Respondent shall further pay $215.52 to Petitioner for the out-of-pocket prescription payments.

In support of the Arbitrator's decision with respect to (K) Temporary Compensation, the Arbitrator finds as follows:

Temporary compensation is provided for in Section 8(b) of the Workers' Compensation Act, which provides, weekly compensation shall be paid as long as the total temporary incapacity lasts, which has interpreted to mean that an employee is temporarily totally incapacitated from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit. It is a well-settled principle that when a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized, *i.e.*, whether the claimant has reached maximum medical improvement.

The parties have stipulated that Petitioner was entitled to temporary total disability through August 31, 2018. RX 3 documents payments of temporary compensation totally $90,389.16. Respondent also claimed additional payment of other benefits. The parties stipulated that all benefit owed from January 28, 2016 through August 31, 2018 have been paid. Respondent disputes entitlement to benefits from that date through Petitioner's release by Dr. Poepping on November 16, 2018, a period of 11 weeks. As more fully addressed in the Arbitrator's finding with respect to Medical above, the Arbitrator finds that Dr. Cole's opinion left the determination of maximum medical improvement to the discretion of the Petitioner and his treating doctor to schedule an FCE with validity testing. Maximum medical improvement was not reached until November 16, 2018.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that he is entitled to temporary total disability benefits for 146 2/7 weeks, commencing January 28, 2016 through November 16, 2018, as provided in Section 8(b) of the Act. Respondent shall be given a stipulated credit of $91,056.75 for 135 2/7 weeks temporary total disability benefits that have been paid through August 31, 2018.

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

Petitioner's date of accident is after September 1, 2011 and therefore the provisions of Section 8.1b of the Act are applicable to the assessment of partial permanent disability in this matter.

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 highway maintainer at the time of the accident and that he did not return to that job. The ATI FCE found he was not able to return to work in his prior capacity as a result of said injury. The Arbitrator notes that there is a great deal of inconsistency in Petitioner's physical capacity and the physical demands required of his job. At the September 21, 2017 FCE performed at Chicago Rehabilitation Service before his shoulder surgery, Petitioner performed in the Medium Physical Demand level with lifting and carrying of 26 to 35 pounds. In July 2018, Petitioner was placed in the Medium Physical Demand level with lifting and carrying of 40 to 65 pounds and could perform 87.9% of his job. His ability did not change through work conditioning. Yet at ATI his capacity in the Light Level. The Arbitrator also notes that the assessment of his job requirements varied from light

to heavy and Petitioner's description was more physical that the job descriptions provided. An amendment to the FCE report, dated April 2, 2019, utilized a job description of a Highway Maintenance Worker as well as DOT number finding that job's physical demand level is Medium. While it is unrebutted that Respondent did not return Petitioner to work upon presentation of Dr. Poepping's restrictions based upon the ATI FCE, the Arbitrator notes this inconsistency in the assessments and that Petitioner had tested at the Medium physical demand level on multiple occasions which was within the job description. The Arbitrator also notes Petitioner has unrelated issues with his neck and back resulting from the motor vehicle injury reported in April 2017 and does not find that this additional area of possible disability is addressed in the FCE. The Arbitrator also notes the unrelated injury in February 2019 to Petitioner's leg which also impacts his current ability to work. Because of these facts and issues, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 59 years old at the time of the accident and 62 years old upon release from care by Dr. Poepping. Petitioner would be considered an older worker. Petitioner has chosen to seek Social Security Disability and has made no effort to find any other employment despite being at maximum medical improvement and released to work with restrictions. 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 Respondent did not return Petitioner to work when provided Dr. Poepping's permanent restrictions pursuant to the ATI FCE. However, as noted in subsection (ii) above, there are inconsistencies in Petitioner's physical abilities and the assessment of the physical demand level of his prior occupation. Petitioner has made no effort to find other employment and has applied for and received SSDI benefits. The Arbitrator notes that, in addition to the disability relating to his accident, Petitioner has suffered other injuries to his back, neck and leg, which have some impact on his employability. Because of these facts and issues, 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 Petitioner underwent an extensor carpi radialis brevis debridement and lateral epicondyle debridement to the left elbow. Dr. Poepping noted improvement in the left elbow. On May 22, 2017, Dr. Cole's left elbow physical examination was normal with full range of motion and 5/5 strength. Dr. Cole opined Petitioner was post lateral epicondylectomy as a result of his work-related injury. He opined that he had a fair to good outcome and could return to full duty with no restrictions based upon the left elbow alone. On January 23, 2018, Petitioner underwent a left shoulder arthroscopic subacromial decompression, distal clavicle resection and extensive debridement. He participated in post-operative therapy and work conditioning. In July 2018, Petitioner was placed in the medium physical demand level with lifting and carrying of 40 to 65 pounds and could perform 87.9% of his job. On October 30, 2018, an FCE with validity testing was performed at ATI The FCE report notes that the results were valid. Petitioner performed at a Light Physical Demand Level. On November 16, 2018, Dr. Poepping noted full range of motion, 4+/5 strength in the left shoulder. There was some tenderness. Petitioner was released within the restrictions of the ATI FCE. Because of these facts, 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 15% loss of use of left arm pursuant to §8(e)10 of the Act for the left elbow injury and 25% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act for the left shoulder injury.

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

KENNETH HOPPER,

Petitioner,

vs. NO: 16 WC 28688

UNIQUE PERSONNEL CONSULTANTS,

Respondent.

20IWCC0196

DECISION AND OPINION ON REVIEW

This matter comes before the Commission on Petitioner's Petition for Review under §19(b) as well as Respondent's Motion to Dismiss Petitioner's Review.

Respondent's Motion to Dismiss Petitioner's Review

Findings of Fact

On April 8, 2019, counsel appeared before Commissioner McCarthy to argue Respondent's Motion to Dismiss Petitioner's Review. Commissioner Coppoletti was also present at the hearing. A record was made. Noting his office received the decision via an August 23, 2018 email from the WCC decisions address, Respondent's Counsel argued Petitioner's Petition for Review filed on September 26, 2018 was not timely. In response, Petitioner's Counsel stated his office did not receive the decision until September 17, 2018 and presented the testimony of Samantha Guarino.

Samantha Guarino is a paralegal in Petitioner's Counsel's office, a position she has held for seven years; she is also Petitioner's Counsel's daughter. 4.8.19 T. 13-14. She handles only workers' compensation matters. 4.8.19 T. 14. Guarino testified she routinely prepares Petitions for Review and understands the procedure for filing them. 4.8.19 T. 14.

Guarino was the senior paralegal assigned to Petitioner's case. 4.8.19 T. 15. Once a case is tried, Guarino reviews the Commission website to ascertain if a decision has been rendered; she

does this weekly if a notable amount of time has passed since the trial. 4.8.19 T. 15. Guarino testified she followed this routine in Petitioner's case. 4.8.19 T. 15-16. Guarino stated, "the case info on the IWCC website stated decision rendered[,] and we hadn't received anything yet so I called the Commission in Chicago and asked them and they said that they see that it was rendered on [August] 20th by Arbitrator Pulia...And I was instructed to email Mr. Griffin to receive the decision, which I did that day." 4.8.19 T. 16. Guarino identified Petitioner's Motion Exhibit 1 as the email she sent to Griffin. 4.8.19 T. 16. Guarino explained Mr. Griffin "responded 'done' and in a separate email he sent the decision that same day"; this was on September 17. 4.8.19 T. 17-18. Prior to that email, Guarino had not received a copy of the decision in any form. 4.8.19 T. 18.

Guarino testified she assisted in the preparation of a review approximately 50-100 times previously, and it takes her no longer than an hour to complete. 4.8.19 T. 18. She assisted with preparation of Petitioner's review; this was completed on September 17, 2018, the same day she received the decision, and she placed it in the mail at the Collinsville post office that day. 4.8.19 T. 19, 22.

Guarino reiterated the first time their office received the decision in Petitioner's case was September 17, 2018. 4.8.19 T. 22. She confirmed all emails to Petitioner's Counsel are automatically copied to her. 4.8.19 T. 22. She denied that Petitioner's Counsel or she ever received an email with the decision, "which is why we reached out to the Commission." 4.8.19 T. 22.

On cross-examination, Guarino testified she is familiar with the email keith@keithshortlaw.com; she explained it was the "previous email. It is forwarded to our current email which is siltrial.com." 4.8.19 T. 23. Asked who in the office would have received an email sent on August 23, 2018 to that address, Guarino testified, "It would have gone to Keith and all of those go to my email as well so it would go to both[,] and they get forwarded, as I mentioned before. The domain changed[,] but they're combined, if that makes any sense." 4.8.19 T. 23. The hearing was then continued for closure of proofs.

On October 23, 2019, the hearing reconvened before Commissioner Mathis. A record was made. Respondent offered into evidence two exhibits: 1) affidavit from Ron Rascia (RXA), and 2) FOIA response from the USPS regarding pickup at the Collinsville mail drop (RXB). Petitioner offered into evidence multiple emails to Charles Griffin requesting copies of decisions the Commission website indicates have been rendered but were not received by Petitioner's Counsel's office (PXA).

Conclusions of Law

Section 19(b) provides that "unless a petition for review is filed by either party within 30 days after the receipt by such party of the copy of the decision and notification of time when filed *** the decision shall become the decision of the Commission and in the absence of fraud shall be conclusive." *820 ILCS 305/19(b)* (West 2000). Respondent argues Petitioner's Petition for Review was not timely filed. Respondent's argument is two-fold: 1) Petitioner cannot prove it did not receive the decision on August 23, 2018, and 2) there is conflicting evidence as to when the Petition for Review was mailed.

Petitioner's Counsel asserted his office did not receive the decision until September 17, 2018. The Commission finds the affirmative statement on the record from an officer of the court is significant as all practicing attorneys are bound by Rule 3.3 of the Illinois Rules of Professional Conduct, which provides, "A lawyer shall not knowingly: (1) make a false statement of fact or law to a tribunal or fail to correct a false statement of material fact or law previously made to the tribunal by the lawyer." *Ill. R. Prof. Cond. 3.3(a)(1) (eff. Jan. 1, 2010)*. In addition to Petitioner's Counsel's statements on the record that his office did not receive the August 23, 2018 email, Petitioner provided the September 17, 2018 emails between Guarino and Griffin as well as the testimony of Guarino regarding the firm's email system and her actions regarding Petitioner's claim. Guarino testified all emails received by keith@keithshortlaw.com are automatically forwarded to her email. 4.8.19 T. 22, 23. She confirmed the Arbitration decision was not received by either the Keith email or her email, which is what prompted her to contact the Commission when she learned on September 17 that a decision had been rendered. 4.8.19 T. 22. Guarino repeatedly stated the decision was received on September 17, 2018, and the Petition for Review was prepared and mailed that same day. In addition, Petitioner provided the contemporaneous emails between Guarino and Griffin which evidence the decision had not been received prior to September 17, 2018.

The Commission finds the decision was not received by Petitioner until September 17, 2018. As the Commission file-stamped Petitioner's Petition for Review 15 days later, on October 2, 2018, the Commission finds the Petition for Review was timely. Therefore, Respondent's Motion to Dismiss Petitioner's Review is denied.

Petitioner's Review of the Arbitration Decision

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues and being advised of the facts and law, provides additional discussion as set forth below, but otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner argues his descriptions of the accident are not inconsistent, as each time he stated he was injured as he manipulated a device which maneuvered the picker. Petitioner further argues Kelly did not definitively testify he did not repair the picker in question. The Commission observes Kelly agreed he could not say with certainty whether he had to make repairs to the steering device on the picker in August 2016 (T. 43-44), explaining it was a long time ago and "in August of 2016 I was taking care of three forklifts and twelve stock pickers, and there's a lot of - - a lot to remember." T. 48-49. As such, the Commission finds Kelly's testimony of not remembering any repairs on that picker is of little probative value. Nonetheless, the Commission finds Petitioner ultimately failed to meet his burden of proof.

There is no question Petitioner provided multiple descriptions of the mechanism of injury. Petitioner claims the discrepancies in his medical histories are nothing more than reasonable variations in the description for a device "that escapes simple identification." We disagree. The Commission concludes Petitioner attempts to inject complexities where none are present. Initially, the Commission observes the instrument in question is a simple steering wheel with a knob attached. While Petitioner's reference to a "lever" as opposed to a knob or steering wheel is odd,

it is not dispositive; rather, the true problem is Petitioner's initial description of a repetitive trauma type incident coupled with his failure to mention any sort of acute jerking event or his arm being yanked out of socket. When the first history of injury, provided the day after the alleged accident, is so diametrically different from what Petitioner described later, it certainly raises questions. Given such, the history/mechanism of injury Petitioner provided to Dr. Poos on August 19, 2016 would be of obvious importance, yet those records were not submitted into evidence. Moreover, the Commission emphasizes Petitioner's descriptions at trial and to Dr. Solman have a noticeable difference as well: while Petitioner testified the lever itself jerked and thereby yanked his arm, there is no such report of the lever moving to Dr. Solman; rather, Petitioner told Dr. Solman he was pulling on a stuck lever and immediately had pain anteriorly in the shoulder. To be clear, the record before the Commission contains three versions of the same incident: in Version A, Petitioner repetitively turned the steering wheel and developed left shoulder pain; in Version B, the wheel itself violently jerked, ripping Petitioner's shoulder out of socket; and in Version C, Petitioner pulled so hard on an immovable object that he pulled his own shoulder out of socket. As the Arbitrator did, the Commission finds Petitioner's failure to provide a consistent history of the alleged acute incident is fatal to his claim for benefits.

The Commission finds Petitioner failed to prove he sustained an accidental injury on August 17, 2016.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Motion to Dismiss Petitioner's Review is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 20, 2018, as modified above, is hereby affirmed and adopted.

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

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

DATED: MAR 18 2020

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

LEC/mck

O: 3/3/2020

43

Stephen J. Mathis

Stephen Mathis

D. Douglas McCarthy

D. Douglas McCarthy

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

HOPPER, KENNETH
Employee/Petitioner

Case# **16WC028688**

UniQUE PERSONNEL CONSULTANTS INC
Employer/Respondent

20IWCC0196

On 8/20/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% 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:

4888 LAW OFFICE OF KEITH SHORT
1355 N BLUFF RD
UNITS C-D
COLLINSVILLE, IL 62234

2904 HENNESSY & ROACH PC
STEPHEN J KLYCZEK
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

20IWCC0196

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

KENNETH HOPPER,
Employee/Petitioner

v.

UNIQUE PERSONNEL CONSULTANTS, INC.,
Employer/Respondent

Case # **16** WC **28688**

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 **Springfield**, on **7/20/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **8/17/16**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned $**3,367.00**; the average weekly wage was $**481.00**.

On the date of accident, Petitioner was **52** 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 $**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

The petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his left shoulder that arose out of and in the course of his employment by respondent on 8/17/16. The petitioner's claim for compensation is denied.

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

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

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

Kaureen D. Pulia

Signature of Arbitrator

8/10/18
Date

ICArbDec19(b)

AUG 20 2018

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 52 year old order picker alleges he sustained an injury to his left shoulder that arose out of and in the course of his employment by respondent on 8/17/16. Petitioner was a temp employee for respondent who was placed at Schutt Manufacturing ("Schutt"). Petitioner worked there for 3-4 months prior to the alleged injury. Petitioner denied any problem with his left shoulder prior to 8/17/16. Petitioner's shift was 11pm to 7am.

Petitioner's job with Schutt was that of an order picker. Petitioner would pick sport items. Petitioner operated a forklift type machine with a board on it. There was a wheel on the left with a knob for steering, and a lever on the right of the machine that moved the machine up and down. Petitioner would ride the machine down the aisles to the racks. Petitioner would ride the machine up and down the racks pulling items and placing them on the pallet until it was full.

Petitioner testified that on 8/17/16 while backing up the machine in an aisle, he accelerated the machine, and the steering wheel knob, which he was holding at the 4:30 position on a clock, jerked and pulled the wheel knob with his left hand on it, from the 4:30 to 7:30 position on a clock. He stated that the steering wheel was a little stiff and hard to steer. Petitioner testified that this action caused his left arm to be pulled out away from his body and out of its socket. Petitioner immediately rolled the accelerator around and drove the machine to the parking spot. He then reported the injury to Alan Schmidt, his supervisor. Petitioner testified that an accident report was made at that time. However, no accident report was offered into evidence. Petitioner testified that he then called the nurse, and the nurse sent him to the emergency room.

On 8/18/16 petitioner presented to the Community Memorial Hospital Staunton Emergency Room. His chief complaint was shoulder/arm problem. Petitioner reported that he developed left shoulder pain that shoots down the left arm on 8/17/16 at 6am while at work. He stated that he attempted to work last night but was unable to do so due to left shoulder/arm pain. The mechanism of injury was repetitive turning of a wheel clockwise and counter clockwise with his left hand/arm. X-rays of the left shoulder showed osteoarthritis without acute fracture or dislocation. The history on the x-ray examination report was "injured while cranking motor at work at 6am yesterday". Petitioner was placed in a sling. He was assessed with a left deltoid muscle strain. Petitioner was restricted to light duty work starting 8/18/16 with no use of the left arm. He was instructed to return on 8/25/16. He was also instructed to followup with Dr. Joshua Poos if his symptoms were not better in 7 days.

Petitioner testified that he saw Dr. Poos, his primary care physician on 8/19/16 and was taken off work. He further testified that he personally handed these restrictions to respondent. However, no records from Dr. Poos were offered into evidence for treatment on 8/19/16.

On 9/2/16 Dr. Joshua Poos drafted a letter to "Whom It May Concern", regarding petitioner. It stated "Mr. Hopper is still currently under my care for a serious medical condition regarding his injury to his left shoulder at work. He is advised to continue his present work restrictions until further notice/release. If you have any questions or concerns please feel free to contact our office." However, no office notes from Dr. Poos with respect to a visit on 9/2/16 or any date prior to this date were offered into evidence. Petitioner testified that he also gave these restrictions to respondent, but they were never accommodated.

On 9/19/16 petitioner completed an Application for Adjustment of Claim. Petitioner alleged an accident on 8/17/16 while turning a wheel on motor. He alleged that this affected his left arm/left shoulder. The Application was signed by petitioner on 9/13/16.

On 9/20/16 petitioner underwent an MRI of the left shoulder. History provided was "pulled muscle on the left shoulder. Work injury on 8/17/16". The impression was a questionable very small articular partial thickness sided tear at the foot plate of the posterior fibers of the supraspinatus tendon; subscapularis and infraspinatus tendinosis; degenerative signal in the superior labrum without a discrete tear; mild glenohumeral joint osteoarthritis; constellation of findings that could be seen in the setting of the adhesive capsulitis; and, severe acromioclavicular joint osteoarthritis.

On 9/30/16 petitioner presented to Dr. Poos. Dr. Poos noted that this visit was in follow-up to a visit about 1 month ago for shoulder pain. However, no office notes for any prior visit were offered into evidence. The history was that petitioner injured his arm at work about 6 weeks ago. He noted that petitioner had no improvement with restrictions and was referred to an ortho, but did not present to the orthopedist. Petitioner continued to complain of pain in the shoulder. He also noted numbness and tingling in the fingers. He reported that his NSAIDs and Flexeril were not adequate for pain control. Dr. Poos examined petitioner and assessed shoulder pain. Dr. Poos prescribed Amitriptyline. He ordered petitioner to present for an orthopedic consultation. He renewed petitioner's Cataflam and Flexeril. Dr. Poos recommended that petitioner also consider physical therapy. He continued petitioner's activity restrictions. Petitioner was instructed to follow-up in two weeks.

On 11/23/16 petitioner presented to Dr. Corey Solman at Orthopedic Sports Medicine & Spine Care Institute, for a Section 12 examination at the request of his attorney, Keith Short. Petitioner alleged a work related injury on 8/17/16. He reported that he was working for respondent in a labor type job where he used a small motored device that was sort of a "mini-forklift". He stated that the particular motor he was using that day he steered with the right hand and pulled a lever with his left hand. He reported that the lever on the motor got stuck and he pulled it very hard with his left arm and immediately had pain anteriorly in the shoulder and in the subdeltoid bursa area. He reported that when he pulled on the lever, his body went up and his shoulder went inferiorly. He stated that night when he went to bed, it hurt when he rolled over on the shoulder. He reported that he saw his primary care physician the day after his visit to the emergency room. He stated that his doctor took him out of his sling so it would not get stiff, and told him he would help him get an orthopedic consultation. Petitioner reported that he had not undergone the orthopedic consultation, injections or physical therapy. He reported that he had been on light duty restrictions as assigned by his primary care physician since his injury. He reported that his condition was unchanged. He denied any problems with his left or right shoulder before 8/17/16.

Following a physical examination, x-rays of the left shoulder, and review of the MRI of the left shoulder Dr. Solman's impression was left shoulder pain with Type II SLAP lesion and biceps tendon pathology, and some possible rotator cuff pathology. Dr. Solman was of the opinion that petitioner clearly had an injury to his left shoulder on 8/17/16 and the need for treatment to his left shoulder. Dr. Solman recommended a diagnostic injection to the left shoulder, followed by a left shoulder arthroscopy with labral debridement and biceps tenodesis with evaluation of the rotator cuff and possible repair, if petitioner had a good result from the injection. Dr. Solman was of the opinion that an inferior traction force on the left arm on 8/17/16, as described by petitioner, is a classic mechanism for the development of biceps tendon and labral pathology and even possibly rotator cuff pathology. He restricted petitioner to light duty with no lifting greater than 10-15 pounds with the left arm below shoulder level, no overhead lifting, and also no pushing or pulling greater than 20-25 pounds with the left arm. Petitioner testified that he personally gave these restrictions to respondent and no job within his restrictions was offered.

Petitioner offered into evidence medical bills for Dr. Solman's examination on 11/23/16 and Community Memorial Hospital dated 8/18/16. Petitioner did not offer into evidence any bills from Dr. Poos.

On 6/13/17 the evidence deposition of Dr. Solman, an orthopedic surgeon, was taken on behalf of the petitioner. Dr. Solman could not state how long the objective findings in the left shoulder had been

there based on the MRI, since there was not a full thickness tear. Dr. Solman noted that petitioner told him he only saw his primary care physician once, on the day after he went to the emergency room following the alleged accident. Dr. Solman testified that petitioner told him that when he saw his primary care physician, the day after his visit to the emergency room, his doctor told him to come out of his sling so he would not get stiff. He further testified that other than petitioner's visit to him, petitioner told him his only other treatment was in the emergency room, and then a visit to his primary care physician the next day. Dr. Solman opined that petitioner had a Type II SLAP lesion (labral tear) with biceps tendon pathology. Dr. Solman opined that the injury petitioner described was the direct cause of the pathology he diagnosed. Dr. Solman based this opinion on petitioner's description that he lifted a lever in a wrenching motion, his body went up and his shoulder went down. Dr. Solman described this as a traction injury and was of the opinion that a traction injury to the shoulder is a classic mechanism for having any type of ligament tear, dislocation, partial dislocation, labral tear, and the other thing that can happen when the arm gets pulled down is that the biceps tendon can actually tear the labrum off of the glenoid.

On cross examination Dr. Solman testified that he had performed other IMEs at the request of Attorney Short. He testified that he has been working with Attorney Short for two years, and had done less than ten IMEs. He stated that he does approximately 75% of his IMEs for attorneys that represent patients. Dr. Solman reiterated his understanding that petitioner was operating a lever with his left hand, that the lever was stuck, and he had to forcefully move that lever, and at the time he felt pain in his left shoulder. He was of the opinion that if there was no lever there would be no causation.

On cross-examination Dr. Solman testified that a forklift has different handles and steering mechanisms, and whatever the device was petitioner indicated that he had pulled on the device as part of his work that that is what precipitated the injury.

Petitioner testified that he had gotten a few phone calls from respondent and when he states that his shoulder is still messed up they hang up on him.

Petitioner testified that currently he has pain and numbness in his left hand from carpal tunnel, and his left shoulder is very weak. He testified that he cannot sleep, but does not take any medications. Petitioner testified that he has been receiving SSDI since 2003 due to an unrelated right knee condition.

Scott Kelly was called as a witness on behalf of respondent. He appeared pursuant to a subpoena. Kelly worked for Schutt on 8/17/16 in maintenance and maintained the forklifts. He identified the machine petitioner was allegedly injured on as a crown order picker (RX1). He testified that the function

of it is to pull stock out of aisles of product. He stated that the order picker would ride on the platform and carry the skid and back in and out and pull product onto the skids. He testified that the lever is used to lift the platform on the order picker. Kelly testified that he has operated the crown order picker and did weekly maintenance on it. He could not recall if he operated the machinery petitioner was working on the alleged injury date before or on the alleged date of injury. Kelly testified that the steering wheel is operated manually. He testified that the force used to steer the steering wheel does not require any shoulder force. Kelly testified that he was unaware of the steering wheel on the crown order picker ever jamming, before, on, or after the alleged injury. He also testified that he was unaware of the steering wheel jamming when backing up the crown order picker. He testified that if the steering wheel did jam he would be the one to fix it, and he did not recall working on the crown order picker on or about the alleged date of accident. He further testified that if there was a problem with the machine the operator would note it on the list and he would fix it, and there was no such notation on the list. Kelly testified that he once had to fix a broken cable on the steering wheel, but does not recall when that was. He further testified that when the cable on the steering wheel breaks, the steering wheel locks and there is no movement.

On cross examination Kelly testified that he could not state with any certainty that he did not have to make changes to the steering of the crown order picker in August of 2016, because he worked on a lot of machines. Kelly testified that operator force is required to turn the steering wheel when backing up and turning. and no additional force is needed unless the operator hits something.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner alleges he sustained a specific injury to his left shoulder that arose out of and in the course of his employment by respondent on 8/17/16.

Following the alleged accident, petitioner provided 3 different mechanisms of injury, including his testimony at trial. The differing mechanisms of injury he provided are as follows:

1. On 8/18/16 - petitioner presented to Community Memorial Hospital Staunton Emergency Room and reported that he developed left shoulder pain that shoots down the left arm on 8/17/16 at 6 am while at work. He reported the mechanism of injury as repetitive turning of a wheel clockwise and counter clockwise with his left hand/arm. The history on the x-ray examination report was "injured while cranking motor at work at 6 am yesterday".

Petitioner made no mention of any jerking of the steering wheel when he was backing up the crown order picker and accelerating the crown order picker.

2. On 11/23/16 petitioner presented to Dr. Solman, at the request of his attorney. He alleged a work related injury on 8/17/16. He reported that he was working for respondent in a labor type job where he used a small motored device that was sort of a "mini forklift". He reported that the particular motor he was using that day he steered with his right hand and pulled a lever with his left hand. He gave a history of the lever on the motor getting stuck and he had to pull it very hard with his left arm. He reported immediate pain in his left shoulder. He reported that when he pulled on the lever, his body went up and his shoulder went inferiorly. Again, the petitioner made no mention of any jerking of the steering wheel when he was backing up the crown order picker and accelerated the crown order picker.
3. At trial on 7/20/18 petitioner testified that the accident occurred while he was holding the steering wheel knob on the crown order pickup machine at the 4:30 position and he accelerated the machine to backup in the aisle. He testified that as he did this the steering wheel jerked causing the steering wheel to be jerked from the 4:30 position on a clock to the 7:30 position on a clock, resulting in his left arm being pulled out away from his body and out of its socket. Petitioner testified that an accident report was made at the time of the accident, however, no accident report was offered into evidence.

In addition to these differing mechanisms of injury petitioner provided his healthcare providers and testified to at trial, the arbitrator notes that the Application for Adjustment of Claim he signed on 9/13/16 includes a mechanism of injury on 8/17/16 while "turning a wheel on a motor".

The arbitrator notes that the accident history provided in the emergency room, to Dr. Solman, and at trial are inconsistent. The arbitrator finds it significant that petitioner is alleging a specific loss injury, but within 48 hours of the alleged injury, the first mechanism of injury petitioner provided at the emergency room was that of "repetitive turning of a wheel clockwise and counter clockwise with his left hand/arm." No specific injury history was provided. Nor did petitioner report a jerking of the steering wheel that caused his left arm to be pulled away from his body and out of its socket.

The next documented mechanism of injury petitioner provided was an injury while turning a wheel on a motor. This history is noted on the Application for Adjustment of Claim that was filed

on 9/19/16. Again, no specific injury history was provided. Nor did petitioner report a jerking of the steering wheel that caused his left arm to be pulled away from his body and out of its socket.

Although no office records of Dr. Poos that were offered into evidence included a mechanism of injury, the records of Dr. Solman, who examined petitioner at the request of his attorney, included a very detailed mechanism of injury wherein petitioner described operating a "mini forklift" that he steered with his right hand and pulled a lever with his left hand. Petitioner specifically told Dr. Solman that the lever got stuck and he pulled it very hard with his left arm and experienced immediate pain in his left shoulder. He even went into further detail and noted that when he pulled on the level, his body went up and his shoulder went inferiorly. The arbitrator finds it significant that this history is totally inconsistent with the repetitive turning of the wheel clockwise and counter clockwise with his left hand/arm that petitioner provided in the emergency room on 8/19/16, and the accident history he testified to at trial, wherein he testified that he was holding the steering wheel knob in his left hand, at the 4:30 position of a clock, and when he accelerated the mini forklift while backing up the machine, the steering wheel jerked and his left hand on the steering wheel knob was pulled clockwise to the 7:30 position, causing his left arm to be pulled away from his body and out of its socket.

Given that the pictures of the crown order picker machine offered into evidence clearly show the steering wheel on the left side of the machine, and the lever on the right side of the machine, the arbitrator finds no way in which the petitioner could have injured his left shoulder if the mechanism of injury petitioner provided Dr. Solman was that of the lever getting stuck and he had to pull it very hard. If this was in fact what happened, then petitioner would have injured his right shoulder, given that petitioner testified that he used his left hand to operate the steering wheel and his right hand to operate the lever. Given that petitioner is claiming an injury to his left shoulder associated with his use of the steering wheel, and no mechanism of injury involving the steering wheel was provided to Dr. Solman, the arbitrator finds the opinions of Dr. Solman less than persuasive.

In addition to these inconsistent accident histories, petitioner testified that the steering wheel was a little stiff and hard to steer. However, Scott Kelly, who maintained the machine petitioner worked on, testified that he did weekly maintenance on the machine petitioner was operating at the time of the alleged accident. He testified that he was unaware of the steering wheel jamming when backing up the machine, given the fact that if that was occurring he would be the one to fix it. He also could not recall working on petitioner's machine on or about the date of the alleged date of

accident. He further testified that if a certain problem arose with a specific piece of equipment the operator would note it on a list and he would fix it. Kelly did not recall the problem petitioner described ever being on the list. Kelly did recall once fixing a broken cable on the steering wheel, but also testified that when this happens the wheel would lock and the machine could not be steered, and there would be no jerking movement. Kelly also testified that when operating the steering wheel, operator force is required because the wheel does not have power steering. However, the operator's force would not require any use of the operator's shoulder.

Lastly, the arbitrator questions why, if petitioner presented to Dr. Poos on 8/19/16, 9/2/16, and 9/30/16, the medical records of Dr. Poos offered into evidence by petitioner, did not include any office notes from the visits on 8/19/16 or 9/2/16, and the only office note of Dr. Poos from 9/30/16 did not include any mechanism of injury. The arbitrator also finds it suspicious that an off work note from 9/2/16 would be in the records, but not the actual office visit note.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his left shoulder that arose out of and in the course of his employment by respondent on 8/17/16.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?
J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?
K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?
L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Having found the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his left shoulder that arose out of and in the course of his employment by respondent on 8/17/16, the arbitrator finds these remaining issues 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 WILLLIAMSON	)	☒ Reverse Accident	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GARY SCOTT WALSTON,

Petitioner,

vs. NO: 14 WC 013596

SOUTHERN WINE & SPIRITS,

Respondent.

20IWCC0197

DECISION AND OPINION ON REMAND

The Circuit Court of Williamson County entered a Judgment on May 3, 2019, reversing the Commission's October 23, 2018, Decision and Opinion on Review, finding Petitioner sustained an accidental injury within the meaning of the Illinois Workers' Compensation Act ("Act") and that his current condition of ill-being is causally related to his accidental injury, and remanding the case to the Commission for consideration of the issues previously deemed moot. Consistent with the Order within the Circuit Court Judgment, the Commission decides the issues of accident date, notice, wages, medical expenses, temporary total disability, and permanent partial disability as stated below:

Accident Date

The Commission categorizes compensable injuries as injuries arising either out a single, identifiable event or by repetitive trauma. *Edward Hines Precision Components v. Indus. Comm'n (Dearing)*, 356 Ill. App. 3d 186 194, 825 N.E.2d 773, 780 (2005). The employee alleging an injury from repetitive trauma has the same standard of proof as claimants alleging accidental injuries from acute events. *Three "D" Discount Store v. Industrial Comm'n*, 198 Ill. App. 3d 43, 47, 556 N.E.2d 261, 264 (1989). The employee claiming a repetitive trauma injury must still show the injury to be work-related and not simply the result of the normal aging progress. *Gilster Mary Lee Corp. v. Industrial Comm'n (Wydeck)*, 326 Ill. App. 3d 177, 182, 759 N.E.2d 979, 983 (2001).

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In the instant matter, the Commission recognizes the Judgment of the Circuit Court of Williamson County finding Petitioner sustained accidental injuries arising out of and in the course of his employment as a result of his increased workload beginning in July 2013. Further, the Circuit Court found Petitioner's current condition of ill-being to be causally related to the increased workload.

The Commission also recognizes the Court did not affix a date certain as the date of Petitioner's accident. The date of Petitioner's accident was disputed by the parties. (AX1)

"[T]he date of accident is a significant one for fixing the legal relationships between the parties." *Oscar Mayer & Co. v. Industrial Com.*, 176 Ill. App. 3d 607, 611, 531 N.E.2d 174, 177 (4th Dist. 1988). There is no inflexible rule to determine the manifestation date in repetitive trauma cases. *Oscar Mayer & Co. v. Industrial Com.*, 176 Ill. App. 3d at 611-612, 531 N.E.2d at 177 (1988). The Commission should consider many factors when deciding when an injury caused by repetitive trauma manifests itself. *Durand v. Indus. Comm'n (RLI Ins. Co.)*, 224 Ill. 2d 53, 71, 862 N.E.2d 918, 928 (2006). The date an employee discovers their condition is related to their employment does not necessarily fix that date as the manifestation date; nor does an employee's last date of work always establish manifestation date. *Oscar Mayer*, 176 Ill. App. 3d at 612, 531 N.E.2d at 177. "[C]ourts considering various factors have typically set the manifestation date on either the date on which the employee requires medical treatment or the date on which the employee can no longer perform work activities." *Durand*, 224 Ill. 2d at 72, 862 N.E. at 92. The facts in repetitive trauma cases must be closely examined to ensure a fair result to all parties. *Three "D" Discount Store v. Industrial Comm'n*, 198 Ill. App. 3d 43, 49, 556 N.E.2d 261, 265 (1989).

Petitioner testified he learned a new lifting technique while rehabilitating a repaired torn rotator cuff. (T. pp. 30, 32) He presented to his primary care physician, Dr. Dennon Davis, on March 21, 2013, with complaints of back pain that began one month earlier. (PX7) He also informed Dr. Davis of initially experiencing pain radiating from his right buttock into his right posterior thigh but that pain pattern was now felt exclusively in his left buttock and into his left posterior thigh. (PX7) Dr. Davis instructed Petitioner to follow up with a chiropractor. (PX7)

Petitioner presented to Dr. Dennis McGuire, a chiropractor, on April 3, 2013, and related to Dr. McGuire of waking up on February 28, 2013, with lumbar spine pain. (PX6) Dr. McGuire recorded Petitioner's pain gradually worsened and came to involve Petitioner's left buttock and, occasionally, his left posterior thigh. (PX6) He described to Dr. McGuire the lifting, stacking and shelving activities he performs as part of his job. He further described how he lifted differently since his rotator cuff surgery and to experiencing increased pain with increased lifting. (PX6; T. p. 33) Petitioner's pain steadily decreased until late July 2013 when Petitioner's work activities increased after he lost an employee and began performing some of that employee's work activities in addition to his own. (PX6) Petitioner's pain subsequently increased to such a degree that Dr. McGuire considered Petitioner a surgical candidate. (PX6) Dr. McGuire recommended Petitioner see a neurosurgeon. (PX6)

Petitioner presented to Dr. David Kennedy, a neurosurgeon, on September 24, 2013, and Dr. Kennedy referred him to Dr. Feinberg, a pain management physician. (T. p. 48; PX8) He first

saw Dr. Feinberg on October 30, 2013, and informed Dr. Feinberg he worked as a district manager for Respondent and he has been experiencing back pain for nine months. (PX9)

Petitioner testified Dr. Feinberg imposed a 10-pound maximum lifting restriction on November 18, 2013. (T. p. 50) He testified further to being taken off work by Respondent on November 18, 2013, stating Respondent would not allow him to return to work until he was released to return to work full duty by his doctor. (T. p. 51) At Petitioner's insistence, Dr. Feinberg amended the lifting restriction on November 20, 2013, to allow Petitioner to lift up to 25 pounds. (T. p. 51)

Dr. Feinberg's treating records contain no record of any restrictions being imposed upon Petitioner's ability to work. (PX9) However, Petitioner's testimony is supported by an email sent to him by Susan Drury, a benefits administrator for Respondent, on November 20, 2013. In her email to Petitioner, Ms. Drury wrote the 25-pound lifting restriction would not allow him to do his job safely and instructed him to remain on leave status until he has been released to return to work full duty. (PX9)

The Commission adopts November 18, 2013, as the manifestation date of Petitioner's accidental injury. In so doing, the Commission recognizes Petitioner related his condition to his employment prior to November 18, 2013, but also recognizes Petitioner continued to perform his job duties until November 18, 2013. "A date based purely on discovery would penalize those employees who continue to work without significant medical complications when the eventual breakdown of the physical structure occurs beyond the statute of limitations period." *Zion-Benton Township High Sch. Dist. 126 v. Industrial Comm'n*, 242 Ill. App. 3d 109, 114, 609 N.E.2d 974, 979 (1993). Petitioner, in this case, exemplifies what is contemplated by the *Zion-Benton* court. Petitioner continued working until he experienced the "breakdown" of his lumbar spine condition requiring lifting restrictions that Respondent was unable to accommodate.

Notice

Section 6(c) of the Act provides notice of an injury shall be given to an employer as soon as practicable but no later than 45 days after the accident. 820 ILCS 305/§6(c) (2013). Section 6(c) also states that no defect or inaccuracy of such notice shall be a bar to the maintenance of the proceedings unless the employer can prove being unduly prejudiced by such a defect or inaccuracy. *Id.* Compliance with the notice requirement is achieved when the employer is given the facts related to the accident within the statutory period. *Seiber v. Industrial Comm'n*, 82 Ill. 2d 87, 95, 411 N.E.2d 249, 253 (1980). Notice that is defective or inaccurate shall not be a bar to the maintenance of proceedings unless the employer shows that it has been unduly prejudiced. 820 ILCS 305/§6(c)(2) (2013); *Silica Sand Transport v. Industrial Comm'n,* 197 Ill. App. 3d 640, 651, 554 N.E.2d 734, 742. (1994). A claim of accident will only be barred if no notice is given. *Silica Sand*, 197 Ill. App. 3d at 651, 554 N.E.2d at 742. The legislature has mandated a liberal construction on the issue of notice. *Atlantic & Pacific Tea Co. v. Industrial Comm'n,* 67 Ill. 2d. 137, 143, 364 N.E.2d 83, 86 (1977).

Respondent received notice of Petitioner's lumbar spine injury on November 21, 2013, in an email Petitioner sent to Susan Drury, a benefits administrator for Respondent. (PX12) In the

email, which was sent in response to an email Ms. Drury sent to Petitioner the previous day, Petitioner questioned Ms. Drury's recommendation that he take leave under the Family and Medical Leave Act and stated to Ms. Drury as to how the work-related injuries to his shoulder changed his lifting mechanics and resulted in his lumbar spine pain. (PX12) The evidence shows Petitioner provided notice to Ms. Drury on November 21, 2013, three days after the manifestation date. As such, Respondent received notice within the time frame required under the Act.

Wages

Computation of average weekly wage is based on the actual earnings of the employee excluding overtime and bonuses. 820 ILCS 305/§10 (2013). Bonuses are not considered when calculating average weekly wage even though they might constitute a considerable percentage of a worker's income. *Levkovitz v. Industrial Comm'n*, 256 Ill. App. 3d 1075, 1080, 628 N.E.2d 824, 828 (1993). Bonuses are extra benefits given by an employer to an employee. *Levkovitz*, 256 Ill. App. 3d at 1801, 628 N.E.2d at 828. A bonus is given to an employee by an employer without consideration. *Arcelor Mittal Steel v. Ill. Workers' Comp. Comm'n*, 2011 IL App (1st) 102180WC, 961 N.E.2d 807, 814 (2011). A distinction exists between incentive-based pay, consideration received for specific work performed as a matter of contractual right, and a bonus, compensation received for no consideration or in consideration of performance at the sole discretion of the employer. *Arcelor,* 2011 IL App (1st) 102180WC, 961 N.E.2d at 815.

Petitioner testified he was a union member and his compensation, except for reimbursement for his use of his personal vehicle in performing his work activities, was set by the collective bargaining agreement that was in effect on the day of the accident. (T. pp. 25-26) Petitioner provided a spreadsheet identifying what he claimed to be his gross income. (PX4) The gross income claimed by Petitioner included "incentive" pay and "rank payout." (PX4) Respondent challenges the inclusion of the "incentive" pay and the "rank payout" to determine Petitioner's wages under §10 of the Act, arguing the "incentive" pay and the "rank payout" are bonuses and, therefore, to be excluded in calculating Petitioner's average weekly wage.

Petitioner's wages and other compensation on the date of accident were subject to the then-current Chicago Area Salespersons and Downstate Illinois Salespersons Collective Bargaining Agreement ("CBA"). Article VII of the CBA addresses both salaries and additional compensation, including compensation paid through "ranking" and "incentive" pools. (PX5, pp. 11, 14-15) All eligible employees receive at least a minimum allotment from the "ranking" pool. (PX5, p. 15) Compensation from the "incentive" pool is distributed to those who meet the stated criteria. (PX5, p. 15) The compensation paid to Respondent's qualifying employees through the "ranking" and "incentive" pools is a contractual obligation imposed upon Respondent through the CBA. The Commission holds, consistent with *Arcelor*, the compensation Petitioner received through the "ranking" and "incentive" pools is part of Petitioner's actual earnings for the purposes of calculating Petitioner's average weekly wage under §10.

Petitioner documented his income for the year that immediately preceded the date of injury in a spreadsheet. (PX4) The spreadsheet divided Petitioner's income into columns indicating "Gross Income," "Earnings," "Incentive," "Rank Payout," "Car Allowance," and "Holiday Pay." (PX4) In calculating his average weekly wage under §10, Petitioner added together only his

"Earnings," "Incentive," "Rank Payout," and "Holiday Pay." (PX4) Respondent calculated Petitioner's average weekly wage by adding together only Petitioner's "Earnings" and "Holiday Pay." The Commission was unable to find "Holiday Pay" discussed in the controlling CBA but considers it to be income to be included in the calculation of average weekly wage under § 10 given the parties treated it as such. Consistent with the paragraph immediately above, the Commission adds Petitioner's "Earnings," "Incentive," "Rank Payout," and "Holiday Pay" to find Petitioner earned $90,655.30 in the year immediately preceding his injury. Dividing $90,655.30 by 52 allows the Commission to arrive at his average weekly wage. Doing so, the Commission finds Petitioner's average weekly wage to be $1,743.37.

Medical Expenses

Section 8(a) of the Act provides, in pertinent part:

> The employer shall provide and pay the negotiated rate, if applicable, or the lesser of the health care provider's actual charges or according to a fee schedule, subject to Section 8.2 in effect at the time the service was rendered for all the necessary first aid, medical and surgical services, and all necessary medical, surgical and hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury." 820 ILCS 305/8(a) (2013).

Respondent's sole dispute regarding medical expenses was as to Respondent's liability and Respondent has been found liable for the Petitioner's condition of ill-being. Therefore, the Commission finds that Respondent shall pay charges for reasonable and necessary medical services set forth in Petitioner's Exhibits 1, 6, 7, 8 and 9, as provided in Section 8(a) and Section 8.2 of the Act, per the fee schedule or the negotiated rate, whichever is less. (See *Perez v. Industrial Comm'n*, 2018 IL App (2d) 170086WC) The parties represented that all of the referenced bills were paid through Respondent's group health plan. As such, Respondent is entitled to credit pursuant to Section 8(j) of the Act for all expenses paid through the group provider. Respondent shall hold Petitioner harmless against any claim for reimbursement against Petitioner by the group carrier for medical bills paid. The Respondent shall pay Petitioner for out-of-pocket expenses as outlined in Petitioner's Exhibits 2 and 3.

Temporary Total Disability

A claimant seeking temporary total disability benefits is not necessarily precluded from such benefits even if the claimant is capable of performing light duty work. See *Freeman United Coal Mining Co. v. Industrial Comm'n*, 318 Ill. App. 3d 170, 179, 741 N.E.2d 1144, 1151 (2000); *Residential Carpentry, Inc. v. Workers' Compensation Comm'n*, 389 Ill. App. 3d 975, 982, 910 N.E.2d 109, 116 (2009). Dr. Feinberg, Petitioner's treating physician, placed restrictions upon Petitioner's ability to work but did not completely prevent him from working. Petitioner testified to being involuntarily taken off work by Respondent on November 18, 2013. (T. p. 52) No documentary evidence was entered into evidence corroborating this, but Petitioner's testimony

went unrebutted. Furthermore, Ms. Drury emailed Petitioner on November 20, 2013, and instructed him to "remain on leave status" until he was released to return to work full duty. (PX12) Ms. Drury's email had the effect of rendering Petitioner temporarily totally disabled.

Petitioner remained off work secondary to his November 18, 2013, accident until Dr. Kennedy released him to return to work full duty effective April 28, 2014. (T. p. 53; PX9) Accordingly, Petitioner is found to have been temporarily totally disabled from November 19, 2013, through April 28, 2014.

Partial Permanent Disability

According to Section 8.1b(b) of the Act, for injuries that occur after September 1, 2011, in determining the level of permanent partial disability, the Commission shall base its determination on the following factors:

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

Applying the factors enumerated in Section 8.1b(b) to the instant case, the Commission finds as follows:

(i) Dr. David Fletcher from SafeWorks Illinois examined Petitioner on June 2, 2014, for the purpose of preparing an AMA impairment rating and concluded Petitioner demonstrated a whole person impairment rating of 15%. (RX8) The Commission considers the AMA impairment rating and assigns some weight to this factor in assessing Petitioner's permanent partial disability.

(ii) Petitioner is a District Manager for Respondent, the same position with the same responsibilities he had prior to his accident. (T. pp. 15, 71) Moderate weight is given to this factor as his return to his pre-accident position mitigates the impact of his injury to his ability to perform his job duties.

(iii) Petitioner was 50 years old on the day of his accident. Significant weight is placed on this factor as he will likely work with a permanent partial disability for another 10 plus years with the aftereffects of his November 18, 2013, accident.

(iv) Petitioner's testimony on December 16, 2016, that he earned more as of that date than he did at the time of his accident is notable. (T. p. 80) This indication that he suffered no diminished earning capacity as a result of his accident is given some weight in assessing the impact of Petitioner's permanent partial disability on his earning potential.

(v) Petitioner worked full duty and without restrictions for more than 1½ years after being released from treatment by Dr. David Kennedy on February 16, 2016. During that time, Petitioner was treated with physical therapy, pain medication and anti-inflammatory medication. (PX8) Petitioner, at the time of his discharge from Dr. Kennedy's care on February 16, 2016, had diagnoses of ongoing pain and a clinically stable lumbar spine. (PX8) Dr. Kennedy was uncertain as to whether Petitioner's lumbar spine at L5-S1 had fully fused. (PX8) Dr. Kennedy left open the possible need for further surgery should Petitioner's condition worsen. (PX8) Petitioner testified no further treatment is scheduled with Dr. Kennedy. (T. p. 62) Petitioner testified he continues to take pain medication prescribed to him by Dr. Dennon Davis. (T. pp. 65-66) Petitioner presented no medical records evidencing that he was seen by Dr. Davis since being discharged from Dr. Kennedy's care. He did provide copies of pharmacy records that show Dr. Davis regularly prescribed Petitioner medications through the date of the arbitration hearing. (PX2) Significant weight is given this factor as no objective disability is corroborated in the treating medical records.

Petitioner sustained an injury to his lumbar spine as a result of his increased workload for Respondent and was unable to return to his job duties as November 18, 2013. After conservative treatment failed to alleviate his pain, he underwent a two-level fusion on March 17, 2014, and was returned to his regular work activities on April 24, 2014, and has worked continuously since that time. His post-operative medical treatment consisted of regular visits to Dr. Kennedy and Dr. Davis, physical therapy, a bone growth stimulator, pain medications and muscle relaxants. Dr. Kennedy discharged Petitioner from his care on February 16, 2016, and there is no record of Petitioner seeing any other physician thereafter. He continued, after February 16, 2016, to obtain prescriptions for pain medication from Dr. Davis but did not provide any record that those prescriptions were in conjunction with any visit to Dr. Davis. He claimed his injuries prevented him from riding his four-wheeler and playing softball but later admitted that he sold his four-wheeler prior to his November 18, 2013, accident date and was unable to play softball due to his shoulder injury. Petitioner's obtaining pain medication without subjecting himself to a physical examination and his debunked claims that his November 18, 2013, accident precluded him from engaging in certain activities calls into question the extent to which Petitioner remains impaired as a result of his November 18, 2013, accident. Based on the foregoing, the Commission finds Petitioner sustained permanent partial disability in the amount of 25% loss of the person as a whole as a result of the work-related accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,162.30 per week for a period of 40-3/7 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 $1,046.02 per week for a period of 125 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 25% loss of the person as a whole.

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IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay for medical expenses outlined in Petitioner's Exhibits 1, 6, 7, 8 and 9, provided in §8(a) and §8.2 of the Act, per the fee schedule or the negotiated rate, whichever is less, for medical services provided to Petitioner's lumbar spine, and further Respondent shall reimburse Petitioner's out-of-pocket expenses as outlined in Petitioner's Exhibits 2 and 3.

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. Respondent shall hold Petitioner harmless against any claim for reimbursement against Petitioner by the group carrier for medical bills paid for services related to Petitioner's lumbar spine.

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 2020
KAD/mav
O: 01/21/2020
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Kathryn A. Doerries

Maria E. Portela

Marc Parker

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BLAKE DEATON,

Petitioner,

vs. NO: 18 WC 37593

SOUTHEAST PERSONNEL LEASING, INC.,

Respondent.

20IWCC0198

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability and 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 Comm'n*, 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 24, 2019 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 the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

20IWCC0198

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

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

DATED: MAR 23 2020
KAD/bsd
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Marc Parker

Maria E. Portela

DISSENT

I respectfully disagree with the majority and would reverse the Conclusions of Law in the Arbitrator's Decision regarding his finding that "there was not a refusal by Petitioner to provide a urine sample." (Arb. Dec. p. 4)

Section 11 of the Illinois Workers' Compensation Act ("Act") provides, in pertinent part, the following:

> No compensation shall be payable if
> (i) the employee's intoxication is the proximate cause of the employee's accidental injury or
> (ii) at the time the employee incurred the accidental injury, the employee was so intoxicated that the intoxication constituted a departure from the employment.
>
> Admissible evidence of the concentration of
> (1) alcohol,
> (2) cannabis as defined in the Cannabis Control Act,
> (3) a controlled substance listed in the Illinois Controlled Substances Act, or
> (4) an intoxicating compound listed in the Use of Intoxicating Compounds Act in the employee's blood, breath, or urine at the time the employee incurred the accidental injury shall be considered in any hearing under this Act to determine whether the employee was intoxicated at the time the employee incurred the accidental injuries.
> If at the time of the accidental injuries, there was 0.08% or more by weight of alcohol in the employee's blood, breath, or urine or if there is any evidence of impairment due to the unlawful or unauthorized use of

(1) cannabis as defined in the Cannabis Control Act,
(2) a controlled substance listed in the Illinois Controlled Substances Act, or
(3) an intoxicating compound listed in the Use of Intoxicating Compounds Act or if the employee refuses to submit to testing of blood, breath, or urine, then there shall be a rebuttable presumption that the employee was intoxicated and that the intoxication was the proximate cause of the employee's injury.
The employee may overcome the rebuttable presumption by the preponderance of the admissible evidence that the intoxication was not the sole proximate cause or proximate cause of the accidental injuries.... *820 ILCS 305/11* (2018).

Petitioner testified not only that he smoked marijuana recreationally, but that he had smoked alone, two days before the accident, in his house after work. (T, pp. 36, 65) Petitioner further testified that he was not aware as to the strength or the tetrahydrocannabinol (THC) level of that marijuana that he smoked that day. (T, p. 67) He provided this as an explanation for the THC findings in his urine test taken at the hospital. (T, p. 36) This test result, obtained from Petitioner at Deaconess Hospital, revealed a positive finding of THC over 50 ng/ml which was disregarded by the majority despite the fact that the Petitioner conceded that the test was positive and he knew the reason. After the hospital advised Petitioner that he tested positive, he testified that he admitted that he had smoked marijuana and "it's obvious that it was in my system. It doesn't just get planted there." (T, pp. 79-80) The act of recreationally smoking marijuana at that time was against the law at the time of the accident. (See history of the Cannabis Control Act, *720 ILCS 550*)

Further, the Arbitrator ruled it was not relevant where the Petitioner obtained the marijuana. (T, pp. 65-66) I also disagree with that ruling; it is reasonable to infer that at the time it was purchased illegally and that fact is also relevant to Petitioner's credibility.

Petitioner had also signed a pre-employment agreement to keep the workplace drug free and as a condition of his employment, where reasonable suspicion of drugs and/or alcohol use exist, Respondent would require that he undergo substance screening by urinalysis for drugs. In part, that document stated specifically, "I also agree to comply with any drug/alcohol testing which SPLI has or may adopt." (T, pp. 54-56, RX2) Further, the Petitioner testified that page one, paragraph three of that document that he signed, reads in part, "I specifically agree to post-accident drug/alcohol testing after a work injury regardless of whether I am able to give consent at that time." (T, p. 57) Further, that same paragraph reads, in pertinent part, "This document is my authority to post-accident drug/alcohol testing in all instances." (T, p. 58)

Petitioner's smoking marijuana was illegal and shows that Petitioner was willing to ignore the law at the time, and further, of violating his employer's workplace policy despite having voluntarily signed a pre-employment agreement representing that he would abide by the safety rules. The action of smoking marijuana recreationally violated both the public and his workplace policies in place at the time and thus tarnish Petitioner's credibility.

The majority, however, ignores these failings. The majority adopts the position that there was not a refusal by Petitioner to provide a urine sample based on Petitioner's testimony and the

fact that Petitioner did not waive any of the provisions of Sections 9140.40 and 9140.50 of the Rules Governing the Procedures at the Workers' Compensation Commission ("Rules").

Section 11 of the Act states collection and testing must be performed in accordance with rules to be adopted by the Commission. However, the provisions in the Rules governing the "various procedures for review of test results of urine samples, verification of positive results, split specimen testing within 72 hours after one is notified of a positive result" (Arb. Dec. p. 4) were never triggered because Petitioner refused to give a urine sample to the Respondent's representative from Medic On-site, Mary Sacks ("Sacks).

Petitioner testified when Sacks came to his hospital after he had surgery, he "told her no but she could come back at a later time if needed whenever I had to pee and I would pee for her, but after she bombarded into the room,...we, you know, asked her to leave because it was so short after me getting back and I had just peed so I wasn't going to be able to give that to her at that moment in time." (T, p. 40)

It is clear, however, Petitioner did not relay to Sacks that she could have the urine sample, thus, he refused to provide or submit to the urine screen. Sacks testified that she has a certification for drug testing, for hair tests, urines, tests, and for the Department of Transportation. She collects bodily fluid samples for the purpose of drug testing and has been doing so for four years. (T, pp. 123-124) Sacks further testified that the procedure for doing so is that "You tell them what they're there for, what kind of sample you need to take and take the sample, seal it shut, send it off to a lab and have it tested so that we can get the results sent to the company." She has done it thousands of times. (T, p. 125)

Sacks testified that she received a faxed assignment with an order to do a drug screen of Petitioner at Room 4502 at Deaconess Trauma Center on November 30, 2018. (T, p. 126) Sacks also received a copy of the document for Acknowledgment of Safe Work Practices and Drug Testing executed by Petition on June 12, 2017. (T, p. 127)

Sacks arrived at the hospital, room 4502 at approximately 4:30 p.m. to get a sample from Petitioner. Petitioner was there with his brother. Sacks spoke with both. She identified herself, telling them that she was from Medic On-site, and she was there to get a urine sample for a drug screen for his company. (T, pp. 128-130) Sacks testified she needed the sample because it was in her work order, it was part of her job, and it would be important to take at that time, on that day, to get the levels "that's in their system." Finally, Sacks testified it would be important to take it at that time because that's as close to possible to the incident that occurred. (T, p. 132)

Petitioner told her it "wasn't going to happen" and then Petitioner's brother said "no" "it's not happening today." (T, p. 130) Sacks was asked to leave. Neither Petitioner nor his brother offered to give her a sample at a later time. (T, p. pp. 130-131)

Sacks created a contemporaneous handwritten document that she signed at 5:30 p.m on the same date, November 30, 2018. (T, p. 134) The last sentence confirmed Petitioner told her "to get out and not come back." (RX4) Sacks also testified that she tried to speak with Petitioner's sister-in-law and Sacks was told that she "was rude" and she was told "she needed to leave." The

Petitioner's sister-in-law demanded Sacks' boss's (telephone) number and Sacks complied. (T, p. 131)

Given the totality of the relevant evidence, it is obvious that the Petitioner unequivocally refused to give the urine sample or cooperate, despite his pre-employment consent. Petitioner testified that "nobody gave her an okay to come in the room, she just barged in." (T, p. 78) Petitioner also testified "I told her that moment in time it wasn't possible because I had just peed. If she would have stuck around and waited she probably would have got one, ...but she left and never came back." (T, p. 78) It is clear that the object of getting the urine sample as soon as possible was to take the test as close to the accident as possible. Petitioner's testimony that he would have provided it does not comport with his hostile descriptions of Sacks "bombarding his room" and "barging into his room" and Sacks confirmed he told her to leave. Petitioner's testimony is also unreliable given that it is undisputed he broke the then-existing law and ignored, if not defied, his pre-employment agreement to keep a safe workplace by keeping the work environment drug free, and then further refused to cooperate by giving a urine sample despite his pre-employment agreement to do so. Further, his aggressive description of Mary Sacks "barging in" lends additional credibility to Sacks' testimony, not Petitioner's. Sacks was doing her job and reported the events with objectivity and without bias.

The fact that Petitioner refused to give a urine sample, to allow Mary Sacks to do her job so she could be sure the sample collection procedure could comply with the Rules governing collection and reliability of the sample, creates a rebuttable presumption that Petitioner was intoxicated and that the intoxication was the proximate cause of his injury per the strictures of Section 11 of the Act.

Although the reversal of the Conclusion regarding the Petitioner's refusal would not be outcome determinative, I would also give little weight to the testimony of Petitioner's only two work witnesses, who were Petitioner's lifelong friends. (T, pp. 50, 94) Michael Rane was plant manager. (T, p. 83) Michael Rane described his relationship with Petitioner as "good friends." Scott and Michael Rane are cousins, and knew each other for their whole lives. Michael Rane testified that he and his cousin Scott were also close friends. (T, p. 95)

Petitioner testified that he first smoked marijuana in high school. (T, p. 61) Petitioner admitted that it was possible that Scott Rane smoked marijuana in his presence, and that it was possible that he smoked marijuana in the presence of Scott Rane. (T, p. 52) Petitioner testified it was possible he smoked marijuana at work, or not at work, with Scott Rane. (T, p. 53) By contrast, Scott Rane testified that he and Petitioner were good friends but denied that he had ever smoked marijuana in the presence of Petitioner. (T, p. 116)

Petitioner testified it was possible but not to his knowledge, had he ever smoked marijuana in the presence of Michael Rane and that it was possible, but not to his knowledge, that Michael Rane smoked in his presence. (T, pp. 53, 54) Michael Rane testified that during the time that he worked with Petitioner, that the Petitioner "absolutely" never smoked marijuana in his presence. (T, pp. 96-97) Michael Rane first became aware that Petitioner smoked marijuana years ago. (T, p. 97) The Rane cousins also testified as lay persons and conceded they had no certifications or

education in determining the level for which a person might be intoxicated with either drugs or alcohol. (T, pp. 93, 115)

Thus, at minimum, I would reverse the Arbitrator's ruling regarding the relevance of where Petitioner had obtained his marijuana, and I would reverse the Arbitrator's Conclusion that Petitioner did not refuse to provide the requisite urine sample he had agreed to in his pre-employment contract, (RX2) that was a condition of his employment. This finding would thus create a rebuttable presumption that Petitioner was intoxicated and that the intoxication was the proximate cause of his injury as outlined in Section 11 of the Act.

Kathryn A. Doerries

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

DEATON, BLAKE
Employee/Petitioner

Case# **18WC037593**

SOUTHEAST PERSONNEL LEASING INC
Employer/Respondent

20IWCC0198

On 7/24/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0693 FEIRICH MAGER GREEN RYAN
R JAMES GIACONE II
2001 W MAIN ST SUITE 101
CARBONDALE, IL 62903

5074 QUINTAIROS PRIETO WOOD & BOYER
LEO R PLUCINSKY
233 S WACKER DR 70TH FL
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STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Blake Deaton
Employee/Petitioner

v.

SouthEast Personnel Leasing, Inc.
Employer/Respondent

Case # 18 WC 37593

Consolidated cases: n/a

20IWCC0198

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on May 30, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, November 29, 2018, Respondent was operating under and subject 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 $37,304.28; the average weekly wage was $717.39.

On the date of accident, Petitioner was 25 years of age, single with 0 dependent child(ren).

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibits 4 and 5, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner temporary total disability benefits of $478.26 per week for 26 weeks commencing November 30, 2018, through May 30, 2019, as provided in Section 8(b) of the Act.

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

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

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

William R. Gallagher

William R. Gallagher, Arbitrator
ICArbDec19(b)

July 23, 2019
Date

JUL 24 2019

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 on November 29, 2018. The Application named two Respondents, Earth Services and SouthEast Personnel Leasing, Inc. At trial, counsel for Petitioner and Respondent, SouthEast Personnel Leasing, Inc., stipulated that Earth Services was not Petitioner's employer at the time of the accident, and SouthEast Personnel Leasing, Inc., was Petitioner's employer at the time of the accident. An oral motion was made to remove Earth Services as a Respondent which was granted by the Arbitrator. Earth Services was redacted from both the Application and Request for Hearing (Arbitrator's Exhibits 1 and 2).

The Application alleged Petitioner sustained an injury to his left arm when it got caught in a conveyor belt (Arbitrator's Exhibit 2). Respondent disputed Petitioner sustained an accidental injury arising out of and in the course of his employment by Respondent on the basis Petitioner was intoxicated at the time of the accident. The case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and temporary total disability benefits (Arbitrator's Exhibit 1).

Petitioner worked for Respondent had a tire shredding plant. Shredded pieces of tires were moved on a conveyor belt propelled by wheels. There were occasions in which the conveyor belt would move to one side of one of the wheels and have to be adjusted. Petitioner testified that on November 29, 2018, the belt moved to one side because a piece of tire got caught in a wheel. Petitioner initially attempted to remove the piece of tire with a broom handle as well as a crow bar, but without success. Petitioner then proceeded to reach into the machine with his left hand which was pulled into the machine.

Petitioner stated a coworker hit the emergency shut off which caused the wheel and conveyor belt to stop. The accident caused an extremely serious injury and Petitioner testified his left hand was barely attached to his arm and was on the ground. Petitioner also sustained a degloving injury to his left lower arm.

Because of the serious nature of Petitioner's injury, he was airlifted to Deaconess Hospital in Evansville, Indiana. While being airlifted, Petitioner received a significant amount of fentanyl which he understood to be the maximum amount permitted.

A drug test was administered at the hospital which was positive for both opiates and THC (marijuana). The report of the drug screening test noted "All positives are presumptive (unconfirmed). False positives and negatives can occur. Use for medical purposes only." (Respondent's Exhibit 5).

Given the fact Petitioner had received a large dose of Fentanyl while being transported to the hospital, the positive result of the tests for opiates was anticipated and Respondent did not raise an issue regarding same. However, because Petitioner tested positive for marijuana, Respondent took the position Petitioner was intoxicated and the accident of November 29, 2018, did not occur in circumstances arising out of and in the course of Petitioner's employment by Respondent.

At trial, Petitioner testified he smoked marijuana at home on the evening of November 27, 2018. Petitioner stated the effects of the marijuana had worn off by the following day, November 28, 2018. Petitioner also stated he did not feel any effect on the day of the accident. Further, Petitioner testified he did not smoke any marijuana on the day of the accident.

On cross-examination, Petitioner testified he only smoked marijuana occasionally, perhaps every couple of weeks or so. Petitioner stated he never smoked marijuana any place other than his residence. Petitioner stated that on the evening of November 27, 2018, he smoked marijuana for just a few minutes. He admitted to having no knowledge as to the strength, type of marijuana, etc. Petitioner again stated he never smoked marijuana while at work.

Respondent tendered into evidence a form called "Applicant Acknowledgment" which Petitioner signed on June 12, 2017. This form contained the following: "I specifically agree to post-accident drug/alcohol testing after every work injury regardless of whether I am able to give consent at that time. This document is my authority to post-accident drug/alcohol testing in all instances." The form also contained the statement that an employee who is under the influence of alcohol or illegal drugs on the jobsite may be terminated (Respondent's Exhibit 2).

Mike Rane testified for Petitioner at trial. Mike Rane was the plant manager and his testimony regarding the circumstances of the accident was consistent with the testimony of Petitioner. Mike Rane stated that he did not observe anything unusual about Petitioner on the day of the accident or that Petitioner behaved in a manner that would indicate he was high. Specifically, Mike Rane stated Petitioner was not stumbling, slurring words or behaving irrationally. Up until the accident, Petitioner performed his job duties, was able to follow directions and complete his job assignments.

On cross-examination, Mike Rane acknowledged he considered Petitioner to be a good friend and had known him for 20 to 25 years. Mike Rane testified he never smoked marijuana with Petitioner and he never saw Petitioner smoking marijuana. It was his understanding Petitioner smoked marijuana on occasion, usually on weekends. Mike Rane agreed he did not have any special training, certifications or education in drug testing or drug abuse.

Scott Rane (Mike Rane's cousin) testified for Petitioner at trial. Scott Rane worked for Respondent and was present when Petitioner sustained the accident. Scott Rane testified he was friends with Petitioner and he "hung out" with him on occasion. He was not aware of the fact Petitioner had smoked marijuana some time prior to the accident. Scott Rane did not observe anything unusual about Petitioner on the day of the accident. He stated Petitioner was not stumbling, slurring his words or behaving irrational. Scott Rane said Petitioner was capable of performing his job duties up until the time he sustained the accident. Scott Rane does not have any special training, certifications or education in drug testing or drug abuse.

On cross-examination, Scott Rane agreed he was social friends with Petitioner. He also stated he never smoked marijuana with Petitioner.

When Petitioner was cross-examined by Respondent's counsel, he testified that while he was hospitalized, an unidentified female entered his room and advised she wanted to obtain a urine sample. Petitioner stated he had just returned from surgery and had just "peed." For that reason, Petitioner informed the unidentified female he was unable to provide a urine sample.

Mary Sacks testified for Respondent at trial. Sacks was hired by Respondent to obtain a urine sample from Petitioner when he was hospitalized. She was the person Petitioner informed he was not able to provide a urine sample. Sacks stated she entered Petitioner's hospital room on November 30, 2018, at approximately 4:30 PM. Sacks said she spoke to Petitioner and his brother informing both of them why she was there. She said Petitioner's brother told her no and she was asked to leave the room. Sacks said that neither Petitioner nor his brother offered to provide a urine sample at later time. Petitioner's sister-in-law then informed her she could come back another day and obtain a urine sample, but Sacks declined to do so because she was directed to get the sample on that same day. Respondent tendered into evidence a chain of custody form completed by Sacks which noted Petitioner had "Refused" to provide a urine sample (Respondent's Exhibit 3).

On cross-examination, Sacks agreed the directive she had received from Respondent was that the sample was to be obtained as soon as possible. However, she also agreed the specific date of November 30, 2018, was not indicated.

Petitioner has received extensive medical treatment and has undergone several surgeries on his left hand/arm. Petitioner's primary treating physicians were Dr. Isaac Fehrenbacher, Dr. Matthew Drake and Dr. Aaron Mull, orthopedic surgeons. The most recent surgery was performed on March 8, 2019. As of April 8, 2019, Dr. Mull opined further surgery was likely, specifically, a tendon transfer procedure, but no specific timeframe was indicated. He recommended Petitioner continue with home exercises (Petitioner's Exhibit 2).

At trial, Petitioner's left arm was in a sling and his left hand was bandaged. Petitioner has minimal use of his left hand at this time. Petitioner has not returned to work since the day of the accident. Petitioner testified he asked Respondent about doing one-handed work, but Respondent does not have any such work available.

Conclusions of Law

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

The Arbitrator concludes Petitioner sustained an accidental injury arising out of and in the course of his employment by Respondent on November 29, 2018.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner sustained an accident which caused a serious injury to his left hand/arm on November 29, 2018. Respondent disputes accident arose out of and in the course of Petitioner's employment by Respondent because of Petitioner's alleged intoxication.

Petitioner consented to have a urine sample obtained subsequent to the accident because consent following a work-related accident was specifically provided for in the "Applicant Acknowledgment" Petitioner signed on June 12, 2017.

While the urine test was positive for marijuana, the lab report noted a positive result was presumptive (unconfirmed).

Sections 9140.40 and 9140.50 of the Rules Governing Practice Before the Illinois Workers' Compensation Commission require various procedures for review of test results of urine samples, verification of positive results, split specimen testing within 72 hours after one is notified of a positive result, etc.

As aforestated, the Petitioner consented to his providing a urine sample; however, Petitioner did not waive any of the provisions of Sections 9140.40 and 9140.50. Accordingly, the Arbitrator finds the positive test results for the presence of marijuana must be disregarded.

When Mary Sacks informed Petitioner he needed to provide a urine sample, Petitioner had just returned to his hospital room following surgery and had just urinated. Petitioner testified he did not "refuse" to provide a urine sample, but was unable to provide one at that time. While Sacks testified neither Petitioner nor his brother offered to provide a urine sample at a later time, Sacks did state Petitioner's sister-in-law suggested she obtain a sample at a later time.

Sacks insisted the direction she received was to obtain the urine sample on November 30, 2018, but, when cross examined, she acknowledged the directive was to obtain the sample as soon as possible.

Based upon the preceding, the Arbitrator finds there was not a refusal by Petitioner to provide a urine sample.

Even if Petitioner had, in fact, refused provide a urine sample, Section 11 of the Act provides that in the event of a refusal of an employee to provide a sample, "...there shall be a rebuttable presumption that the employee was intoxicated."

The Arbitrator finds that even if Petitioner had refused to provide a urine sample, the testimony of Mike Rane and Scott Rane would rebut the presumption Petitioner was intoxicated. Both Mike Rane and Scott Rane credibly testified that on the day of the accident Petitioner was not stumbling, slurring his words or behaving irrationally. Further, both testified Petitioner was capable of performing his job duties up until the time he sustained the accident. The Arbitrator acknowledges that Mike Rane and Scott Rane testified as laypeople, not experts; however, their testimony as to their observations of Petitioner was credible.

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

Based upon the Arbitrator's conclusion of law in disputed issue (C) the Arbitrator concludes Petitioner's current condition of ill-being is causally related to the accident of November 29, 2018.

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibits 4 and 5, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In support of this conclusion the Arbitrator notes the following:

There was no dispute the medical services provided to Petitioner were reasonable and necessary.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 26 weeks, commencing November 30, 2018, through May 30, 2019.

In support of this conclusion the Arbitrator notes the following:

Petitioner sustained a serious injury to his left arm/hand and is presently limited to perform only one handed work.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TRACEY WILLIAMS,

Petitioner,

vs. NO: 10 WC 28918

JP MORGAN CHASE,

Respondent.

20IWCC0199

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, notice, causal connection, medical benefits, temporary total disability (TTD) benefits, permanent partial disability (PPD) benefits, penalties and attorney's fees, statute of limitations, and evidentiary rulings, 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 Order section of the Arbitrator's Decision on Page 2. The Commission finds that Petitioner is entitled to TTD from September 9, 2009 through September 26, 2011, and from November 9, 2011 through January 30, 2012. The Commission accordingly amends the number of weeks covering the TTD time period from 121 5/7 weeks to 118 5/7 weeks. Petitioner's treating physician, Dr. Roderick Birnie, determined that Petitioner had reached maximum medical improvement (MMI) on January 30, 2012; this was the last date Petitioner treated for her bilateral carpal tunnel syndrome. Dr. Birnie discharged Petitioner on a return as-needed basis on January 30, 2012. Petitioner was not entitled to TTD benefits after January 30, 2012. The Commission therefore strikes the following language from Page 2 of the Arbitrator's Decision: "Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 9/9/09 through 2/26/19. . ."

20IWCC0199

The Commission affirms the Arbitrator's award of credit to Respondent in the amount of $18,131.80 for short term disability benefits previously paid to Petitioner in lieu of TTD.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed May 16, 2019, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services of $14,571.35, and as identified in Petitioner's Exhibit 4, pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits of $356.00 per week for 118 5/7 weeks, commencing September 9, 2009 through September 26, 2011, and from November 9, 2011 through January 30, 2012, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $18,131.80 for short term disability benefits previously paid to Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $320.40 per week for a period of 61.5 weeks, as provided in Section 8(e)9 of the Act, for the reason that the injuries sustained caused fifteen percent (15%) loss of use of the right hand and fifteen percent (15%) loss of use of the left hand, for a total sum of $19,704.60.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for penalties and attorney's fees is denied.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $58,500.00. 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 the Circuit Court.

D. Douglas McCarthy

DATED: MAR 24 2020

DDM/pm
O: 2-5-20
052

Stephen J. Mathis

DISSENT

I respectfully dissent. As the Court noted in *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill. 2d 524, 530, 505 N.E.2d 1026 (1987), "an employee who alleges injury based on repetitive trauma must still meet the same standard of proof as other claimants alleging an accidental injury. There must be a showing that the injury is work related and not the result of a normal degenerative aging process." "There is no requirement that a certain percentage of time be spent on a task in order for the duties to meet the legal definition of 'repetitive.'" *Edward Hines Precision Components v. Industrial Commission*, 356 Ill. App. 3d 186, 192, 825 N.E.2d 773 (2005). Instead, the Commission may review the manner and method of a claimant's job to determine if such duties are sufficiently repetitive to establish a compensable accident under a repetitive trauma theory of recovery. See *Williams v. Industrial Commission*, 244 Ill. App. 3d 204, 211, 614 N.E.2d 177 (1993), citing *Perkins Product Co. v. Industrial Commission*, 379 Ill. 115, 120 (1942) ("the claimant's injury 'was directly connected with the manner and method in which she was required to do her work, and to use her arm in the discharge of her duties'").

Petitioner failed to prove a causal relationship between her work duties and her conditions of ill-being (carpal tunnel syndrome and ulnar impaction syndrome). Both Dr. Coe, Petitioner's expert, and Dr. Atluri, Respondent's expert agree that Petitioner's job duties were repetitive. As such, the question presented is whether the duties were *sufficiently* repetitive in nature, occurrence, and force to *cause* her resulting conditions of ill-being. See *Williams v. Industrial Commission*, 244 Ill. App. 3d 204 (1993). The majority in answering this question in the affirmative relies on the opinions of Dr. Coe, but such reliance is misplaced. Dr. Coe testified as to causation and the basis of his opinion as follows:

> So based on everything that I learned in this case, and just one more time for you, it's the history that she gave to me with her description of what she did, how she did it, what she felt and experienced, the treatment medical records, as well as Miss Williams' report that she did improve after the carpal tunnel release surgeries, though she had continued to experience some residuals after the surgery, and then my clinical examination of Miss Williams at the end of May of 2017, five-and-a-half or so years after the surgery. PX1, p. 29-30.

This is merely an assertion without the necessary explanation.

Throughout his testimony, Dr. Coe acknowledges he possessed no information regarding Petitioner's job duties other than the description provided to him by Petitioner. Dr. Atluri also based his opinion, in part, on the description provided to him by Petitioner. The majority seemingly acknowledges both physicians possessed the same understanding of Petitioner's job duties but yet finds "the record reflects he [Dr. Atluri] had no clear understanding of Petitioner's actual work duties[,] therefore[,] his opinions lacked a solid foundation, although it must be added Petitioner's examining expert[,] Dr. Coe also did not have a solid understanding of Petitioner's job duties as well." *Arbitration Decision,* p.11- affirmed and adopted by the majority. Despite conceding Dr. Coe's understanding of Petitioner's job duties was no more robust than that of Dr.

20IWCC0199

Atluri, the majority disregards Dr. Atluri's opinion *in toto* and adopts Dr. Coe's without further explanation.

Unlike Dr. Coe's mere assertion, Dr. Atluri provides an explanation as to how he arrived at his causation opinion. Dr. Atluri explains as follows:

> My understanding of her work activities is that there was a significant exposure to repetition. However, she didn't meet the threshold for the other aspects of exposure. She didn't have to do the type of frequent forceful activity. She didn't have the impact or heavy forceful use with awkward position of the hands and wrists. That's why I felt they were not work related. RX1, P. 22-23.

The majority not only relies on Dr. Coe's faulty causation opinion but also an objectionable hearsay opinion offered by Dr. Cohen. Dr. Cohen offered an opinion as to causation in his January 22, 2010 "To Whom It May Concern" correspondence. PX3. Respondent timely objected stating, "The records are going in. I'm objecting to the narrative opinion contained in those records though." T. 35. The arbitrator overruled the objection finding the records certified pursuant to Section 16 of the Act which the majority adopts. Such finding is faulty as the purpose of Section 16 of the Act is to ease the foundational requirements for the admission of medical records not to shield objectionable hearsay testimony. Respondent's objection should have been sustained and the narrative opinion as to causation offered by Dr. Cohen stricken.

For the above stated reasons, I respectfully dissent. I find Petitioner failed to prove her conditions of ill-being were caused or aggravated by her job duties.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS, TRACEY
Employee/Petitioner

Case# **10WC028918**

JP MORGAN CHASE
Employer/Respondent

20IWCC0199

On 5/16/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.35% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5122 PORRO NIERMANN LAW GROUP LLC
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6205 HEYL ROYSTER VOELKER & ALLEN
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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

TRACEY WILLIAMS,
Employee/Petitioner

v.

JP MORGAN CHASE,
Employer/Respondent

Case # 10 WC 28918

Consolidated cases: _____

20IWCC0199

An *Application for Adjustment 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 M. Harris, Arbitrator of the Commission, in the city of **Chicago**, on February 26, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of 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. X☐ Other **Statute of Limitations Section 6(d)**

FINDINGS

On **11/5/09**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner timely filed her Application for Adjustment of Claim within the statute of limitations.

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

In the year preceding the injury, Petitioner earned $ 27,768.00; the average weekly wage was $534.00.

On the date of accident, Petitioner was **46** years of age, ***married*** with 2 dependent children.

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

ORDER

Petitioner has proven by a preponderance of the credible evidence that her current condition of ill-being relating to her bilateral hands/wrists is causally related to the accidental injuries sustained with a manifestation date of November 5, 2009.

Respondent shall pay reasonable and necessary medical services of $14,571.35 for the services identified in PX4, as provided in Section 8(a) and the Commission Fee schedule of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $356.00/week for a period of 121-5/7 weeks, commencing 9/9/09 to 9/26/11 and 11/9/11 to 1/31/12, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 9/9/09 through 2/26/19, and shall pay the remainder of the award, if any, in weekly payments. Respondent shall be given credit for $18,131.80 for short term disability benefits paid under Section 8(j) of the Act.

Petitioner sustained permanent partial disability to the extent of 15% loss of use of use of the right hand and 15% loss of use of the left hand pursuant to §8(e)(9) of the Act, being a total of 61.5 weeks of compensation at a weekly PPD rate of $320.40. Respondent shall accordingly pay Petitioner additional compensation for permanent partial disability sustained for 61.5 weeks at a weekly PPD rate of $320.40, being the total sum of $19,704.60.

Petitioner has not proven Respondent is liable for payment of any fees or penalties under the Act. Petitioner's request for penalties and fees is accordingly 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.

Robert M. Harris

Signature of Arbitrator Robert M. Harris

May 16, 2019
Date

MAY 16 2019

MEMORANDUM OF DECISION OF ARBITRATOR
STATEMENT OF FACTS

Tracey Williams ("Petitioner") worked for Respondent as a mail extractor from 2002 through September of 2009. (T.18-19) Postal totes would arrive at her workstation full of envelopes from customers. (T.19-20) Each tote contained between 800 and 900 envelopes and Petitioner processed 2 ½ totes per shift. (T.21) Each envelope contained checks and correspondence from customers. (T.20) To perform the work, she grabbed up to 25 envelopes with her right hand, she bent her wrist to position the top of the envelopes to allow her to sweep a letter opener in her left hand through each envelope. (T.21-23) The envelopes were about 8 inches long and she swept the opener along the length of each envelope to open the tops. (T.24-25) She performed the opening quickly, describing the motion as flicking both hands to complete the task for each envelope. (T.25) She also keyed information about accounts into the computer system, used a variety of binder clips to secure paperwork and rolled batches of papers up which she secured with big rubber bands for storage. (T.65-68) She worked 40 hours weeks 50 weeks per year. (T.25-26) Petitioner estimated that she opened up to 8,000 envelopes per week, 400,000 per year and between 1,600,000 to 2,000,000 envelopes during her work with respondent. (T.26-27) She gradually developed pain in her wrists and saw a physician in 2006 who gave her splints to wear at night. (T.27-28) The splints improved her symptoms but she had the splints for less than a year and she could not use the splints for work. (T.28-29) There was no way to modify the job to accommodate the splints. (T.29) The workload actually increased over the next three years. (T.29-30)

On September 9, 2009 Petitioner started treating with Dr. Stein at the University of Chicago. (T.30) She complained most about left forearm pain at this first visit, but she also reported symptoms consistent with carpal tunnel syndrome (CTS). (T.30) She followed up with Dr Stein for multiple visits. (T.30) During the November 5, 2009 visit, Dr. Stein informed petitioner that her CTS was causally related to her repetitive work duties. (T.31) Petitioner eventually went to see Dr. Cohen at Midwest Orthopedics for the CTS. (T.34) She demonstrated her work duties for Dr. Cohen. (T.34-35) Dr. Cohen causally related Petitioner's CTS to the work activities. (T.35) Petitioner attempted to get the surgery through Dr. Cohen but her husband's insurance would not pay for the treatment as the condition was work related. (T.36-37) Respondent provided no treatment in the case. Petitioner returned to Dr. Stein who sent her to Dr. Bernie for surgery. (T.37)

A left carpal tunnel release was performed in July 2011 and on the right in November of 2011. (T.37-38) Petitioner described how her symptoms changed with the surgeries. Before surgery, she experienced bilateral wrist pain, finger numbness, finger stiffness and pain shooting up the arms. (T.38) The symptoms she had by 2009 were significantly worse than when she had the doctor visit back in 2006. (T.39) Petitioner testified her hand and arm symptoms improved somewhat with the releases but she never got full capacity back for the hands. (T.41) The hand numbness did not completely resolve, the weakness in the hands did not resolve and she still experienced pain in the wrists on occasion. (T.41-42) She also developed trigger thumb on the right side after surgery, which was addressed through a steroid injection. (T.39) The pain from the injection was so horrible that she could not have another injection. (T.40)

Medical Records

Petitioner initially saw Dr. Adam Stein and Dr. Tracie Wilcox on September 9, 2009 reporting a painful sensation over the posterior side of the left forearm when she flexed her wrist for her job. (PX2 p.4) She also had complaints consistent with carpal tunnel syndrome (CTS). (PX2 p.4) She was able to complete her work tasks at that point in pain. She also noted she was not able to perform many activities when she got home after work. (PX2 p.4) Dr. Stein's examination revealed positive bilateral Tinel's signs and he diagnosed Petitioner with a

work-related overuse injury, recommending therapy, bracing and occupational therapy. (PX2 p.5) Dr. Wilcox agreed with the assessment and treatment plan. (PX2 p.5)

Petitioner returned to Dr. Stein and saw Dr. Hong on October 1, 2009 complaining of CTS, left greater than right, along with left wrist pain. (PX2 p.28) She was working with therapy to try to improve her symptoms to avoid surgery. (PX2 p.28) Petitioner's left wrist was still bothering her and she wanted an x-ray. (PX2 p.28) Left-hand x-rays were normal on October 1, 2009. (PX2 p.19) Dr. Stein noted that Petitioner was no longer able to continue working as a mail sorter due to the symptoms and he completed short term disability paperwork for her. (PX2 p.28) Dr. Stein referred Petitioner to a hand surgery specialist for treatment for consideration of injections or a carpal tunnel release. (PX2 p.29) Petitioner reported that she was leery of getting surgery, but she would be willing if conservative treatment did not improve her condition. (PX2 p.29) Petitioner noted she was no longer able to perform her mail sorter duties secondary to the pain and inability to fully move her wrist. (PX2 p.29) Dr. Hong agreed with the assessment and treatment plan. (PX2 p.29)

Petitioner returned to the clinic on October 22, 2009 for pain in her chest, left arm and left face. (PX2 p.33) Dr. Yung noted Petitioner was using a left forearm brace and that she was on short term disability on account of the CTS preventing her from performing the mail sorter work. (PX2 p.33)

Petitioner returned to see Dr. Stein and Dr. Andrew Davis on November 5, 2009. (PX2 p.44) Dr. Stein diagnosed Petitioner with bilateral CTS brought on from work-related usage. (PX2 p.44) This is the first discreet reference in the records to the CTS being caused by her work duties. Dr. Stein also documented Petitioner's left wrist pain on the posterior side of the wrist. Her hands did not hurt at rest. However, any movement of the wrist provoked both the carpal tunnel symptoms and left wrist pain. (PX2 p.44) Dr. Stein noted Petitioner was currently off work due to her work-related CTS and that her mail sorter position required quite frequent use of the wrists. (PX2 p.45) Dr. Stein recommended that Petitioner resume therapy, wear braces at night and then see a hand surgeon if the complaints did not improve. (PX2 p.45) Dr. Andrew Davis agreed with the assessment and treatment plan. (PX2 p.45)

Petitioner was evaluated for occupational therapy on November 16, 2009. (PX2 p.152) Petitioner's mail extractor job was assessed as requiring hand manipulation and strength. (PX2 p.152) Petitioner reported paresthesias in both hands, although her gross light touch was intact. Her pain levels were 0/10 when resting and 7/10 with activity. She was fitted with splints and educated on activities she could perform on her own to address the symptoms and she was told to follow up with her MD. (RX2 p.153)

Petitioner next saw both Dr. Stein and Dr. Monica Vela on December 18, 2009. (PX2 p.68-69) Dr. Stein noted Petitioner had CTS which was likely related to her work duties. (PX2 p.68) Dr. Stein noted Petitioner's mail sorter job required her to mainly use her forearms and hands all day and that she was now unable to do that work on account of the severe pain. (PX2 p.68) Dr. Stein completed a disability form to that extent for her employer. Dr. Stein also reported his conversation with her employer. The employer informed him that they denied her workers compensation claim mainly because they did not receive any medical follow up for the injury. (PX2 p.68) Dr. Stein noted that Petitioner was off work due to the pain and awaiting approval from workers compensation. (PX2 p.69) Dr. Vela agreed with the assessment and the treatment plan. (PX2 p.69)

On January 22, 2010 Petitioner consulted with Dr. Mark Cohen at Midwest Orthopedics. (PX3 p.3) Dr. Cohen noted Petitioner's carpal tunnel symptoms came on with work duties, her symptoms were clearly exacerbated while she performed the activities, and that is why she was on temporary disability at the time. (PX3 p.3) Dr. Cohen opined Petitioner' symptoms "may certainly be associated with her work activities". (PX3 p.3)

At the time of Dr. Cohen's examination, Petitioner had 35 lbs. of grip strength in the right hand and 30 lbs. of strength in her dominant left hand. (PX3 p.3) An EMG/NCV found evidence of chronic moderate bilateral sensorimotor median neuropathy entrapment at the wrists. (PX3 p.11) During the follow up visit on February 10, 2010, Dr. Cohen explained that the electrical tests had confirmed the CTS diagnosis and that splinting had failed to resolve the symptoms. (PX3 p.5) Provocative testing elicited positive responses in both hands for CTS. (PX3 p.5) He recommended surgical releases and he sought approval from workers compensation for the treatment. (PX3 p.5) Respondent approved no treatment.

Petitioner saw Dr. Yasmin Sacro at the University of Chicago Medical Center on December 23, 2010 for an unrelated knee complaint. (PX2 p.74) Dr. Sacro documented that Williams' employer had let her go because of her CTS and that she was without a job. (PX2 p.75) Petitioner returned to Dr. Sacro for the CTS on July 11, 2011. (PX2 p.108) At this point, Petitioner's wrist splints had not relieved the symptoms and her numbness was constant in each finger of her hands. (PX2 p.108) Petitioner's numbness was the main complaint and her pain was occasional. She wanted to have surgery. The hand examination was largely unremarkable except for positive Tinel's and Phalen's results. (PX2 p.109) Petitioner was referred for surgery.

Petitioner saw Dr. Birnie on July 14, 2011 for a surgical consult. (PX2 p.114) Dr. Birnie referenced her past work history of medical-extractor clerical-type work without providing detail. The plan was to release the dominant left hand first. (PX2 p.114) This surgery was performed on July 25, 2011 by Dr. Birnie and Dr. Jimmy Jiang. (X2 p.124, 126) The physicians found a hyperemic compressed median nerve in the carpal tunnel during surgery. (PX2 p.126) Dr. Birnie saw Williams during several follow up visits, noting by September 8, 2011 that she was doing well with minimal discomfort. (PX2 p.147) Petitioner had full range of motion and resolution of *most* of her preoperative symptoms. (PX2 p.147) Dr. Birnie allowed Petitioner to return to normal activities and told her to come back as she needed.

Petitioner was still complaining of residual pain at the October 20, 2011 visit with Dr. Birnie. (P2 p.152) Petitioner complained that her right hand was really symptomatic and she was ready for surgery to that side. (PX2 p.152) Dr. Sacro also documented at the October 25, 2011 visit that she still had left hand numbness. (PX2 p.164) The right CTS was released in November 2011 and Petitioner returned to see Dr. Birnie on November 21, 2011. (PX2 p.170) Dr Birnie reported that she was doing well after the surgery. During the Dece,ber 19, 2011 visit, Petitioner continued experiencing pain but her preoperative symptoms had resolved. (PX2 p.175) Her swelling was going down and her range of motion was good. Petitioner was told to avoid putting weight on the hands. (PX2 p.175) Petitioner's presentation was similar at the January 30, 2012 visit. (PX2 p.185)

Section 12 Examination - Dr. Jeffrey Coe

Petitioner saw Dr. Jeffrey Coe for an examination on May 30, 2017. (PX1 p.9) Dr. Coe has been board certified as an occupational medicine specialist since 1991. (PX1 p.5) Occupational medicine is the specialty which deals with the health of people at work. (PX1 p.5) The first third of his practice is devoted to clinical examinations for workers and employers. (PX1 p.6) The second third of the practice is working as an advisor and consultant for employers, insurers, 3rd party administrators, labor unions and some governmental agencies. (PX1 p.7) The third part of his practice is devoted to IME work, 60% of which are for the respondent. (PX1 p.7-8) He also teaches occupational medicine at the University of Illinois Medical Center. (PX1 p.8) Petitioner told him she worked as a mail extractor and she described and demonstrated the work for him. (T.42) Dr. Coe had never heard of this position before and spent some time discussing the details with her so he understood what it demanded. (PX1 p.10) She processed up to 2,000 envelopes per day by hand. While automated equipment was sometimes available, it was commonly broken down or defective. (PX1 p.11) To process the envelopes, she

would grab a bunch of envelopes with the right hand and use a letter opener with the left to open the envelopes. (PX1 p.11-12) This would be done rapidly. (PX1 p.12) After she opened each envelope, she would verify the content, collate the checks and stubs, she would bundle these documents in batches and roll them up, securing them with rubber bands. (PX1 p.12) Some of the envelopes had staples in them which she had to remove by hand and she would have to staple others together. (PX1 p.12) She also had to flip through the packs of paper which she did by wearing a rubber finger cot on her left thumb. (PX1 p.12) A major issue with the job was how rapidly the production had to be done and the fact that she as monitored on the production level. (PX1 p.13) There was a threat of termination for workers who could not keep up with the work levels. (PX1 p.14) Dr. Coe reviewed her medical records, noting that a hand specialist (Dr. Mark Cohen) felt that her CTS was related to her work duties. (PX1 p.16) Bilateral carpal tunnel releases were initially successful as they reduced her symptoms, but she continued experiencing residual symptoms consistent with CTS even after the surgeries. (PX1 p.17) Dr. Coe examined her about six years after the surgeries. (PX1 p.17) At that point, she still had pain in the palms of both hands, most noticeable with wrist extension. (PX1 p.18) She still had discomfort with prolonged or forceful wrist activities like gripping, twisting and squeezing during ADLs. (PX1 p.18) She still experienced weakness in both hands which is a common complaint from cutting across the transverse carpal ligament during the releases. (PX1 p.18) Petitioner summarized her recovery by claiming improvement in the symptoms and continuing weakness in the hands. (PX1 p.19) At the time of Coe's examination, her mail extractor position had been eliminated and she was working at home performing healthcare work. (PX1 p.20) Dr. Coe did not believe she would have been able to return to the mail extractor position after the releases and recommended that she limit repetitive and forceful gripping with the hands. (PX1 p.20) Examination revealed scarring on both hands with pillar tenderness, a common consequence from the surgical procedure. (PX1 p.22-23) She complained of wrist pain with extension motion of the wrist. (PX1 p.23) She still had signs of a positive Tinel's finding on both wrists which Dr Coe attributed to scarring from the surgeries. (PX1 p.25) The scarring would likely not be responsive to surgical options and it would not improve her. (PX1 p.26) She also had slight decreased to light touch sensation in the distal phalanges, more so on the right than the left hand. (PX1 p.26) Given the amount of time which had passed since the surgery, the findings were permanent. (PX1 p.26-27) Pinch grip strength was found to be 8lbs. on the right side and 10lbs on the left, but the strength for women her age was normally 15 to 17lbs. (PX1 p.28) Based on the presentation, the medical records, the examination findings and his understanding of her mail extractor job, her work was a factor in her development of the bilateral CTS. (PX1 p.30) She required work limitations against repetitive and forceful and prolonged gripping with either hand. (PX1 p.30) Dr. Coe noted that Williams would not have been able to return to the mail extractor job with respondent. (PX1 p.31) On cross, Dr Coe discussed the healthcare work she performed at this point. (PX1 p.45) She was caring for her handicapped son, doing laundry, assisting in dressing. (PX1 p.45) She was receiving grant money for the care. (PX1 p.46)

Section 12 Examination - Dr. Prasant Atluri

Respondent sent Petitioner for an examination with Dr. Prasant Atluri on March 23, 2010. (RX1 p.7) Dr. Atluri is a board certified orthopedic surgeon with a certificate of added qualification in surgery of the hand. (RX1 p.5) Petitioner told him that her symptoms set in gradually and progressed and that she attributed the symptoms to repetitive work activities. (RX1 p.9) She claimed that she first felt bilateral forearm pain accompanied by numbness and tingling into her fingers. (RX1 p.9) The primary care physician had treated her with splints which did help, but she could not wear the splints during the day. (RX1 p.10) Dr. Cohen diagnosed her with CTS and recommended surgery. (RX1 p.10) She experienced severe pain in the ulna, wrist, and forearm and in her left wrist, she experienced some dorsal ulnar pain which was worse with wrist extension. (RX1 p.10) The symptoms fluctuated in intensity from moderate to severe, but her symptoms were continuous in the right hand and intermittent in the left. (RX1 p.10) She also had some popping in one of the hands and some stiffness. (RX1 p.10) Dr. Atluri obtained a job description, noting the work involved repetitive use of her hands for stapling as well as

computer work. (RX1 p.11) He thought she handled envelopes and processed checks by putting the checks into a device. (RX1 p.11) She used a keyboard and binder clips. (RX1 p.11) His examination revealed mild tenderness at the base of the right thumb but not the left. (RX1 p.11) She had a positive Tinels on both sides and she was very tender over the ulnar wrist on the right side. (RX1 p.12) She had positive digital compression test over the carpal tunnel of both wrists and pain with a TFC grind on the right side but not the left. (RX1 p.12) Her right wrist extension appeared somewhat impaired. (RX1 p.12) The electrodiagnostic studies revealed chronic moderate bilateral distal medium neuropathy. (RX1 p.13) X-rays revealed ulnar positive variances on both side and an impact lesion on the lunate bone in the right hand where the longer ulna bone met the lunate. (RX1 p.13) The left side also had an impact lesion on the lunate. (RX1 p.14) Dr. Atluri was not provided with video footage of the actual job, which he normally found useful for his causal analysis. (RX1 p.14) He diagnosed Williams' conditions as bilateral CTS and possible bilateral ulnar impaction syndrome (UIS). (RX1 p.15) The impaction syndrome is caused by wearing down and tearing of the TFCC ligament between the ulnar and lunate as the bone rub against each other, eventually causing damage to the cartilage, softening of the bones and even cystic changes in the lunate itself. (RX1 p.17) Those are changes you can see on x-rays. (RX1 p.17) However, she also had relevant pain at the ulnar aspect of the wrist. (RX1 p.17) He thought her prognosis was good for the CTS but only fair for the UIS. (RX1 p.18) The reason the prognosis was fair is that the symptoms from this condition progress as does the treatment. (RX1 p.19) Steroid injections, splinting and icing work at the early stages but the condition progresses and can lead to a ratcheting up of surgical options, from arthroscopes in to osteotomies to reconstructive procedures. (RX1 p.19) Patients with UIS tend to lose range of motion and strength as the condition progresses. (RX1 p.19) He recommended carpal tunnel releases to address the CTS and conservative care for the impaction syndrome. (RX1 p.20) Surgery might be an option as the impaction condition progressed. (RX1 p.20) On causation, he did not believe that her work activities contributed to either diagnosis as the conditions were commonly idiopathic. (RX1 p.21) For CTS, activity related symptoms are due to frequent forceful use of the hands and wrist associated with awkward positioning on a frequent basis. (RX1 p.22) For the UIS, one needed forceful, frequent, repetitive activity over a long duration of time. (RX1 p.22) The classic maneuver which aggravated the impaction syndrome was ulnar deviation of the wrist and forearm rotation. (RX1 p.22) As he understood her job, her job was repetitive, but she did not perform frequent forceful activity or have the impact or heavy forceful use with awkward positioning of the hands and wrists. (RX1 p.22-23) That is why he felt her diagnoses were not work related. (RX1 p.23) He also noted she had risk factors for developing CTS, including obesity, hypertension, age and gender. (RX1 p.23) Her risk factors would make her more susceptible for developing CTS if she performed activities of daily living involving forceful gripping, heavy lifting with awkward positioning of her hands and wrists. (RX1 p.24) She also had no need for work restrictions from the diagnoses. (RX1 p.25)

Cross-examination revealed that Dr. Aluri performed 200 to 250 IMEs per year, 90% for the defense. (RX1 p.25-26) He had been doing that for years. (RX1 p.26) All he knew about Williams' work duties was what he put down in his report. (RX1 p.26-27) He did not know whether she was flexing or whether she was deviating in an ulnar fashion during her work duties. (RX1 p.27) He noted that a number of studies had attempted to quantify how forceful an activity must be to result in CTS, but the data conflicted between the studies. (RX1 p.28) The studies appeared to require a combination of factors, including a certain amount of force associated with a certain amount of frequency and associated some amount of awkward positioning of the body part. (RX1 p.28) The most common cause of CTS was idiopathic, meaning it has nothing to do with activity. (RX1 p.29) He defined idiopathic as "the nerve just got sick". (RX1 p.30) Sick nerves could be caused by a million different things, including activity. (RX1 p.31) He admitted that only 7 to 8% of the population ever develops symptomatic CTS and the vast majority of the working population never develops the condition. (RX1 p.31-32) Generally, activities which contribute to CTS include activities which increase the pressure in the carpal canal. (RX1 p.32) This included flexion, swelling and accumulation of liquid in the canal which can result from

repetitive use of the joint. (RX1 p.32) There was no known established threshold for how much repetition was needed for the symptoms to show up. (RX1 p.32) The CTS diagnosis also required flexion or extension of the wrist, movements which increased the pressure in the carpal canal. (RX1 p.33) But any movement of the wrist past neutral caused some increase in pressure in the carpal canal. (RX1 p.33) To associate movement with CTS, he initially claimed that he needed a flexion threshold of about 70 degrees, but he then admitted the research had not correlated any specific percentage of flexion with development of CTS. (RX1 p.33-34) He also had no idea how much Williams had to flex her wrist to perform her job. (RX1 p.34) He assumed she used the wrist in a normal fashion to staple, use binder clips, keyboard and write. (RX1 p.34) However, if there was something unique about her position which was outside those parameters, that detail could affect his causation opinion. (RX1 p.35) He had not documented anything beyond those activities. (RX1 p.35) He was also not aware of any research which had measured how much the canal pressure changed with any activity. (RX1 p.37) If Williams repetitively flexed her wrist to perform her work activities, that could change his causation opinion. (RX1 p.38) He noted that her job was highly repetitive, so he would not characterize the work as purely clerical. (RX1 p.40) He knew that her complaints same on while she was performing her work duties and that onset and progression with specific work duties can indicate a causal relationship. (RX1 p.41) For the risk factors, while obesity was a risk factor, he did not know what percentage of the obese population develops symptomatic CTS and he admitted that the obesity would make her more susceptible to developing CTS. (RX1 p.42-43)

Causation for the UIS required compaction of the ulna bone against the lunate. (RX1 p.44) The repeated impact on the lunate caused the bone to degenerate. (RX1 p.44) Dr Atluri also had no idea whether Petitioner was performing repetitive ulnar deviation in her work duties. (RX1 p.45) He had not documented what she was doing with her wrists. (RX1 p.45) He knew Williams had an ulna bone which was longer, a set up which caused more relative load to be transmitted through the ulna to the lunate than a set up with a normal ulna length. (RX1 p.45-46) So the force of any gripping, lifting or hand use got transmitted to the location of the UIS. (RX1 p.46) The repeated squeezing of the triangular fibrocartilage complex between the ulna and lunate could lead to a breakdown and degeneration of the cartilage, as well as breakdown of the bone structure of the lunate and ulna. (RX1 p.46) The pain she was experiencing from the UIS was probably a combination of chemical irritation of the nerves from an inflammatory reaction in the area as well as just the mechanical grinding of the two bone together. (RX1 p.49) UIS pain could affect the persons' ability to work as well as to perform certain types of movements. (RX1 p.50) And restrictions might be warranted to avoid the types of activities which were causing pain for the patient. (RX1 p.51) Dr. Atluri denied that he released Petitioner to return to regular duties. (RX1 p.51) If she was performing ulnar variant activities, the condition would simply worsen and would become painful. (RX1 p.51) Ulnar variant activities can accelerate the UIS condition. (RX1 p.51) He also admitted that once a patient has UIS and the cartilage is wearing away, the inflammatory reactions are going on, the lunate is starting to dissolve. (RX1 p.51) While the symptoms might wax and wane, the condition would worsen over time. (RX1 p.52) If the UIS is symptomatic, one of the ways the patient can address it is to avoid the ulna deviating movements. (RX1 p.52) One of the cardinal ways we can tell whether we are using a joint beyond its normal ability to bear load is the presence of symptoms. (RX1 p.53) It is your body telling you to not do that movement. (RX1 p.53) In the event a patient is performing a specific activity and it is causing the pain, Dr. Atluri acknowledged that correlation could indicate a causal relationship between that activity and the injury occurring to the joint. (RX1 p.53)

On redirect, he explained further the mechanics behind development of UIS. Forceful gripping loads the wrist naturally and the amount of load transmitted to that area of the wrist is greater in people with positive ulnar variance. (RX1 p.58) Simple forceful gripping moves the wrist in to ulnar deviation all by itself, i.e, awkward positioning. (RX1 p.59) When you add repetition into the mix, the activity becomes a legitimate risk factor for development of UIS. (RX1 p.59) While he lacked the job details, he admitted that she would have performed

some level of ulnar deviation with her work activities and handling of mail. (RX1 p.59) But he would not consider the activities he thought she performed to present an atypical ulnar deviation. (RX1 p.59) In the event that the CTS releases did not fully resolve the CTS symptoms, it could be due to incomplete release of the tunnel during the surgery or scarring developing from the surgery which can cause traction neuritis or even strangulation of the nerve from the scarring. (RX1 p.61)

CONCLUSIONS OF LAW

The Arbitrator initially notes that during the February 26, 2019 trial, the parties stipulated that "*statute of limitations*" was a disputed trial issue which would accordingly be a threshold trial issue (See, Arb. Ex. #1, 2/26/19, admitted into evidence). However, Respondent argues Petitioner failed to address and argue the statute of limitations threshold issue in his post-trial submissions to the Arbitrator. This assertion is inaccurate. Petitioner did not omit or fail to address and argue this issue in his post-trial submissions to the Arbitrator. Petitioner did address and argue this issue, albeit somewhat in a disorganized manner, in Sections D (date of accident) and C and F (accident and causation). These issues are discussed below.

Issue C - Did Petitioner sustain an accident arising 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 accident? Regarding these issues, the Arbitrator finds and concludes the following:

The Arbitrator fids and concludes Petitioner has proven by a preponderance of the credible evidence she sustained accidental injuries arising out of and in the course of her employment with Respondent on November 5, 2009 (the "manifestation date") and Petitioner has further proven by a preponderance of the credible evidence that her current condition of ill-being in her bilateral hands/wrists is causally related to her work duties/employment with Respondent based on a proven theory of repetitive trauma.

The Arbitrator acknowledges the record contains a less than ideal presentation of the facts relating to Petitioner's actual job duties performed, the precise details of which were in dispute or missing and/or not available for analysis, if they even could be measured and quantified. **Nonetheless, Petitioner has proven her case; as the Arbitrator emphasizes, "There is no legal requirement that a certain percentage of a claimant's workday be spent on repetitive tasks in order to establish the repetitive nature of a claimant's job duties."** *Edward Hines Precision Components v. Industrial Comm'n,* 356 Ill. App.3d 186, 193-94 (2005).

The Arbitrator further emphasizes there can be little doubt that Petitioner's job duties were "repetitive" in nature; the work activities she performed were clearly done on a repetitive basis, performed countless times over the years. The real question in dispute is whether these job activities were a competent cause of her conditions of ill-being, a question only qualified expert medical opinions can properly address. Only Dr. Alturi opined they were not.

The Arbitrator finds and concludes Petitioner's job duties were "repetitive" in nature and did cause her conditions of ill-being. The causation finding is supported by the highly repetitive nature of the work, the onset and progression of relevant symptoms with the work, the lack of any evidence of other specific activities or causes to explain the appearance of the conditions of ill-being, the universal agreement by Petitioner's treaters that her

work was causing the injuries as well as the causation opinion from Dr. Coe. Respondent's examining expert Dr. Atluri did not opine there was a relationship between the carpal tunnel syndrome (CTS) and the work, but the record reflects he had no clear understanding of Petitioner's actual work duties and therefore his opinions lacked a solid foundation, although it must be added Petitioner's examining expert Dr. Coe also did not have a solid understanding of Petitioner's job duties as well. Likely no expert in this case had an ideal understanding of Petitioner's job duties; however, with that in mind, **sufficient, relevant and competent evidence was presented and available to the Arbitrator to consider in order for him to make a reasoned determination of accident and causation. 100% accuracy is not a legal requirement.**

The record indicates Petitioner's use of her hands for the mail extractor work was exceptionally repetitive. By her estimate, Petitioner opened 8,000 envelopes per week, 400,000 envelopes per year and between 1,600,000 and 2,000,000 envelopes during her work with Respondent. (T.26-27) Even if those numbers are inaccurate or exaggerated, they are nonetheless significant. Petitioner gradually developed pain in her wrists with this work. (T.27) Petitioner's supervisor, Herrod, thought the totes averaged 600 to 650 envelopes per tote, which would lead to the opening of 1,200 to 1,300 envelopes per shift. (T.108-109) However, Ms. Harrod's estimate was in line with Petitioner' estimates of her production levels. Herrod recognized that Petitioner had received employee performance awards and a bonus around the time Herrod was managing her, including an award for error-free work in early 2009 (T.130-131) an award in March of 2008 indicating she was performing at a 129% level which Herrod agreed was "off the charts" and a monetary bonus for her work during 2009. (T.136) Assuming Williams processed 2 ½ totes per shift as she claimed, Herrod agreed that she would be opening 1,625 envelopes per shift. (T.140) Herrod explained that not only would the worker have to grasp the envelopes and opener while sweeping through the top of each envelope, they would also have to grasp and pull out whatever documents were found inside each envelope. (T.142) So each envelope required multiple instances of grasping. If we use the 1,600-1,625 envelope estimates, and we assume at least 2 grasps per envelope, the job demanded 16,000 grasps per week, 800,000 per year and 6,400,000 over her eight-year career with Respondent. The job was clearly highly repetitive. The work also clearly involved continuous grasping, twisting and handling with both hands. (T.153) Herrod documented that these activities were performed continuously throughout the shift. (T.153) She believed that her workers performed millions of those movements during the work year for the job. (T.153-154) Even with all those movements, Herrod did not consider the job a tough job like heavy labor. (T.154)

The Arbitrator finds it persuasive that the record shows further true that Petitioner's CTS symptoms appeared and progressed over time with the work activities she performed. **This also suggests causation**. The records reveal her symptoms came on over a period of years before the December 2006 U of C visit where the physician gave her splints to use at night. (T.70) Petitioner credibly testified she did not know what was causing her symptoms in 2006 and she continued working up through 2009 when she could no longer work, due to the pain and numbness in the hands and wrist and pain shooting up the forearms. (T.91-93) Petitioner also credibly testified she did not know in December of 2006 that she was diagnosed with CTS but that she was treated for her worst symptoms (T. 27, 71-73). The symptoms continued to worsen as she performed the work through 2009. (T.71) The appearance and progression of relevant symptoms while engaged in her work duties reasonably supports a finding of a causal relationship between those work activities and her injuries/condition of ill-being.

Each **treating physician** who addressed causation also agreed Petitioner's hand complaints were work related; only Dr. Atluri, Respondent's examining expert, did not opine causation, and the Arbitrator notes he did not have a complete understanding of what Petitioner's job duties entailed. Dr. Stein causally related the CTS to the work duties as early as the 11/5/09 visit. (PX2 p.44) Petitioner described her work activities to Dr. Stein. There is no dispute regarding this. (T.33) Dr. Stein also documented Petitioner's left wrist pain on the posterior side of the wrist. Petitioner's hands did not hurt at rest and any wrist movement provoked both the carpal tunnel

symptoms and left wrist pain. (PX2 p.44) Dr. Stein documented that Petitioenr's mail sorter position required quite frequent use of the wrists. (PX2 p.45) Dr. Andrew Davis agreed with Dr. Stein's analysis. (PX2 p.45) Petitioner next saw both Dr. Charles Stein and Dr. Monica Vela on 12/18/09. (PX2 p.68-69) Dr. Stein again related the CTS to her work duties, explaining that her mail sorter job required her to mainly use her forearms and hands all day and that she was now unable to do that work on account of the severe pain. (PX2 p.68) Dr. Vela agreed with Dr. Stein's assessment. (PX2 p.69) Dr. Mark Cohen next saw Williams. (PX3 p.3) Petitioner demonstrated her work activities for Dr. Cohen. (T.34-25) Dr. Cohen documented that Petitioner's CTS symptoms came on with her work duties, her symptoms were clearly exacerbated while she performed the activities, and that is why she was disabled at the time. (PX3 p.3) Dr. Cohen also thought the symptoms were associated with her work activities. (PX3 p.3)

Significantly, the Arbitrator notes none of the treating physicians attributed Petitioner's CTS - whether as *the* sole cause or as *a* contributing cause - to anything *other than* her work duties for Respondent. Further, there was *no* evidence of any intervening, superseding accident or condition or cause that severed the chain of causation.

Petitioner also described and demonstrated her work activities in detail to Dr. Coe so he could conduct his analysis for causation. Dr. Coe is a board certified occupational medicine specialist who has been addressing causal mechanisms for decades for employers, insurance carriers, agencies and employees. Dr. Coe had never heard of the mail extractor position before and spent some time discussing the details of the job so he generally and sufficiently - if not id4ally - understood what it demanded. (PX1 p.10) Petitioner described and demonstrated what she did in the mail extractor job. (T.42) Dr. Coe spent considerable time during his deposition explaining what the job physically demanded of her and how it contributed to her carpal tunnel syndrome. The details largely mirror the testimony which the parties elicited at trial. Dr. Coe agreed with Dr. Mark Cohen that her CTS was related to her work duties. (PX1 p.16) Based on the presentation, the medical records, the examination findings and his understanding of her mail extractor job, Dr. Coe believed her work duties were a factor in her development of the bilateral CTS. (PX1 p.30)

The Arbitrator highlights that the only physician who disputed causation was Respondent's Section 12 medical expert.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999). **It is the Commission's function to choose between conflicting medical opinions.** *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill. 2d 1, 4, 31 Ill. Dec. 789, 394 N.E.2d 1166, 1168 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 232, 590 N.E. 2d 78, 82 (1992).

Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 31 Ill.Dec. 789, 394 N.E.2d 1166 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 168 Ill. Dec. 756, 590 N.E. 2d 78 (1992).

Accordingly, the Arbitrator accepts the view that causation has been proven and attaches greater weight to the opinions of Petitioner's treating physicians and Dr. Coe, rather than the sole dissenting opinion of Dr. Alturi.

The evidence reveals Dr. Atluri had a less than ideal understanding of her work and he frankly admitted that research had not identified how much grasping or movements or weight demands were needed to develop CTS. Dr. Atluri is an orthopedic hand surgeon like Dr. Cohen. Dr. Atluri understood that Williams' symptoms set in gradually and progressed and that she attributed the symptoms to repetitive work activities. (RX1 p.9) On causation, he disputed whether her work activities contributed to the CTS diagnosis as the conditions were commonly idiopathic. (RX1 p.21) CTS had been associated with frequent forceful use of the hands and wrist and frequent awkward positioning of the wrists. (RX1 p.22) But he had little understanding of what Petitioner was doing for her work. He conceded that her job was repetitive, but he did not believe she performed sufficiently frequent forceful activity or awkward positioning of the hands and wrists. (RX1 p.22-23) He also lacked any details about the work other than what he put down in his report. (RX1 p.26-27) He did not know whether she was flexing or whether she deviated in an ulnar fashion during her work duties. (RX1 p.27) He knew the research did not agree as to how frequent or how forceful an activity must be to result in CTS. (RX1 p.28) Petitioner had other risk factors which had been associated with CTS, but her risk factors accounted for only a tiny fraction of CTS cases. He also admitted that research had not quantified the amount of repetition, flexion or weight that a person had to perform to develop CTS. In any event, Dr. Atluri's analysis of the case was undoubtedly impaired by his impaired understanding about what Petitioner was doing at work with her hands. The overwhelming agreement of the treating physicians and Petitioner's examining physician was that the CTS was related to her work duties. Petitioner had described the work to Dr. Cohen, Dr. Coe and Dr. Stein, and Stein and his colleagues treated Petitioner over a lengthy period of time with multiple references in their records about the nature of the work duties and their relationship to the CTS. There is no evidence that Petitioner detailed her work duties for Dr. Atluri and he admitted he had nothing other than was in his note. Petitioner has proven that her bilateral CTS is causally related to her mail sorter work with Respondent.

Petitioner has also proven a causal relationship between her UIS and the work activities for Respondent. For the UIS, Dr. Atluri made the diagnosis and he mechanically outlined what was necessary for a person to develop this injury. UIS occurs when the ulna bone compacts against the lunate bone. (RX1 p.44) Repeated impact causes the bones to degenerate. (RX1 p.44) While Dr. Atluri did not know whether Petitioner performed repetitive ulnar deviation in her work duties, he knew she had a longer ulna bone which caused more relative load to be transmitted through the ulna to the lunate than she would have had with a normal ulna length. (RX1 p.45-46) Dr. Alturi explained that any gripping, lifting or hand activity got transmitted to the location of the UIS and that the repeated squeezing of the triangular fibrocartilage complex between those bones could lead to a breakdown and degeneration of the cartilage, as well as breakdown of the bone structure of the lunate and ulna. (RX1 p.46) Even simple forceful gripping moved the wrist into an ulnar deviation all by itself, as it involves awkward positioning. (RX1 p.59) When activities require repetitive ulnar deviation, the activities become a legitimate risk factor for development of UIS. (RX1 p.59) Dr. Atluri also explained that one of the cardinal ways we can tell whether we are using a joint beyond its normal ability to bear load is the presence of symptoms. (RX1 p.53) The symptoms are telling you to not do that movement. (RX1 p.53) In the event a patient performs a specific activity and it causes the pain, that could indicate a causal relationship between that activity and the injury occurring to the joint. (RX1 p.53)

During the hearing, Petitioner demonstrated the mail extraction for the Arbitrator, gripping the envelopes in the right hand and cocking the right wrist toward the ulnar side to allow for her left hand to sweep the letter

opener through the tops of the envelopes. (T.52-54) As she made each pass through an envelope, she further deviated ("flicked" as she described it) the wrist toward the ulnar side to contribute to the opening. (T.53) While she did this, she was pinching the opening in the left hand and sweeping it through the envelope tops again by swinging the left wrist between ulnar and radial deviations. Thus, given the mechanics of the work and Dr. Atluri's explanation as to how the injury develops, it is further apparent that Petitioner's bilateral UIS is also causally related to the work duties. The duties required the exact movements which Dr. Atluri said would impact the lunate against the ulna, grinding down the TFCC ligament. For each envelope opened, she flicked the right wrist toward the pinky side and her pain set in while performing this specific work. (T.54-55) Further, there is no evidence Petitioner performed repetitive duties with either hand outside of work which might have accounted for development of UIS. (T.55) Thus, Petitioner has proven a causal relationship between her mail extractor work and the conditions of CTS and UIS.

Issue 0 - Statute of Limitations under Section 6(d) and Issue D - What is the date of the accident? Regarding these issues, the Arbitrator finds and concludes the following:

Petitioner has proven that she sustained an accident arising out of and in the course of her employment with Respondent and that November 5, 2009 is a reasonable and appropriate manifestation date for her injuries. **November 5, 2009 was the first date that any physician *expressly* related the CTS to the work activities and the first date on which Petitioner was made *specifically* aware of the relationship between her work duties and her physical condition.**

Petitioner certainly reported CTS symptoms during one visit in December 2006 and received night-time braces which she wore for less than a year. However, Petitioner credibly testified the physician at that time (Dr. Carl Meyer) did not tell Petitioner she was suffering from CTS (or that it was work-related) and the symptoms actually improved while she used the braces. (T.27, 72-73) Petitioner did not treat for the CTS over the next three years, and the condition progressed to the extent that she stopped working on 9/9/09. Petitioner's workload increased during that intervening period. (T.29-30) Petitioner saw Dr. Stein on 9/9/09 but the focus was on the forearm pain. She mentioned symptoms consistent with CTS at that visit, but Dr. Stein did not expressly relate the CTS to her work until the 11/5/09 visit.

The Arbitrator highlights that Dr. Meyer, to whom Petitioner reported CTS symptoms during one visit in December 2006 and received night-time braces as a result, never offered any testimony or evidence indicating he told Petitioner she had CTS and that this was work-related when he treated her on that one day in December 2006. Therefore, Petitioner's testimony regarding that visit went unchallenged and remains unrebutted.

Manifestation dates are commonly characterized as the date when the fact of injury and causal relationship to work would have become plainly apparent to a reasonable person. See *Peoria County Belwood Nursing Home v. Indust. Com'n*, 115 Ill.2d 524, 531 (1987). However, "fairness and flexibility are the common themes" when settling on manifestation dates for repetitive trauma injuries. *Durand v. Indust. Com'n*, 224 Ill.2d 53, 71 (2006) The dates should not be fixed so rigidly as to punish workers who choose to keep producing for their employers as their bodies break down. After all, the Act was designed to protect injured employees rather than to grant windfalls for employers by setting dates and barriers which are little more than legal fictions (an artificial accident date to repetitive injuries). The *Durand* court recognized that repetitive trauma injuries may take years to develop to a point of severity precluding the employee from performing in the workplace. *Durand*, 224 Ill.2d at 68. The Court highlighted the need to protect workers who continue to produce for their employer as the injuries worsen.

An employee who discovers the onset of symptoms and their relationship to employment, but continues to work faithfully for a number of years without significant medical complications or lost working time, may well be prejudiced if the actual breakdown of the physical structure occurs beyond the period of limitation set by statute. *Durand*, 224 Ill.2d 53, 68 (2006). Thus, the date when an employee notices a progressing injury is not the only date the employee can select for a manifestation date, as "fact of injury" is not synonymous with "fact of discovery". See *Durand* at 68-69. Rather, the manifestation date "remains flexible" with multiple factors feeding into the potential date (date of discovery, date of physical collapse, dates of treatment, last date of work). See *Id.* The bottom line is that Respondent's demand that we use 2006 as the manifestation date runs contrary to each of the concerns recognized by the Supreme Court and it is contrary to the core goals of the Act. Fairness and flexibility hardly lend themselves to a 2006 date of accident. Petitioner continued performing the mail extractor work for three years after 2006 as her injuries progressed and the workload increased. Petitioner performed at an exceptional level of production compared to her fellow workers, though that fact is hardly determinative. Respondent would obtain a pure windfall if we were to accept its proposed 2006 manifestation date.

In summary, first, as noted in the causation discussion above, Respondent's work duties she performed caused, or at least was a causative factor, in the breakdown of Petitioner's body. Second, Respondent reaped the benefit of Petitioner's work production as her body broke down. Third, Respondent made no claim that it was unduly prejudiced (or prejudiced at all) by Petitioner's claim of a 11/5/09 manifestation date and Respondent offered no proof of prejudice at trial. (T.15) Fourth, and lastly, Respondent has so far avoided payment for TTD and treatment for Petitioner's progressing injuries. (T.44-45) Thus, 11/5/09 is a reasonable and appropriate determination for the manifestation date.

Issue E- Was timely notice of the accident given to Respondent? Regarding this issue, the Arbitrator finds and concludes the following:

The same concerns for flexibility and fairness apply to the notice requirement for manifestation dates. Petitioner was certain she discussed her injuries with her supervisor one week before her 9/9/09 visit with Dr. Stein. (T.59) She advised Ms. Herrod of the bilateral hand pain and pain shooting up the arms. (T.59) Ms. Herrod did not recall Williams complaining that it was difficult to open the mail with a paper slicer. (T.115) Ms. Herrod believed she would remember that comment. (T.115) However, she later admitted during cross-examination that she did not recall the content of any of her conversations with petitioner. (T.155) That is understandable as a decade had passed since her last conversation with Williams and Ms. Herrod was in charge of multiple workers. Curiously, respondent did not even identify the specific notice policy it had in place for work injuries. Ms. Herrod denied that workers would report injuries to her as company policy restricted her from knowing anything about the medical conditions of the workers she was supervising. (T.148-150) Instead, employees were supposed to report injuries to "workers comp" who would then reach out to the company. (T.150) When pressed on who "workers comp" was, Ms. Herrod replied "I'm not sure who they would report it to." (T.151) Ms. Herrod ultimately admitted that Respondent's insurance company had her fill out a job demands sheet for Williams' job when they became involved in the case. (T.145) She believed she filled out the form by November of 2009 but she did not recall when in November. (T.152) **At the time Herrod completed this form, she understood that Petitioner was claiming that her condition was work related.** (T.146) Thus, given the manifestation date of 11/5/09, Petitioner has proven that Respondent received timely notice of her work injuries.

Dr. Stein had also completed short term disability forms indicating that Williams was no longer able to complete the mail sorter work on account of the worsening bilateral hand conditions. Independent of the supervisor's admission that the company knew about petitioner's injuries by November, Dr. Stein was advising

respondent that her condition was work related a month earlier. Respondent claims no surprise or prejudice from the notice it received about Williams' condition of ill-being. Given respondent's failure to identify an actual reporting requirement, its failure to show any prejudice from the notice it was given as well as the appellate court's application of a fluid notice requirement for repetitive trauma injuries [*Oscar Meyer & Co. v. Indust. Com'n*, 176 Ill.App.3d 607, 611 (1988) (requiring notice of only a potential disability is a useless act since it is not until the employee actually becomes disabled that the employer is adversely affected in the absences of notice of the accident)], Petitioner has proven that she provided timely notice of her injuries to respondent.

Issue L - What period of temporary total disability benefits are owed? Regarding this issue, the Arbitrator finds and concludes the following:

Petitioner started missing work for her hands as of 9/9/09 (T.59) and she never returned to work as a mail extractor. The pain and numbness in her hands and wrists and forearms led to her stopping work. (T.92-93) Dr. Stein completed disability forms for petitioner at that point. Respondent authorized no treatment and her husband's group insurance would not pay for the CTS releases. Petitioner ultimately returned to the University of Chicago for treatment and public aid paid for the releases. (PX4) The left hand CTS release was done on 7/25/11. (T.37-38) The surgeon told Petitioner her to return to normal activities in September of 2011 but the respondent had already terminated her because of the work she had missed for the CTS (see Dr. Sacro's 12/23/10 note- PX2 p.75). Respondent terminated her by March or May of 2010. The right CTS release was done on 11/9/11. (T.38) During the 12/19/11 visit, she was still experiencing pain but her preoperative symptoms had resolved. (PX2 p.175) Petitioenr's swelling had improved and her range of motion was good. She was advised to avoid putting weight on the hands. (PX2 p.175) Her presentation was similar at the final visit on 1/30/12. (PX2 p.185) None of her treating physicians ever released her back to mail extractor work (T.44), although Dr. Bernie released her for normal activities between the time she ended treatment for the left CTS (9/26/11- T.46) and the date of her right CTS release on 11/9/11. Petitioner' final visit with the surgeon came on 1/30/12. (PX2 p.185) She remained off work until 2017 when Department of Human Services began compensating her for caring for her severely disabled son. (T.47)

When a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized, i.e., whether the claimant has reached maximum medical improvement. *Interstate Scaffolding v Illinois Workers Compensation Comm'n*, 236 Ill.2d 132, 142, 923 N.E.2d 266, 271 (2010). In this case, no physician ***explicitly*** opined that Petitioner had reached MMI prior to the hearing but treatment for the bilateral CTS essentially ended after the 1/30/12 visit and Petitioenr's condition had not materially changed from that point through the time she saw Dr. Coe in 2017. Thus, the 1/30/12 visit is a logical and appropriate date for MMI. Therefore, Petitioner has proven that she was temporarily and totally disabled from 9/9/09 through 9/26/11 and again from 11/9/11 through 1/31/12, for a total of 121 5/7 weeks of unpaid TTD.

Issue J - Has respondent paid all appropriate charges for all reasonable and necessary medical services? Regarding this issue, the Arbitrator finds and concludes the following:

Respondent provided no medical treatment related to Petitioner's injuries. Given the findings on accident, notice and causation, Respondent is responsible for the CTS releases and follow up medical treatment. Those charges were paid by a combination of her husband's group insurance and Medicaid. (PX4) Respondent is therefore responsible to pay Petitioner $13,643.15 for the HFS payments and $928.20 for group payments made by the Sheet Metal Workers Local Welfare Fund. Further, given the findings on UIS, respondent remains

responsible for treatment for this condition, assuming Petitioner seeks treatment for the UIS and the conditions are not materially worsened by a competent intervening accident.

Issue L – What is the nature and extent of the injuries? Regarding this issue, the Arbitrator finds and concludes the following:

The Arbitrator notes the date of accident herein predates the effective date of Section 8.1b regarding permanency determination.

The Arbitrator emphasizes Petitioner was last seen by a treating physician for her injuries on January 30, 2012, more than seven years ago, when she last visited Dr. Birnie (PX2, p. 185).

While Petitioner asserts Petitioner was never "released" to return to mail extractor work by any physician, this is inaccurate and misleading; when Petitioner last visited her treating physician Dr. Birnie on January 30, 2012, he **did not place any specific *work* restrictions on her at all and he certainly did not specifically prohibit her from working in any type of employment, let alone restrict or remove her from her usual and customary employment.** (PX 2, p. 185) Dr. Birnie actually found Petitioner to be doing quite well (after right hand carpal tunnel release) with **"full resolution of her preoperative symptoms of numbness and tingling in her fingers."** (PX2, p. 185). The evidence clearly shows Petitioner has not visited nor been treated by any physician for her conditions since January 30, 2012, more than seven years ago, when she last visited Dr. Birnie (PX2, p. 185). This strongly suggests – if not proves – her condition is clearly not serious. Therefore, her injuries have not resulted in any residual disability or impairment to the extent that Petitioner is restricted from any employment as of 2012.

Further, Petitioner offered no vocational evidence regarding her ability or inability to work or be placed in suitable available labor market employment and Petitioner accordingly makes no claim for any maintenance or vocational rehabilitation. In fact, Petitioner takes care of her disabled son as a paying job, assisting him with activities of daily living, a position which requires use of her hands. **In short, there is no evidence indicating Petitioner is restricted from or is physically unable to engage in her usual and customary employment duties, or, in fact, any other employment duties**

Further, the Arbitrator highlights there is no recent opinion regarding disability from a treating physician. This absence has impact on the determination of permanency.

Lastly, Petitioner offered testimony regarding her current condition. The CTS releases provided some initial relief of the symptoms Petitioner experienced from the CTS. The left release resolved the numbness and tingling she had before the operation. (T.83) Petitioner also noted improvement with the right CTS release. (T.84-85) Petitioner denied that she recovered full range of motion in her hands and wrists. (T.84) Petitioner had not sought treatment directed at her hands since 2012. (T.88) Petitioner testified she taking pain medicine for her continuing complaints. (T.88)

Petitioner described the difficulty the injuries had caused for daily activities. (T.89) Petitioner testified she has trouble performing activities around the house, including opening jars, handling pots and pans and even bathing both herself or her disabled adult kids. (T.56) She had to assist her son with basic activities like bathing, putting on his pants, tying his shoes and cooking for him. (T.90) This work involves use of her hands and arms and she has difficulty with it. (T.89) Petitioner testified she had none of these problems before she started the mail extractor work. (T.57)

However, even though Petitioner told Dr. Coe she had numerous symptoms and complaints when he examined her on May 30, 2017, Dr. Coe testified Petitioner told him "She said that she had no intention, no plan to go back and see him [treating physician Dr. Birnie] when I saw her in 2017. She told me she was performing no treatments or therapies for her hands including home treatments or home therapies that she had learned, so there was no treatment going on at that time." (PX1, p. 38). **Again, this is not indicative of someone who has significant impairment or disability.**

Further, although Dr. Coe admitted he did **not** review Petitioner's post-operative records, he agreed that when he examined Petitioner years after her surgeries, she "had full range of motion and near complete resolution [of her preoperative symptoms] but she still did have some postoperative left-hand symptoms." (PX1, pp. 341-42). Dr. Coe summarized his examination findings as follows: "But, again, the condition that I found when I examined her in 2017 was of a pretty successful outcome from carpal tunnel syndrome release surgeries with only mild anticipated postoperative sequelae, changes." (PX1, p. 47). Given all of that testimony, Dr. Coe still opined he would not have recommended Petitioner that she return to work as a mail extractor as she described that job to me" - even though Petitioner's own treating physicians **never** made any such recommendations. (PX 1, pp. 48-49).

Therefore, Dr. Coe's Section 12 opinion regarding Petitioner's work ability/restriction is not credible.

Based on the above factors, Petitioner has proven that she sustained permanent partial disability to the extent of 15% loss of use of both the right and left hands pursuant to §8(e)9 of the Act.

Issue M- Should penalties or fees be imposed upon respondent? Regarding these issues, the Arbitrator finds and concludes the following:

The Arbitrator finds and concludes Petitioner has not proven entitlement to additional penalties or fees under sections 19(l) and 19(k) and attorney fees under section 16 of the Act.

Petitioner asks for penalties under sections 19(l) and 19(k) and attorney fees under section 16 of the Act. Section 16 fees and section 19(k) penalties both require an unreasonable or vexatious delay in payment. *Vulcan Materials Co. v. Industrial Comm'n,* 362 Ill.App.3d 1147, 1150, 842 N.E.2d 204 (2005). The standard for awarding penalties and attorney fees under sections 19(k) and 16 is higher than the standard for awarding penalties under section 19(l). For the award of penalties and attorney fees under sections 19(k) and 16, it is not enough for the claimant to show that the employer simply failed, neglected, or refused to make payment or unreasonably delayed payment without good and just cause. See *McMahan v Indust. Com'n*, 183 Ill.2d 499, 515 (1998). Instead, penalties and attorney fees under 19(k) and 16 are "intended to address situations where there is not only delay, but the delay is deliberate or the result of bad faith or improper purpose." *Id.*, at 516.

Typically, "an employer's reasonable and good faith challenge to liability ordinarily will not subject it to penalties under the Act." *Matlock v. Industrial Comm'n,* 321 Ill.App.3d 167, 173, 746 N.E.2d 751 (2001). Where an employer is in possession of facts that would justify a denial of benefits, penalties and fees are generally inappropriate. *Electro–Motive Division v. Industrial Comm'n,* 250 Ill.App.3d 432, 436, 621 N.E.2d 145 (1993). However, good faith must be assessed objectively, and the question is whether an employer's denial of benefits was reasonable. *Electro–Motive,* 250 Ill.App.3d at 436, 621 N.E.2d 145.

Respondent never provided Petitioner treatment or TTD. However, Respondent did retain Dr. Atluri, a qualified expert in the field, for a Section 12 examination to address medical causation. While not without flaws, Respondent could have reasonably relied upon Dr. Atluri's opinions and causation analysis. There was also a reasonable, good-faith dispute regarding the manifestation date and therefore the issues of whether the Application was timely filed and notice was timely provided.

Therefore, the Arbitrator finds and concludes Petitioner has not proven entitlement to additional penalties or fees under sections 19(l) and 19(k) and attorney fees under section 16 of the Act.

Robert M. Harris

Robert M. Harris, Arbitrator
Dated: May 16, 2019

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

Esteban Hernandez,
Petitioner,

vs.

Hausner Hard Chrome,
Respondent.

20IWCC0200

NO: 14 WC 41467

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary disability, permanent disability and 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 February 6, 2019, is hereby affirmed and adopted.

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

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

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

DATED: MAR 24 2020
o2/20/20
MP/rm
046

Marc Parker

Barbara N. Flores

DISSENT

I respectfully dissent from the majority's award of 14% MAW and would have instead found that Petitioner sustained a loss of 5% MAW based on the §8.1b statutory factors. This permanency award would encompass only Petitioner's low back injuries. Petitioner did not treat for his head laceration after the accident date and failed to prove that any of his current symptoms were related to the head laceration. Additionally, although Petitioner testified that he received three stitches to his head, the medical records do not discuss any stitches. For these reasons, Petitioner failed to establish any permanency for the head laceration.

Nevertheless, Petitioner established a loss of 5% MAW for his spinal injuries, which were non-surgically treated with medication, work restrictions, physical therapy, facet joint injections, medial branch blocks, and radiofrequency ablations. The last treatment note in the record is dated December 30, 2016, and there is no evidence to show that Petitioner treated for his injuries beyond that date. Although Petitioner personally decided that he could no longer do his regular job with Respondent, he conceded that Dr. Burgos had returned him back to full duty work in December of 2016. There were no recent off-work slips from any medical providers that kept Petitioner off work or on limited duty restrictions.

Nevertheless, Petitioner chose to find other employment through a temporary agency and as a part-time driver for two hotels. Petitioner testified that his jobs through the temporary agency had different payrates with one paying 25 cents more and another paying one dollar more. However, Petitioner failed to provide further details on his exact payrates, and it is not clear from the record how much Petitioner earned during that period of employment. There was also no evidence presented regarding what Petitioner currently earns from driving part-time for the two hotels. Therefore, Petitioner failed to establish any loss of earnings as a result of his work accident and his decision to stop working for Respondent.

The above factors, which specifically correlate with criterion (ii), (iv), and (v) of §8.1 b of the Act, support modifying the permanent partial disability award down to 5% MAW for Petitioner's low back injuries and awarding no permanency for Petitioner's head laceration. I would have modified the Decision of the Arbitrator accordingly.

DLS/met
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Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0200

HERNANDEZ, ESTEBAN
Employee/Petitioner

Case# **14WC041467**

HAUSNER HARD CHROME
Employer/Respondent

On 2/6/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.44% 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:

5094 SKLARE LAW GROUP LTD
MICHAEL R TRYBALSKI
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CHICAGO, IL 60602

0532 HOLECEK & ASSOCIATES
BARNALI ROY-MOHANTY
PO BOX 64093
ST PAUL, MN 55164-0093

20IWCC0200

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

Esteban Hernandez
Employee/Petitioner

v.

Hausner Hard Chrome
Employer/Respondent

Case # **14** WC **41467**

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 **11/30/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

On **11/25/2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**31,751.20**; the average weekly wage was $**610.60**.

On the date of accident, Petitioner was **50** 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 is entitled to a credit of $**3,896.24** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**3,896.24**.

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

ORDER

Temporary total disability

Respondent shall pay Petitioner $**407.07**/week from **11/26/2014** through **3/4/2015**, which represents a period of **14-1/7** weeks, because Petitioner was temporarily totally disabled during this period, pursuant to Section 8(b) of the Act.

Respondent shall be given a credit of $**3,896.24** for TTD, $**0.00** for TPD, and $**0.00** for maintenance, for a total credit of $**3,896.24**.

Medical benefits

Respondent shall satisfy the $**110,498.84** in outstanding medical charges (itemized below), pursuant to Section 8(a) and subject to Section 8.2 of the Act, as such charges were incurred for the reasonable and necessary medical treatment that is causally related to the November 25, 2014 accident.

1.	Advanced Physical Medicine (Px. 4)	$1,846.15
2.	EQMD, Inc (Px. 5)	$4,142.69
3.	Pinnacle Pain Management Specialists (Px. 9)	$29,115.00
4.	APM Surgical Group (Px. 11)	$69,150.00
5.	Addison Medical Associates (Px. 13)	$6,245.00
	TOTAL	**$110,498.84**

Respondent shall be given a credit of $**19,529.72** for medical benefits that have been paid as outlined in Respondent's Exhibit #12.

Permanent Partial Disability

Respondent shall pay Petitioner $**366.36**/week for **70** weeks because Petitioner has sustained a loss of use of his person as a whole to the extent of **14%** thereof, pursuant to Section 8(d)2 of the Act.

Respondent shall pay Petitioner benefits that have accrued since **3/5/2015** 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

2/6/2019
Date

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Esteban Hernandez,	)	
	)	
Petitioner,	)	
	)	
v.	)	No. **14 WC 41467**
	)	
Hausner Hard Chrome,	)	
	)	
Respondent.	)	

ATTACHMENT TO ARBITRATION DECISION

On December 9, 2014, Petitioner filed an Application for Adjustment of Claim for this matter. (Ax2) In it, he alleged that on November 25, 2014, he injured his head and back during the course of his employment. (Ax2) The case was heard by Honorable Brian Cronin, Arbitrator of the Workers' Compensation Commission, in the city of Chicago, on November 30, 2018. A Spanish speaking interpreter provided interpreting services on behalf of Petitioner. After hearing the proofs and reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues below and includes those findings in this document.

I. Findings of Fact

Petitioner, Esteban Hernandez, testified that he was employed by Respondent, Hausner Hard Chrome, and was hired on April 21, 2008 as a Truck Driver. His job duties included loading pieces for Respondent and taking the pieces to another company and returning the pieces back to Respondent for chroming. (Transcript ("Tr.") 12-13)

On November 25, 2014, Petitioner testified, he was delivering two "pieces of parts", which weighed 60 - 80 pounds each, to a company named Faster & Better. (Tr. 15) He was driving a 14-foot truck that belonged to Respondent. He was driving alone. He arrived at Faster & Better between 8:00 and 8:30 am. (Tx. 16) On that date, Petitioner testified, he arrived at the parking lot of Faster & Better and parked the truck. He parked where he normally parked because he had a small skid and they use a forklift to unload it. He noticed a little bit of snow in the parking lot. While getting out of the truck, he took one step but was not able to hold because there was ice under the snow. He was trying to keep his balance but could not. As he fell, he "bounced off the door" and hit his forehead. (Tr. 17) Petitioner further testified that he lost consciousness for about three seconds. He touched his forehead and noticed blood on it. Before attempting to get back in his truck, he called his boss; his boss told him to wait there and that they would come there to help him. (Tr. 17)

During cross-examination, Petitioner testified that he knew he lost consciousness because he looked at the clock in the truck before and after he fell. (Tr. 49-50)

None of the medical records indicate that Petitioner lost consciousness after he fell.

Petitioner testified that there was no one nearby when he slipped and fell.

Petitioner testified that after the slip and fall, other than noticing the laceration on his forehead, he felt pain in his back, and then a little while later, in his shoulders. (Tr. 22)

Petitioner further testified that a half hour later, two men named Robert and Francisco arrived at the Faster & Better parking lot. Francisco picked up Petitioner's truck Robert drove him to the company doctor, Alexian Brothers in Bensenville. (Tx. 29) Neither Robert nor Francisco appeared at trial.

At Alexian Brothers, Petitioner voiced only head and back complaints. He later learned that he had undergone a CT scan of his head. After that, he was sent back to the clinic where he had x-rays taken and received 3 stitches. (Tr. 31)

The medical records of Alexian Brothers Medical Center indicate that on November 25, 2014, Petitioner presented to Alexian Bros Medical Center in Bensenville and was diagnosed with "Open wound, scalp ... and posttraumatic headache." (Px1) He was referred to the Alexian Bros Medical Center in Elk Grove Village for diagnostic testing. At the Elk Gove facility, in addition to undergoing a CT scan of the head, Petitioner underwent x-rays of the lumbar spine. (Px1)

In the x-ray report from the Department of Diagnostic Imaging, Parviz Nabavi, M.D., wrote: "Clinical data: Patch pain. Patient fell on ice." Dr. Nabavi then made the following findings with regard to the x-ray images:

> "There is a transitional vertebra with 6 lumbar type vertebrae. It could be due to lumbarization of S1. There is no visible fracture or dislocation. The disc spaces appear preserved. It small (sic) osteophytes are seen at the vertebral endplates in the lower lumbar region." (Px1)

Anish K. Chatterjee, M.D., offered the following impression of the CT scan of the head, without contrast:

> "No intracranial hemorrhage or mass effect. Frontal scalp soft tissue swelling is present." (Px1)

On December 8, 2014, Petitioner first presented to Aleksandr Goldvekht, M.D. at Advanced Physical Medicine. (Px3) The history he took states, in pertinent part, the following:

> "Patient stated that on 11.25.14, he was working for Hausner Hard Chrome, when he parked his truck and was exiting when he slipped on ice and fell injuring his low back. He stated that as he was getting up he struck his head injuring his neck and experiencing a severe head-aches (sic) instantly. He stated that since the fall, he has been experi-encing severe pain in his neck, lower back and severe headaches" (Px3)

Dr. Goldvekht examined Petitioner and found, *inter alia*, that the cervical spine range of motion was decreased in bilateral lateral flexion and the lumbar spine range of motion revealed bilateral lateral flexion and extension was moderately decreased and painful with severe spasms at the end range. He found the Kemp's test to be positive bilaterally and the SLR test to be negative. Dr. Goldvekht assessed Petitioner with cervical and lumbar discogenic pain and opined that his condition remains guarded. He prescribed prescription pain medications and a course of physical therapy. He instructed Petitioner to follow up in 4 weeks and to remain off work until then. He opined that if Petitioner experiences no improvement in 4 weeks, he would order an MRI of the cervical and/or lumbar spine to rule out disc pathology. (Px3)

When Petitioner returned to Dr. Goldvekht on January 5, 2015, he reported that his neck was slightly better with therapy, but that his lower back was still causing him a severe amount of pain. Dr. Goldvekht again conducted a physical examination. Kemp's test was again positive bilaterally. Dr. Goldvekht kept

Petitioner off work, continued his pain medications and physical therapy, and ordered an MRI of the lumbar spine. (Px3)

Gregory Goldstein, M.D., offered the following impression of the January 13, 2015 MR images of Petitioner's lumbar spine:

> "Lumbar spondylosis as detailed above with annular bulging from L4-S1. At T12-L1, there is a 2 mm. posterior central/ left paracentral protrusion." (Px3, Px6)

Among his axial image findings, Dr. Goldstein identified facet hypertrophy at T12-L1, L4-L5, and L5-S1, and bilateral facet hypertrophy at L1-L2, L2-L3, and L3-L4. (Px3, Px6)

When Petitioner returned to Dr. Goldvekht on January 19, 2015, he reported no change in his complaints. There were no changes in examination findings. Kemp's test was still positive bilaterally. Dr. Goldvekht continued to assess Petitioner with cervical and lumbar discogenic pain and opined that his condition remains guarded. He noted the radiologist's interpretation of the January 13, 2015 MRI. Dr. Goldvekht kept Petitioner off work through February 16, 2015, re-dispensed his pain medications, continued to recommend physical therapy, and referred him to Dr. Jain for interventional pain management. (Px3)

The Advanced Physical Medicine records reflect that Petitioner began physical therapy on December 10, 2014 and continued through January 30, 2015, at which time he reported that he feels much better with PT, and is "good with all ADLs, exercises." The physical therapist recommended discharge for achieving PT goals and instructed him to continue his home exercise program. Dr. Goldvekht restricted him from work through February 16, 2015. (Px3)

On January 26, 2015, Petitioner first saw Neeraj Jain, M.D., of Pain Care Specialists (n/k/a Pinnacle Pain Management Specialists). (Px8) Within the **HISTORY OF PRESENT ILLNESS** in the **INITIAL EVALUATION**, Dr. Jain recorded the following:

> "The patient presents for an initial visit and consultation following a work-related injury that occurred on November 25, 2014. The patient relates that on that day, he was driving for work delivering: he works at Haugner. He relates that he was getting out of his car and there was ice on the ground. As he was getting out of his car, he split and his feet came out from under him. He landed on his back, his head bounced off the ice and came back up and hit the door of the truck causing a laceration on his forehead. He relates that he immediately reported the injury to his supervisor and they took him to the Alexian Brothers Clinic, which is the Occupational Health Clinic. He relates that at Alexian Brothers Clinic, they gave him an x-ray on his lower back and then sent him to Elk Grove Emergency Room where they did a CT scan on his head and gave him stitches for his laceration and released him.
>
> The patient relates that after that he continued to have headaches and lower back pain with occasional radiation of pain into his lower extremities." (Px8)

Dr. Jain's review of systems was negative except for mild (psychiatric) depression as well as headaches and some dizziness since the accident. Petitioner

related to Dr. Jain that he sustained a head injury 4 or 5 years ago when he apparently fractured his skull and required surgery. (Px8)

Physical examination of the musculoskeletal system revealed lumbar axial pain with pain to palpation along the paraspinal muscles. Hypertonicity was noted. Range of motion was intact and caused reports of minimal pain with flexion and extension. No motor or sensory deficits. No focal weaknesses. Negative straight leg raise bilaterally. (Px8)

Dr. Jain also recorded the findings of the MRI of the lumbar spine. (Px8)

Dr. Jain then opined that "as the patient does continue to have lumbar pain without any radicular symptoms and pain to palpation along the paraspinal muscles despite disc bulging as the majority of the patient's pain does seem to be facetogenic in nature as the patient does lack radicular symptoms, the patient will be referred for bilateral L3-L4, L4-L5, and L5-S1 facet joint injections." Dr. Jain also recommended that Petitioner continue with physical therapy and pain medications (Mobic, Flexeril and Tramadol), and remain off work. (Px8)

In his **INITIAL EVALUATION** and in all **FOLLOW-UP VISIT** notes, Dr. Jain wrote the following:

> "It is my opinion that the patient's symptoms for which he is being seen today are directly related to the injury. It is my opinion that the treatment rendered thus far has been reasonable and of necessary frequency and duration. These opinions are stated to a reasonable medical probability. These opinions are based on patient's history, physical exam, imaging studies, and medical records that I have been provided and reviewed thus far." (Px8)

On February 5, 2015, at the request of Respondent and pursuant to Section 12 of the Act, Petitioner presented to Michael D. Kornblatt, M.D., who is associated with Illinois Bone & Joint Institute. Dr. Kornblatt authored a report in which he wrote that on November 25, 2014, "the patient was evaluated at Alexian Brothers Medical Group." (Rx1) He also wrote: "Notes are handwritten and illegible. Diagnoses include laceration on forehead with scalp contusion and lumbar contusion. Neurologic examination was within normal limits. The patient was provided sedentary duty restrictions." (Rx1)

Dr. Kornblatt also wrote:

> "The patient did follow up with Dr. Zimmers on November 26, 2014. The patient was allowed to drive. The patient again followed up at Alexian Brother Medical Group on December 1, 2014. He was to apply ice and heat. He was to continue with ibuprofen." (Rx1)

The medical records of Alexian Brothers Medical Group and Dr. Zimmers were not offered into evidence.

At Dr. Kornblatt's February 5, 2015 Section 12 exam, he recorded that Petitioner complained of mid-lumbar back pain that will at time radiate up to the thoracic region. Petitioner denied radicular pain, an inability to sit, stand or walk. Petitioner noticed more back pain having discontinued use of his medication as well as with bending and lifting. Dr. Kornblatt reviewed records, reviewed diagnostic test results, and conducted a physical examination of Petitioner. He found, *inter alia*, that Petitioner demonstrated a range of motion of his lumbar spine of flexion 80°, extension 20°, and lateral bending rotation 20° bilaterally. Dr. Kornblatt also found straight leg raising to be negative to 90° bilaterally. Dr. Kornblatt opined that his diagnosis is consistent with "resolved cervical strain,

lumbosacral strain, and contusion. (Rx1) Dr. Kornblatt noted that "the above diagnoses are a direct result of the work-incident of November 25, 2014, as the mechanism of the work incident is consistent with the stated diagnoses as the patient denies previous similar injury or symptomatology." He also wrote that the "patient's physical examination referable to the cervical spine and lumbar spine fails to reveal abnormal objective findings which is consistent with a diagnosis of strain and contusion." (Rx1)

Dr. Kornblatt further opined, "I do feel that the injured worker has warranted appropriate conservative management referable to the cervical strain, lumbar strain, and lumbar contusion." Adding further that, "at this time, it is my opinion that the injured worker has undergone an appropriate amount of physical therapy and warrants no further formal medical care referable to his ongoing subjective complaints of mechanical low back pain." (Rx1)

Dr. Kornblatt wrote that he felt it is inappropriate for Petitioner to have been off work since inactivity is detrimental to the healing process. He opined: "the patient has yet to reach maximum medical improvement" (Rx. 1). Dr. Kornblatt predicted that MMI and a full-duty release would occur after completion of an additional 2 weeks of restricted work duties …" In the meantime, he released Petitioner to occasional lifting of 30 pounds and frequent lifting of 15 pounds. (Rx 1)

Pursuant to Dr. Jain's recommendation, Petitioner underwent bilateral L3-4, L4-5, and L5-S1 facet joint injections on February 9, 2015. (Px10, pp. 4-5) The operative report from APM Surgical Group, LTD. lists Petitioner's diagnosis as: 1) lumbar facet syndrome, 2) lumbar discogenic pain, and 3) lumbosacral radiculopathy. (Px10, pp. 4)

Petitioner was examined and presented for approximately 10-11sessions of physical therapy at Addison Medical Associates between February 11, 2015 and March 26, 2015. (Px12)

Petitioner returned to see Dr. Jain for a follow up appointment on February 23, 2015. (Px8, pp. 17-21) Petitioner noted improvement to some of his symptoms/conditions, but not others following the injections performed on February 9, 2015. (Px8, p. 17) Dr. Jain advised Petitioner to continue with his physical therapy regiment. Various modifications were made to Petitioner's prescription medications. Petitioner was instructed to remain off work. (Px8, p. 19) Dr. Jain reiterated his opinion that Petitioner's "symptoms for which he is being seen today are directly related to the injury." (Px8, p. 17)

In the March 4, 2015 record from Addison Medical Associates, Dr. Saeed wrote: "Patient cannot work today due to weakness and is able to return to work tomorrow." (Px8, p. 22)

Petitioner was seen again by Dr. Jain on March 23, 2015 at which time he noted "significant improvement with initial facet injections done on February 9, 2015." (Px8, p. 22) Petitioner noted that he had returned to work light duty – including a restriction of no lifting over twenty pounds. (Px8, p. 22)

Dr. Jain recommended a second lumbar facet injection at L4-L5 and L5-S1. (Px8, p. 22) Petitioner was cleared to continue working light duty, but with the increased restriction of no lifting over 10 pounds. (Px8, pp. 23-24)

Dr. Jain also included notes regarding Petitioner's Section 12 examination by Dr. Michael Kornblatt on February 5, 2015. According to Dr. Jain, Dr. Kornblatt spent a "minimal amount of time" examining Petitioner and noted further that Dr. Kornblatt "did capitulate to causation and indicated the patient was

not at MMI, but somehow able to predict in the future that the patient would reach MMI in two weeks." (Px8, p. 22) Dr. Jain noted: "I disagree wholeheartedly with Dr. Kornblatt about MMI being achieved in mid-February, this did not happen and he certainly is not at MMI right now." (Px8, p. 23)

Petitioner saw Dr. Jain again on April 20, 2015. (Px8, pp. 27-31) At that time Petitioner noted that, with regard to work, "he has returned to modified duty with a 10-pound lifting limit according to the IME; however … he cannot return as they do not have modified work for less than 25 pounds." (Px 8, p. 27)

On May 18, 2015, Petitioner was again seen by Dr. Jain. (Px8, pp. 32-36) Dr. Jain's notes indicate Petitioner "was recommended for bilateral lumbar facet injections and these have not been done. They remain unauthorized despite recalcitrant low-back pain. The patient did attempt to return to work with modified duty and he was intolerant of it. Apparently, his work place stated if he wants to return to work, he should be able to do 25-pound pushing pulling, lifting, and carrying." (Px8, p. 32)

Dr. Jain again recommended a repeat "bilateral lumbar facets at L4-L5 and L5-S1." (Px8, p. 32)

On June 15, 2015, Petitioner again presented to Dr. Jain. (Px8, pp. 37-41) Petitioner noted that he had "returned to work modified duty 25-pound pushing, pulling, and carrying and his workplace had accommodated this; however, throughout the day pain increases." Petitioner noted further that he "has significant pain at night and he feels that he has not resumed his previous activities of daily living or does not have the ability to increase vocational activities beyond the 25 pounds." (Px8, pg. 37)

Petitioner was next seen by Dr. Jain on July 13, 2015. (Px8, pp. 42-46) Petitioner noted continued lumbar axial pain and his continued reliance on medications. (Px8, p. 42) Dr. Jain recommended Petitioner continue current medication use and modified work duty. (Px8, p. 42) Dr. Jain also noted that "delay in authorization adversely affects outcome both in terms of habituation to medication, psychological decline and affliction. It also decreases likelihood of functional return to work and symptom resolution." (Px8, p. 42)

On August 24, 2015, Petitioner proceeded with a second round of bilateral facet joint injections at L4-5 and L5-S1. (Px10, pp. 6-7)

Petitioner had a follow-up appointment with Dr. Jain on August 31, 2015. (Px8, pp. 50-54) Petitioner noted that "since the injections, his back has actually worsened." (Px8, p. 50)

Petitioner had follow-up appointments with Dr. Jain on September 28, 2015. (Px8, pp. 55-57), October 26, 2015, (Px8, pp. 58-60), November 23, 2015, (Px8, pp. 61-63), December 14, 2015, (Px8, pp. 64-65), and January 11, 2016. (Px8, pp. 66-68)

On December 7, 2015, Petitioner proceeded with a third round of injection procedures. (Px10, pp. 8-9) Specifically, those procedures performed included: 1) bilateral L3, L4, L5, and dorsal root of L5 medial branch nerve block, and 2) facet joint injection at L3-4, L4-5, and L5-S1. (Px10, p. 8)

A fourth round of injections was completed on January 18, 2016. (Px10, pp. 10-11)

On January 26, 2016, Dr. Jain noted that following the December 7, 2015 bilateral medial branch blocks, Petitioner had a 70% improvement for

approximately 5 days. Dr. Jain then proceeded with a "Left L2, L3, L4, and L5 and dorsal root of L5 medial branch radiofrequency ablation." (Px10, pp. 12-13).

Lastly, Petitioner underwent a sixth procedure on February 2, 2016. (Px10, pp. 14-15). Specifically, the procedures on that last date of service consisted of a "Right L2, L3, L4, L5 and dorsal root of L5 medial branch radiofrequency ablation." (Px10, p. 14)

On the date of his last treatment, February 2, 2016, Petitioner noted that after the first hour following the procedure, the percentage of regular pain relief that he experienced was 60 - 70%. (Px8, p. 70)

On June 16, 2016, Respondent requested a retrospective Utilization Review ("UR") for certification of the injections and ablations performed by APM Surgical Group (Dr. Jain) from February 9, 2015 through February 2, 2016. Steven Barna, M.D., who specializes in anesthesiology and pain management, conducted the UR. In his report he included the ODG Guidelines for each of the following procedures: facet joint diagnostic blocks, facet joint intra-articular injections (therapeutic blocks), and facet joint radiofrequency neurotomy. Dr. Barna provided analysis and clinical basis for his conclusions. Dr. Barna non-certified all injections. His UR findings were not appealed by provider Neeraj Jain, M.D. (Rx2)

On August 24, 2016, at the request of Respondent and pursuant to Section 12 of the Act, Petitioner presented to Richard L. Noren, M.D. for an examination. (Rx5) Dr. Noren is associated with Pain Care Consultants. Petitioner had an interpreter. Dr. Noren reviewed the available records, took a history, and conducted a physical examination. On examination, the doctor noted "several fictitious findings" and positive Waddell signs. Dr. Noren diagnosed Petitioner with lumbar strain related to his fall of 2014, which he expected would resolve. The doctor opined that past

treatment, including the facet injections, medial branch blocks, and radiofrequency ablation procedures were medically unnecessary and not indicated. He further opined that Petitioner is at MMI and is capable of returning to work with no restrictions. (Rx5)

Dr. Noren also rendered an AMA impairment rating of Petitioner on August 24, 2016. He stated that he used the AMA 6th Guide and referred to Chapter 17 regarding the lumbar spine and pelvis, specifically Table 17.4, page 570. Dr. Noren concluded, to a reasonable degree of medical and surgical certainty and with reasonable interpretive standards, that Mr. Hernandez's impairment rating is 0-1% maximum. (Rx6)

On April 19, 2017, Respondent requested a retrospective UR for certification of Petitioner's PT treatment from February 17, 2015 through March 16, 2016. Based on ODG Guidelines, Bobby Enkvetchakul, M.D., who specializes in occupational medicine, non-certified physical therapy beyond 10 visits over an 8-week period in a report dated April 21, 2017. (Rx4)

The deposition of Richard L. Noren, M.D., was taken on April 26, 2017. Dr. is board-certified in anesthesiology and pain management. (Rx10, Dep. Ex. 1) Dr. Noren examined Petitioner on August 24, 2016 and authored a report. (Rx10, Dep. Ex. 2, Rx5) Dr. Noren testified he reviewed the following documents, which included medical records: a letter from Medical Consultants dated August 18, 2016, a letter from Steven Barnard of Travelers Insurance dated August 18, 2016, the medical records of Dr. Goldvekht, the medical records of Alexian Brothers Medical Group, x-rays of the lumbar spine, a CT scan of the head, an MRI of the lumbar spine dated January 13, 2015, the medical records of Dr. Jain, the operative reports of Dr. Jain, and records from Windy City Anesthesia. In reviewing Dr. Goldvekht's records, Dr. Noren testified that Dr. Goldvekht did not find any evidence of muscle

weakness in the motor groups he tested. In general, Dr. Noren continued, evidence of weakness would suggest sciatic or radicular-type pain. (Rx10)

Dr. Noren testified that Dr. Jain's recommendation for facet injections was unreasonable. (Rx10) With regard to Dr. Jain's clinical exam, Dr. Noren opined, Petitioner had an intact range of motion in that he had minimal pain with flexion/extension. Dr. Noren noted that people with severe pain related to facet joints typically will not be able to forward flex or certainly cannot extend without severe pain. Dr. Noren testified that on January 26, 2015, Petitioner reported a 2 out 10 pain to Dr. Jain; although that is an uncomfortable level, it is typically not someone whom you would inject or do surgery on. On February 23, 2015, following the February 9, 2015 injections, Dr. Noren noted that Petitioner reported the same level of pain, 2 out of 10, that he reported before the injections. Moreover, Petitioner that day demonstrated lumbar spine forward flexion of 90° without pain, and, potentially, Dr. Noren opined, that degree of forward flexion would be painful if the pain was coming from discs or facet joints. (Rx10)

On March 23, 2015, Dr. Jain recommended that he continue the Meloxicam, the anti-inflammatory, physical therapy and remain off work. (Rx10)

Dr. Noren testified that on August 24, 2015, Dr. Jain repeated the facet injections at the bottom 2 levels. Dr. Noren considered the repeat injections to be unreasonable and noted that there is no record that the initial treatment provided any pain relief: 2 out of 10 both before and after the injections. When Petitioner returned to Dr. Jain on August 31, 2015, he reported that his pain had worsened. However, Dr. Noren testified that it is not unusual when you place 4 different needles in someone's back that he might complain of pain. (Rx10)

Dr. Noren testified that on September 28, 2015, Dr. Jain recommended diagnostic medial branch blocks. Petitioner returned to Dr. Jain on January 11, 2016, at which time he reported 70% pain relief with those injections. There was no

physical examination. (Rx10) Dr. Jain repeated the medial branch blocks on January 18, 2016. There were 8 injections that day. (Rx10)

Then Dr. Noren noted that Dr. Jain did facet injections at the L4-L5 and L5-S1 levels but that those injections did not do any good as his pain score did not change. After the medial branch blocks, Dr. Noren noted, Dr. Jain proceeded with a diagnostic test for the medical branch radiofrequency ablation and added the L3-L4 level. In order to burn the nerves to three joints, Dr. Jain had to do 4 nerves on each side. Dr. Noren opined that there was no reason for him to have injected any of those injections. He further opined not only was it unreasonable, but Dr. Jain's choice of levels appears to be random based on his office notes, Dr. Goldvekht's office notes and the MRI. (Rx10)

Dr. Noren also explained the impact anesthesia has on the injections. He stated that the literature and guidelines of the American Society of Interventional Pain Specialists indicate that when one does medial branch blocks for the diagnosis and intention of doing radiofrequency ablation, one is supposed to do the procedure with minimal to no sedation because the sedation will affect the outcome of the diagnostic block. At the time of the medial blocks, Petitioner was given Propofol, a general anesthetic. (Rx10)

Dr. Noren noted that Dr. Jain proceeded to do the radiofrequency ablation on the left side on January 26, 2016 and the radiofrequency ablation on the right side on February 26, 2016. He also noted that when Dr. Jain went to do the radiofrequency ablation, he burned a nerve and the joint level above that he had not tested. That is, he then actually burned the nerves to L2-L3, L3-L4 and L5-S1. He did not even test for the L2-L3 joint but did the radiofrequency ablation at that level. (Rx10)

With regard to the right-sided radiofrequency ablation on February 26, 2016, Dr. Noren testified that the procedure was unreasonable for various reasons. Petitioner did not have facet joint pain because he had no pain with flexion or

extension. Petitioner did not have adequate medial branch blocks performed for diagnosis because he received general anesthesia. Moreover, he had radiofrequency ablation done on a level that was not even tested diagnostically. (Rx10)

Dr. Noren testified that when he saw Petitioner on August 24, 2016, an interpreter was present. Petitioner told him that he was a truck driver before, but that now he drives a van for a hotel. Petitioner complained of constant back pain and intermittent bilateral foot pain. Petitioner complained of neck and hand pain after a motor vehicle accident in August of 2016. Dr. Noren found that Petitioner exhibited an unusual response during the sensory examination. Although Dr. Noren used a paper clip for testing, Petitioner repeatedly withdrew his foot from the paper clip despite the fact that Petitioner told him he had decreased sensation in the foot. Dr. Noren found that to be a big inconsistency. He testified: "I have not really ever seen that before where somebody who has numbness withdraws in a behavior consistent with a sharp sensation." (Rx10)

Dr. Noren also testified that Petitioner exhibited an inconsistency when he tested for foot and ankle strength. Dr. Noren concluded that Petitioner has full strength in his legs. After speaking with Petitioner via an interpreter, reviewing the records and conducting a physical examination, Dr. Noren concluded that Petitioner had a lumbar strain related to his fall in 2014. This anesthesiologist found that the MRI showed no specific acute injury and that during his examination of Petitioner, and that he exhibited multiple fictitious findings that suggest symptom magnification. Dr. Noren found that Petitioner had reached MMI on the date he examined him. (Rx10)

With regard to the AMA impairment rating that he performed, Dr. Noren testified that he followed the guidelines in the AMA Sixth Guide. He used objective findings like the MRI, a physical exam, and then functional things like a pain disability questionnaire or Oswestry disability questionnaire. Petitioner's Oswestry

score was 40%, which implies that he has a significant impairment but is not crippled. In determining the actual level of impairment, Dr. Noren testified, he based the diagnosis on the MRI, which showed no herniation. That immediately put him into a Class 1 impairment. Then, since there was no specific objective finding that would result in his complaints, he would be anywhere from Class 0 to Class 1. So, based on a reasonable degree of medical certainty, Dr. Noren testified, he found that the maximum impairment would be 1% and the minimum impairment would be 0%. (Rx10)

Petitioner did not object to Dr. Noren's qualifications, including his curriculum vitae, his Section 12 report of August 24, 2016, or his AMA impairment report of August 24, 2016. (Rx10)

On cross-examination, Dr. Noren testified that he has been doing impairment ratings and IMEs for probably 8-10 years. The number of IME individuals would be 35 of his patient population. He earns 15-20% of his income from IMEs, AMAs, and record reviews. Over the years, Dr. Noren testified, he has given 1 speech to Chubb Insurance, 1 to Liberty Mutual Insurance, 1 to United Healthcare, and 2 to the Illinois Association of Case Managers and Rehabilitation Nurses. He did review two letters from Travelers Insurance. (Rx10)

For treatment of spondylosis, Dr. Noren could recommend a range of treatment options from just rest up to steroid injections. He would treat each patient based on individual circumstances. Part of Dr. Noren's opinion that the injections were not reasonable or necessary was based on the lack of relief and improvement that Petitioner experienced. Also, Petitioner had a good range of motion of his spine. Moreover, there was nothing to show that he had any impingement in the facet joint. Dr. Noren has injected a patient, the patient did not receive the expected relief, and he has proceeded with another injection. However, Dr. Noren testified, he would not have injected a patient like Petitioner, who had 2/10 pain. When a patient comes

in with a hypothetical diagnosis that should respond to a specific injection, and the patient does not get any relief, Dr. Noren would not repeat it. He would do some other diagnostic test or do something else to try to delineate the source of his pain. Dr. Noren agreed that one cannot determine 100% prior to giving a patient an injection if that patient will get relief. Depending on the circumstances, Dr. Noren would not repeat an injection if the first injection brought no relief. In the case of a patient with an objective pathology, e.g., one who has an L3-L4 disc herniation pushing on the L4 nerve root, if the patient receives no relief or short-lived relief, he might repeat the injection since he has a clear objective source of the pain. When one is injecting a patient's back for vague complaints of facet joint pain based on Dr. Jain's assessment, Dr. Noren would not repeat such an injection. (Rx10)

With regard to the sensory exam that Dr. Noren conducted on Petitioner, the idea is that a patient should not be withdrawing because there would not be pain if the area tested is numb. In the case of Petitioner, he actually withdrew before Dr. Noren even touched him, and Dr. Noren repeated it. Dr. Noren thought it is unusual for someone to withdraw when he sees a paper clip used for a sensory test. As Dr. Noren looked at his examination of Petitioner, he did not see anything that he would not describe as normal, with the exception of the sensory exam. Petitioner reported numbness, which Dr. Noren thought cannot be anatomically explained based on the MRI. (Rx10)

Dr. Noren opined that Petitioner did sustain an injury as a result of the November 25, 2014 incident. (Rx10)

On redirect examination, Dr. Noren testified that he has made 21 presentations over the course of 23 years. He presented to medical groups and some of them were insurance companies involved with workers' compensation. He has presented to attorneys, the Illinois Association of Workers' Compensation Attorneys, which he

believed had both Respondents and Petitioners present. He has presented to drug companies as well. (Rx10)

The evidence deposition of Michael D. Kornblatt, M.D., was taken on June 5, 2017. Dr. Kornblatt is board-certified in orthopedic surgery. (Rx7, Dep. Ex. 1) He authored an IME report dated February 5, 2015. (Rx7, Dep. Ex. 2, Rx1) Dr. Kornblatt testified that prior to authoring the IME (a/k/a Section 12) report, he reviewed the records of (1) Alexian Brothers Medical Group (2) Dr. Zimmers (3) Advanced Physical Medicine physical therapy, and (4) MRI scan of the lumbar spine dated January 13, 2015. Dr. Kornblatt noted Dr. Goldvekht's December 8, 2014 exam failed to show neurologic abnormalities, which included a negative straight leg raising test. Dr. Kornblatt opined that the MR images indicated diminished fluid within the disc space and normal facet joints. Dr. Kornblatt testified that Petitioner presented with normal age-related lumbar disc degeneration and no symptoms of radicular pain. After examining Petitioner, Dr. Kornblatt testified, he found no abnormal objective findings. (Rx7, pp. 15, 17) After speaking with Petitioner, examining him and reviewing his medical records, Dr. Kornblatt testified, he diagnosed him with a cervical train, a lumbar strain, and a contusion and causally related those injuries to the work incident. Dr. Kornblatt further testified that it was his opinion that Petitioner did not require any further treatment, which would include pain management/injections, or diagnostic testing. He opined that facet injections are warranted for patients who have facet abnormalities, such as arthritis, subluxation and sometimes a little fracture. He opined that Petitioner's condition did not warrant medial branch blocks or radiofrequency ablations. Taking everything into account, he further opined, Petitioner's subjective complaints of mild, non-specific back pain warranted no specific treatment. The doctor opined that the past conservative medical treatment, which included some physical therapy, was warranted. (Rx7)

Dr. Kornblatt felt that Petitioner did not warrant extensive time off work. However, at the time he examined Petitioner, he recommended 2 weeks of restricted work duty prior to reaching MMI. (Rx7)

On cross-examination, Dr. Kornblatt testified that he did not recall if a translator was present when he examined Petitioner. Dr. Kornblatt testified that he reviewed the actual MRI films and gave his own interpretation. When Dr. Kornblatt opined in his report that Petitioner could return to work after 2 weeks of restricted duty, that release related to his low back and neck conditions. Dr. Kornblatt testified that 40% of his time is devoted to IMEs. Dr. Kornblatt testified that he has no idea how much face-to-face time he had with Petitioner at the IME. (Rx7)

The deposition of Steven A. Barna, M.D., was taken on June 9, 2017. Dr. Barna testified that he is board-certified in anesthesiology and pain medicine. He testified that he spends 90+% of his time in a large orthopedic group treating mostly spine pain, back pain, and neck pain. He has been a panel physician utilization reviewer since 2013 for an independent company that provides URs for workers' compensation patients. At one time, Dr. Barna testified, he was asked to be medical director of the Massachusetts General Hospital Pain Center. (Rx8)

In performing the utilization review for this case, Dr. Barna used the "Official Disability Guidelines", 14th Edition, 2016, which is called ODG for short. The ODG is based on a consensus of available literature, or a meta-analysis. Dr. Barna testified that he authored a four-page utilization review report. (Rx8, Dep. Ex. 2, Rx2) He testified that the UR was for Esteban Hernandez for treatment received for the lumbar facet joint, which included the radiofrequency ablation on the left and right side. Dr. Barna testified that he was provided with 77 pages of medical records for the UR. The only things that may not have been provided to him were the actual reports of the imaging studies. He testified that he was asked to review the L3-L4, L4-L5, and L5-S1 facet joint injections done on February 9, 2015, the L4-L5 and

L5-S1 facet joint injections done on August 24, 2015, the medial branch nerve block at L3, L4, and L5 done on December 7, 2015, the medial branch nerve block at L3, L4, and L5 done on January 18, 2016, the radiofrequency ablation on the left at L2, L3, L4, and L5, which was done on January 26, 2016, and the radiofrequency ablation on the right at L2, L3, L4, and L5, which was done on February 2, 2016. (Rx8)

Dr. Barna testified that his summary of Petitioner's clinical condition was that he had a slip and fall in November 2014, underwent conservative care that included physical therapy and various medications, and complained of neck pain, thoracic pain, and lumbar back pain. Dr. Barna testified as to the ODG guidelines for facet joint diagnostic blocks. (Rx8, Rx2, page 2, 1-11) Dr. Barna then testified as to the ODG guidelines for facet joint intra-articular injections (therapeutic). (Rx8, Rx2, very bottom of page 2 and top of page 3, 1-5) Dr. Barna then testified as to the ODG guidelines for facet joint radiofrequency neurotomy. (Rx8, Rx2, middle of page 3, 1-6)

Dr. Barna, based on his review of Petitioner's records, the UR guidelines, and his own expertise, offered his analysis and clinical basis for his conclusions. First, he reviewed the January 26, 2015 note from Pain Care Specialists that indicates any radicular symptoms have subsided at this point, but there is some mention of some type of radicular symptoms. There is some low back pain still. Second, although Dr. Barna did not have the actual MRI report, the treating doctor's notes indicate some bulging and mild foraminal stenosis at L4-L5 and L5-S1, but no mention of any facet changes on the MRI and no mention of any abnormalities at L3-L4. Dr. Barna referred to the treating doctor's summary of the MRI results: two-millimeter end plate spurring and broad-based bulge with mild bilateral neuroforaminal stenosis at L4-L5 and L5-S1. (Rx8)

With regard to Dr. Jain's examination, which Dr. Barna found was "pretty brief", Petitioner complained of 2/10 pain that increased to 4/10 with activity. Then, Dr. Jain found actual pain with palpation along the paraspinal muscles as well as hypertonicity. But the range of motion was intact and caused a report of minimal pain with flexion and extension. Dr. Barna noted that Dr. Jain found no motor or sensory deficits, no focal weakness, and negative straight leg raising bilaterally. He opined Dr. Jain's assessment was that due to a lack of radicular symptoms, Petitioner's pain seems to be facetogenic in nature. He noted that Dr. Jain then referred him for bilateral L3-L4, L4-L5, and L5-S1 facet injections and recommended he continue with physical therapy and medications. (Rx8)

Dr. Barna testified that the ODG guidelines for therapeutic facet injections only allow two levels, but Dr. Jain did three levels. Moreover, Dr. Jain injected the L3-L4 level even though there is no mention, based on his review of the MRI, of any abnormality at L3-L4. Furthermore, Petitioner does mention a history of radicular pain, which implies leg symptoms. It is unclear if it was 1 or both legs. Dr. Jain's review of the MRI mentions no abnormality of the facet joint at L4-L5 or L5-S1. (Rx8) However, Dr. Jain's physical exam note does mention paravertebral tenderness and spasm, which does meet the criteria for an exam finding for facet joint. The exam does indicate there is minimal change or aggravation with any kind of flexion or extension. There is no note for rotation. (Rx8)

So, Dr. Barna concluded that the treatment Dr. Jain rendered to Petitioner on February 9, 2015 was not appropriate. (Rx8)

With regard to the August 24, 2015 therapeutic facet joint injections at L4-L5 and L5-S1, Dr. Barna also thought those were inappropriate, even if one were to allow the first set to be done. Under the ODG guidelines, a therapeutic facet injection is only allowed one time. (Rx8)

As to the December 7, 2015 treatment, the medial branch blocks, Dr. Barna testified that the problem is that there was no basis to have done the first and second therapeutic facet injections. Once the therapeutic facet injections were justified, at least once, then the doctor moves on to medial branch diagnostic with a plan to do the neurotomy. (Rx8)

With regard to the January 18, 2016 treatment, Dr. Barna gave the same answer as he gave for the last date of treatment. (Rx8)

As to the neurotomies that Dr. Jain performed on Petitioner of January 26, 2016 and February 2, 2016, Dr. Barna testified that he would give the same answer and stated that it is all based on a house of cards. He opined that there never should have been any facet joint treatment, therapeutic, and then medial branch block along the way. (Rx8)

Dr. Barna testified that non-certification means not approved and that it should not have been performed. Dr. Barna offered his opinions upon a reasonable degree of medical certainty and stated that none of his opinions have changed. (Rx8)

On cross-examination, Dr. Barna testified as to the signs or symptoms of facet joint pain. The classic symptoms include acute low back pain that stays in the back and does not radiate, particularly down an extremity. The signs would be physical exam findings, typically paravertebral, lumbar tenderness to palpation, usually some significant exacerbation with the patient extending or rotating and/or limitation to a significant degree and range of motion in either extension or rotation. Lack of signs would include a muscle spasm that could point toward some myofascial or trigger point or just to a deep tissue muscle or ligament - - or perhaps a radicular neurological finding or abnormality, a pinched nerve causing some kind of back pain. If there is an exacerbation of pain with flexion - - that is something that would facet joint-related pain. So, exacerbation of pain with flexion might point to a disc-related pain as opposed to a facet joint-related pain. (Rx8)

Dr. Barna was asked if radiation of pain into the extremities is something he would never expect to see or would not typically expect to see for facet joint pain. He explained that the predominant pain should be axial back pain, but a little bit of radiation toward the buttocks can be reported with facet joint pain. However, if there is pain shooting down into the leg, whether it be the groin, hip, front, back, above the knee, then that could be something that is related to an actual radicular symptom, depending on the level of nerve root that is involved. Alternatively, it can also sometimes be a disc-related pain. (Rx8)

Dr. Barna testified that he reviewed 77 pages of medical records, including Dr. Kornblatt's IME report of February 5, 2015. Such report indicates, *inter alia*, Petitioner's complaints of mid-lumbar back pain that sometimes radiates to the thoracic region and further Petitioner denial of radicular leg pain and a denial of an inability to sit, stand or walk. The report also indicates a tenderness with palpation to the upper lumbar spinous process. (Rx8) Dr. Barna did not recall reviewing Dr. Kornblatt's report before he wrote his own report. (Rx8)

Dr. Barna testified that he did not have the opportunity to review the actual report of the MRI taken of Petitioner's lumbar spine on January 13, 2015. Dr. Barna's understanding of Dr. Jain's interpretation of that MRI is that the only abnormalities cited were at L4-L5 and L5-S1 and that there was no mention of any facet changes by L4-L5 or L5-S1. Additionally, the only mention of changes was of some mild foraminal stenosis and some disc bulging at those two levels. (Rx8)

Dr. Barna testified that the extent of the records he reviewed are Dr. Jain's records, the Advanced Physical Medicine Surgical Group records, and the IME report. (Rx8)

Dr. Barna testified that it would not change his opinion to know that on January 19, 2015, Petitioner noted continued low back pain. If Petitioner complained on that date of low back pain aggravated by bending, Dr. Barna testified

that bending usually leads to facet joint pain and is usually more disc-related pain that is made worse with bending forward. So, low back pain aggravated by bending would not be supportive of facet joint pain. (Rx8) Dr. Barna had no comment with regard to whether low back pain aggravated by lifting, carrying, pushing or pulling would be supportive of facet joint pain. He opined that an inability to sit for long periods of time would support disc-related pain since sitting would relieve facet joint pain, whether it be a disc herniation, degeneration or bulging. (Rx8)

Dr. Barna testified that he recalls reviewing the second paragraph of Dr. Jain's Initial Evaluation in which Petitioner reported that after his injury, he continued to have headaches and lower back pain with occasional radiation of pain into his lower extremities. (Rx8) Dr. Barna did not have an opportunity to review a questionnaire completed by Petitioner on February 9, 2015. (Rx8)

Petitioner was given a pain relief worksheet to track his pain relief since his February 9, 2015 injections. (Px8, p. 15) Petitioner indicated that for the first hour after the procedure, he experienced a percentage of pain relief of 60-70%, for the day of the procedure, he experienced a percentage of pain relief of 50-60%, for the third day after the procedure, he experienced a percentage of pain relief of 40-50%, for the seventh day after the procedure, he experienced a percentage of pain relief of 30-40%, and, overall (no date given), since the beginning of treatment, he experienced a percentage of pain relief of 20-30%. (Px8, p. 15) On February 23, 2015, Petitioner rated his pain at 2 out of 10. (Px8, p. 21) On March 23, 2015, April 20, 2015, and May 18, 2015, Petitioner rated his pain at 3 out of 10. (Px8, pp. 26, 31, 36)

With regard to Dr. Jain's April 20, 2015 report in which he stated, overall, that Petitioner had a 70% improvement initially for several weeks following the February 9, 2015 injections, Dr. Barna recalled reading that. (Rx8) Dr. Barna had written in his UR report, regarding the need for the February 9, 2015 facet injections,

that the request is not supported. He also wrote that there was no indication that the patient had any facet joint pain, signs or symptoms and consequently non-certified such injections at L3-L4, L4-L5 and L5-S1. (Rx2, p. 3)

With regard to Dr. Jain's May 18, 2015 report in which he stated the patient had greater than 70-80% therapeutic response for over six weeks (following the February 9, 2015 injections) but the pain has returned as he attempted to return to a manually-oriented vocational situation, Dr. Barna stated that he was provided with this report. (Rx8) Dr. Jain continued to recommend a second set of facet joint injections at L4-L5 and L5-S1. In his UR report, regarding the need for the December 7, 2015 medial branch blocks, Dr. Barna wrote that there was no indication the patient received greater than 70% improvement in pain with the diagnostic injections to warrant a medial branch block. (Rx2, p. 3)

With regard to Dr. Jain's June 15, 2015 report in which he stated that the pain relief was 70%, however the pain has returned, Dr. Barna recalled reading that. (Rx8)

Dr. Barna testified that in preparing his UR report, and with regard to the request for the August 24, 2015 injections, he wrote: "It is unclear if that patient had 70 percent improvement with the previous facet joint diagnostic block." (Rx8, pp. 63-64)

On August 31, 2015, following the August 24, 2015 therapeutic injections to Petitioner's facet joints, Dr. Jain's assistant wrote: "Pain worse since injections. Patient says he can't do full-duty. Can't lift 50 pounds." (Px8, p. 53) Yet on that same day, he rated his pain at 3 out of 10. (Px8, p. 54)

Dr. Barna recalled reading Dr. Jain's report dated September 28, 2015. (Rx8)

Petitioner was given a pain relief worksheet to track his pain relief since his December 7, 2015 injections. (Px8, p. 63) Petitioner indicated that for the first hour after the procedure, he experienced a percentage of pain relief of 30-40%, for the day of the procedure, he experienced a percentage of pain relief of 20-30%, for the

third day after the procedure, he experienced a percentage of pain relief of 20-30%, and for the seventh day after the procedure, he experienced a percentage of pain relief of 20-30%. (Px8, p. 63)

Dr. Barna recalled opining in the UR report, with regard to a request for treatment rendered on January 18, 2016, that there was no indication the patient received 70% pain relief initially, plus 50% pain relief for six weeks with the previous medial branch blocks. (Rx8) Dr. Barna recalled reading Dr. Jain's January 11, 2016 office note in which he wrote that the patient had 70% improvement for approximately 5 days. (Rx8)

In preparation for giving his opinion, Dr. Barna testified, he was not provided with pain scales completed by Petitioner for dates of service before or after August 24, 2015. (Rx8)

Petitioner was given a pain relief worksheet to track his pain relief since his January 26, 2016 procedure. (Px8, p. 69) Petitioner indicated that for the first hour after the procedure, he experienced a percentage of pain relief of 60-70%, for the day of the procedure, he experienced a percentage of pain relief of 40-50%, for the third day after the procedure, he experienced a percentage of pain relief of 40-50%, for the seventh day after the procedure, he experienced a percentage of pain relief of 40-50%, and, overall (no date given), since the beginning of treatment, he experienced a percentage of pain relief of 40-50%. (Px8, p. 69)

On redirect examination, Dr. Barna testified that a pain relief scale is not the only basis on which to recommend the treatment Petitioner received. He testified that Petitioner's pain scale from August 24th contradicts what Dr. Jain wrote. Dr. Barna further testified that the inconsistency in that one pain scale is only one part of the denial. The other more important basis is "what's the diagnosis here" and "what's the appropriate direction" as opposed to an inappropriate direction leading to risk without benefits. (Rx8)

On recross examination, Dr. Barna testified that in forming his opinion, it is important for him to have all the medical records that are pertinent or could be pertinent to him. Dr. Barna felt that the most important records were those of Dr. Jain's because he was the physician on the ground who was assessing Petitioner and reviewing available information, including imaging or exam findings. After all, Dr. Jain put out the diagnosis of lumbar radiculopathy and lumbar discogenic pain. Furthermore, Dr. Jain's review of the MRI in no way points to facet joint pain. Also, Dr. Jain should have done his own theoretical review of the August 2015 pain scale completed by Petitioner, which was contradictory to his own assessment, and should not have proceeded any further with facet procedures. (Rx8)

Finally, Dr. Barna testified, if he were to learn that at the end of the day, after his neurotomy, that Petitioner is pain free and having a fully meaningful life back to work, then the proof would be in the pudding. He testified that he does know what the outcome is, but from the information he had, at no point was the facet joint the way to go. (Rx8)

The deposition of Bobby Enkvetchakul, M.D., was taken on July 6, 2017. (Rx9) Dr. Enkvetchakul is board-certified in occupational and environmental medicine. (Rx9, Dep. Ex. 1) He testified that evidence-based guidelines are based on scientific literature, not just opinions. He further testified regarding his review protocol and utilization of the ODG guidelines as the reasonable standard for medical professionals. Dr. Enkvetchaku was asked to conduct a retrospective UR. He reviewed 34 pages of medical records. He knew that Petitioner sustained a lumbar strain as a result of a slip and fall on November 25, 2014. He did not know how exactly many PT sessions Petitioner had completed prior to the start date, February 17, 2015, of the period he was reviewing. He authored a UR report dated April 21, 2017. (Rx9, Dep. Ex. 2) The ODG guidelines state that for a lumbar strain or sprain, they recommend 10 visits or 8 weeks. He testified that it was his opinion

that PT after February 17, 2015 was not recommended. Dr. Enkvetchakul's curriculum vitae and UR report were not objected to by Petitioner's counsel at the time of deposition. (Rx.9)

On cross-examination, Dr. Enkvetchakul testified that he did not have any physical therapy notes or records from Advanced Physical Medicine, Pinnacle Pain Management, or any diagnostic, MRI, or other imaging. Dr. Enkvetchakul reiterated that he performs 6-8 URs per day for the last number of years and about 25-33% of his day is spent working on URs. The ODG guidelines state that for a lumbar strain or sprain, they recommend 10 visits over 8 weeks. The ODG does not specifically outline an exact treatment plan for any particular condition. Dr. Enkvetchakul's understanding was that Petitioner started a course of physical therapy in December 2014. It appears that Petitioner attended at least 10 PT sessions over 8 weeks. For any type of medical treatment, particularly on a retrospective basis, Dr. Enkvetchakul looks at whether it was an effective treatment. Did it help the patient in some way, even subjectively? He did not see any change in Petitioner's condition and really did not see any change in his subjective complaints despite ongoing treatment. In Dr. Enkvetchakul's practice, he would not have continued this treatment. He testified that he did not have any of Petitioner's treating medical records before February 11, 2015 or after March 26, 2015. (Rx9)

Regarding his work status, Petitioner testified that after 3 months, he returned to work for Respondent but did not perform his regular duties. His doctor put him on a 20-pound lifting restriction and Respondent partially accommodated him. Petitioner worked light duty. However, Petitioner continued, they asked him to work too much and he would end up vomiting and leaving work to go to the doctor. Petitioner testified that he felt he could not do the job anymore. (Tr. 39-40, 88). He applied for employment with a temporary agency around February 2015. (Tr. 57). He worked as a machine operator, a cleaner for a flower shop, and a cleaner of metal

machinery. (Tr. 61-63). He testified that he was paid more at the jobs than what he earned while working for Respondent. (Tr. 41-42). One job paid $.25/hour more and another job paid $1.00/hour more. Petitioner did not provide any information as to the exact time of employment and duration of employment. Sometime between February and March 2015, Petitioner applied for unemployment benefits. (Tr. 63). Petitioner testified that he did not voluntarily terminate his employment with Respondent. Respondent showed Petitioner Rx13, which was admitted for impeachment purposes only. (Tr. 65-68, Rx13).

In January 2016, Petitioner applied for a job at O'Hare Inn and Suites as driver who transported hotel guests and their luggage to and from the airport. (Tr. 69-70). Petitioner said that he noticed that this position was light-duty. Petitioner testified that he tries not to pick up the heavy bags and that he is not obligated to help a guest with his or her luggage; "it's only if you want to help the client." He is currently working two part-time jobs as a driver for two different hotels. (Tr. 75). Petitioner did not testify as to his current earnings.

On August 12, 2016, Petitioner was involved in a motor vehicle accident while working for another employer, O'Hare Inn and Suites. (Rx. 15) Petitioner claimed back, neck and shoulder injuries. (Tx. 71-72). Petitioner testified that the MVA "aggravated" his low back condition. He stated: "It was the lower back and the shoulders, the same three areas." (Tr. 71-72). Dr. Burgos' record of August 30, 2016 indicates that on August 12, 2016, Petitioner was driving a van and was hit from behind. Petitioner complained of lower back pain, leg pain, neck pain, and weakness of both legs. (Rx16) Petitioner testified that when the ambulance arrived after the MVA, he reported pain in his head, neck and lower back. (Tr. 72-73) He treated with Dr. Burgos and another doctor, who said Petitioner needed physical therapy. (Tr. 72-73) Petitioner had physical therapy but no injections. Dr. Burgos told Petitioner that he can go back to work. (Tr. 73-74)

Petitioner testified that as a result of his injuries he sustained, he notices that just his lower back continues to bother him. (Tr. 45) When he works long hours, Petitioner testified, he has a lot of pain. There were about 2-3 times that he was unable to sleep due to the pain. He currently experiences low back pain and rates it, on a 10-point scale, a 2 on the low end and a 4-5 on the high end. (Tr. 45-46).

Petitioner has not made a claim for disfigurement of his forehead and no forehead scar was apparent when he testified.

II. Conclusions of Law

In support of his decision relating to issue (C) "Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?", the Arbitrator finds the following:

In order for an injury to be compensable under the Act, it must have arisen out of and in the course of the claimant's employment. 820 ILCS 305/2. An injury arises out of a claimant's employment if the injury is causally connected to the employment. *Hosteny v. Illinois Worker's Comp. Comm'n*, 397 Ill.App.3d 665, 676 (1st Dist. 2009). Specifically, "the origin or cause of the injury must be some risk connected with the claimant's employment." (Id.)

Petitioner testified that on November 25, 2014, while making a delivery for Respondent, he slipped and fell on ice while getting out of his truck. He further testified that he treated that day at Alexian Brothers Medical Center for injuries he sustained from such slip and fall. Petitioner also testified that he called his boss soon after the injury occurred and that Robert and Francisco, both from Respondent, arrived a half-hour later.

As the medical records of Alexian Brothers Medical Center corroborate his testimony that he hurt his head and low back and as Respondent called no witnesses to rebut Petitioner's testimony regarding the accident, the Arbitrator finds that on

November 25, 2014, Petitioner sustained an accident that arose out of and in the course of his employment by Respondent.

In support of his decision relating to issue (F) "Is Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator finds the following:

Petitioner claims that as a result of the November 25, 2014 accident, he sustained a laceration to his forehead and an injury to his facet joints. In Petitioner's Application for Adjustment of Claim, he alleged that he sustained an injury to his head and back. (Ax2)

Respondent claims that as a result of the November 25, 2014 accident, Petitioner sustained a superficial laceration of the forehead and a lumbosacral strain. (Rx5) On February 5, 2015, Dr. Kornblatt also noted that Petitioner had sustained a cervical strain, which had resolved. (Rx1)

With regard to his head injury, on direct examination, Petitioner was asked if "prior to November 25, 2014" he was "experiencing any medical conditions or any symptoms involving [his] head, [his] back or his shoulders." Petitioner replied "No." (Tr. 26) On cross-examination, when asked if it was still his testimony that he did not treat for his head prior to November of 2014, Petitioner replied "Yes." (Tr. 78) Respondent's counsel asked: "Isn't it true that this particular record indicates prior left temporal lobe trauma that necessitated surgery?" Petitioner replied: "That happened in 1987, and it wasn't the left. It was the right side." Petitioner did recall such prior treatment for his head. (Tr. 81-82)

Petitioner testified that on November 25, 2014, as he fell, he "bounced off the door" and hit his forehead. Petitioner further testified that he lost consciousness for about three seconds. (Tr. 17) However, on December 8, 2014, Petitioner told Dr. Goldvekht that on November 25, 2014, "he parked his truck and was exiting when

he slipped on ice and fell injuring his lower back" and that "as he was getting up he struck his head injuring his neck and experiencing (sic) a severe headaches (sic) instantly." (Px3, p. 4)

Then, on January 26, 2015, Petitioner saw Dr. Jain. He reported that he sustained an injury on November 25, 2014. Dr. Jain also recorded the following:

> "He relates that he was getting out of his car and there was ice on the ground. As he was getting out of his car, he split and his feet came out from under him. He landed on his back, his head bounced off the ice and came back up and hit the door of the truck causing a laceration on his forehead." (Px8, p. 4)

As previously noted, Petitioner testified that when he fell, he lost consciousness for about 3 seconds. Yet, none of the medical records reflect that Petitioner suffered a loss of consciousness. Petitioner also testified that a bandage was applied to his head and that he received 3 stitches in his forehead, but none of the medical records reflect such treatment. The Arbitrator notes that Petitioner did not offer into evidence the medical records of Alexian Brothers Medical Group.

Alexian Brothers Emergency Department physician Christophe Serpico, M.D., diagnosed Petitioner with a contusion of the head and lists his language as "English." (Px1, p. 6)

Petitioner testified that as a result of the injuries he sustained, he notices that *just* his lower back continues to bother him. (Emphasis added.) (Tr. 45)

The Arbitrator considers the injuries Petitioner sustained as a result of the August 12, 2016 motor vehicle accident to be a temporary aggravation of a pre-existing condition. Petitioner underwent a course of physical therapy but no injections following the MVA. The Arbitrator bases his conclusion on Petitioner's

testimony and Dr. Burgos' records. (Rx16) Moreover, Dr. Noren examined Petitioner 12 days after this MVA and noted that Petitioner complained of neck and hand pain. (Rx10)

The Arbitrator gives little weight to Dr. Enkvetchakul's opinions since he did not review many of Petitioner's treating records.

The Arbitrator finds, by a mere preponderance of the evidence, that Petitioner's conditions of ill-being of his lumbar facet joints and his contusion/superficial laceration to his forehead are causally related to the accident.

Evidence in favor of causal connection of facet joint injuries:

1. Dr. Jain's opinions, including his opinion that Petitioner has recalcitrant low back pain
2. Petitioner documented that he experienced pain relief after the February 9, 2015 injections, after the December 7, 2015 medial branch blocks, after the January 26, 2016 ablation, and after the February 2, 2016 ablation.
3. The treating medical records
4. Positive Kemp's test, bilaterally, as found by Dr. Goldvekht on December 8, 2014, January 5, 2015, and January 19, 2015
5. Negative straight leg raising test, as found by Dr. Goldvekht, Dr. Kornblatt, and Dr. Jain
6. Petitioner's complaints to Dr. Kornblatt
7. The radiologist's interpretation of the January 13, 2015 MRI, which included facet hypertrophy at T12-L1, L4-L5, and L5-S1, and bilateral facet hypertrophy at L1-L2, L2-L3, and L3-L4.
8. Dr. Barna's opinions are flawed since he was not provided with all the medical records before he offered his opinions

Evidence against causal connection of facet joint injuries:

1. Dr. Noren's opinions, which include his findings of axial back pain but also fictitious findings and positive Waddell signs
2. Dr. Kornblatt's opinions, which includes his interpretation of the January 13, 2015 MRI as showing facet joints within normal limits
3. Dr. Barna's opinions, which include his opinion that minimal pain with flexion and extension of the lumbar spine is not indicative of facet joint problems
4. Petitioner's mention to Dr. Jain on January 26, 2015 of occasional radiation of pain into his lower extremities
5. In his treating records, Dr. Jain lists three diagnoses: lumbar discogenic pain, lumbar facet syndrome, and lumbosacral radiculopathy
6. There is some variation between Petitioner's reports of pain relief at follow-up visits to Dr. Jain and his self-reported pain scales
7. Neither Dr. Jain nor Dr. Goldvekht testified to more fully explain their findings and conclusions

Finally, despite the inconsistencies in the histories of his head injury as a result of the accident, the Arbitrator finds Petitioner to be credible. Notwithstanding his recalcitrant back pain, Petitioner was certainly motivated to return to work.

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

Section 8.7(i)(3) of the Act states:

"An employer may only deny payment of or refuse to authorize payment of medical services rendered or proposed to be rendered on the grounds that the extent and scope of medical treatment is excessive and unnecessary in compliance with an accredited utilization review program under this Section."

Therefore, in addressing Respondent's denial of medical based on reasonableness and necessity, the Arbitrator only considers the findings and opinions of the treating physicians, which include Dr. Jain and Dr. Saeed, and the findings and opinions of the UR physicians, Dr. Barna and Dr. Enkvetchakul.

After carefully reviewing the evidence, the Arbitrator finds that all of the medical treatment, as laid out in Petitioner's Exhibits 1-13, is both reasonable and necessary in treating the accidental injuries. Petitioner did receive pain relief, albeit temporary, from the injections and ablations.

The Arbitrator further finds that Respondent has not paid for all appropriate charges for that reasonable and necessary medical treatment as documented in the itemized billing statements of Petitioner's Exhibit numbers: 4, 5, 9, 11, & 13, and orders payment thereof.

The Arbitrator relies on the treating medical records and finds Dr. Jain's opinions to be more persuasive than the opinions of Dr. Barna and Dr. Enkvetchakul. Dr. Jain stated:

"It is my opinion that the patient's symptoms for which he is being seen today are directly related to the injury. It is my opinion that the treatment rendered thus far has been reasonable and of necessary frequency and duration. These opinions are stated to a reasonable medical probability. These opinions are based on patient's history, physical exam, imaging studies, and medical records that I have been provided and reviewed thus far." (Px8)

The Arbitrator is not persuaded by the opinions outlined in the utilization review reports and therefore gives them less weight. Neither Dr. Barna nor Dr. Enkvetchakul reviewed all of Petitioner's treating records before formulating their opinions.

Respondent shall satisfy the $110,498.84 in outstanding medical charges (itemized below), pursuant to Section 8(a) and subject to Section 8.2 of the Act, as such charges were incurred for the reasonable and necessary medical treatment that is causally related to the November 25, 2014 accident. The breakdown is as follows:

1. Advanced Physical Medicine (Px. 4)..... $1,846.15
2. EQMD, Inc (Px. 5)..... $4,142.69
3. Pinnacle Pain Management Specialists (Px. 9).....$29,115.00
4. APM Surgical Group (Px. 11)..... $69,150.00
5. Addison Medical Associates (Px. 13)..... $6,245.00

TOTAL **$110,498.84**

Respondent shall be given a credit of $19,529.72 for medical benefits that have been paid as outlined in Respondent's Exhibit #12.

Respondent is not liable for any treatment rendered as a result of Petitioner's August 12, 2016 motor vehicle accident.

In support of his decision relating to issue (K) "What temporary benefits are in dispute? TPD and/or TTD", the Arbitrator finds the following:

With regard to TPD benefits, Petitioner failed to prove his entitlement to TPD benefits. Before he began his part-time jobs as driver for Residence Inn and Renaissance Hotel, and prior to his employment with O'Hare Inn & Suites, Petitioner worked for 3 employers. Petitioner did not provide the names of the 3 employers, the 3 dates on which he began working, and the exact amount he earned for each one. As there is insufficient evidence to award TPD benefits, the Arbitrator denies Petitioner's claim for TPD benefits.

With regard to TTD benefits, the Arbitrator notes that the November 25, 2014 referral note from Alexian Brother Medical Center listed Petitioner's current work capacity as "Unknown." Petitioner testified that at that time, he received a slip from Alexian Brothers that restricted him from lifting or pulling more than 25 pounds, but that Respondent did not respect such restrictions. Petitioner testified that he sought a second opinion from Advanced Physical Medicine. Dr. Goldvehkt at Advanced Physical Medicine kept Petitioner off work completely from December 8, 2014 through February 16, 2015 and Dr. Jain kept Petitioner off work completely from January 26, 2015 through at least the end of February 2015.

In the March 4, 2015 record of Addison Medical Associates, Dr. Saeed wrote: "Patient cannot work today due to weakness and is able to return to work tomorrow." (Px12)

In Dr. Jain's March 23, 2015 follow-up note, he stated that Petitioner has returned to work with a 20-pound lift, however, he is complaining of severe back pain and mid-thoracic pain. (Px8, p. 22)

Petitioner testified he that he started working at a new job in April or June of 2015. (Tr. 60-61) In April of 2015, Petitioner testified, he filed for unemployment benefits. (Tr. 64)

Petitioner testified that he applied for the job of driver for O'Hare Inn & Suites in January 2016, but that he is currently working a part-time job as a driver for Residence Inn and a part-time job as a driver for Renaissance Hotel.

The Arbitrator finds that Petitioner is entitled to temporary total disability benefits of $407.06/week for 14-1/7 weeks, commencing November 26, 2014 through March 4, 2015, as provided in Section 8(b) of the Act. Respondent is entitled to a credit in the amount of $3,896.24 for temporary total disability benefits that they have paid Petitioner.

In support of his decision relating to issue (L) "What is the nature and extent of the injury?", the Arbitrator finds the following:

Pursuant to Section 8.1b of the Act, for accidental injuries that occur on or after September 1, 2011, the following criteria are to be used in the determination of permanent partial disability:

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

Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

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

With regard to subsection (i) of §8.1b(b), the reported level of impairment pursuant to subsection (a), the Arbitrator notes that the record includes an impairment rating of 0% to 1%, as determined by Dr. Noren, Respondent's Section 12 physician, pursuant to the 6th Edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment ("Guides"). (Tr. 48, Rx6, Rx10, Dep. Ex. 3) Dr. Noren made a Diagnosis Based Impairment and referred to Table 17.4 of the Guides. The Arbitrator therefore gives moderate weight to Dr. Noren's impairment rating and finds that this evidence weighs in favor of decreased permanency.

With regard to subsection (ii) of §8.1b(b), the occupation of the injured employee, the Arbitrator notes the record reveals Petitioner was employed as a delivery truck driver at the time of the accident. On the date of accident, Petitioner was to unload 2 pieces that weighed 60-80 pounds each. Petitioner testified that, following his post-accident treatment, he returned to a light-duty job for Respondent.

However, because Respondent required him to work too much and he was unable to do it, he discontinued working for Respondent. (Tr. 38-40) Petitioner did not undergo an FCE after his second ablation. No job description of his full-duty position with Respondent was offered into evidence. Although Dr. Kornblatt and Dr. Noren released him to return to full-duty work, his treating physician, Dr. Jain, has not. Dr. Jain wrote, on January 11, 2016, the following: "He has been put on modified duty and has completed physical therapy." Petitioner is currently working two part-time jobs as a driver transporting guests to and from two different hotels. Petitioner testified that he asked for part-time work because he feels that he cannot do full-time work. Petitioner testified that he tries not to pick up heavy bags and that he is not obligated to help a guest with his or her luggage; "it's only if you want to help the client." The Arbitrator finds that these facts weigh in favor of increased permanency. The Arbitrator gives moderate weight to this factor.

With regard to subsection (iii) of §8.1b(b), the age of the employee at the time of the injury, the Arbitrator notes the record reveals Petitioner was 50 years old. The Arbitrator takes judicial notice that Petitioner has expended more than ⅔ of his work life (18 → 65). The Arbitrator gives minor weight to this factor. He finds that Petitioner's age weighs in favor of slightly decreased permanency as he has somewhat fewer years of productivity remaining.

With regard to subsection (iv) of §8.1b(b), the employee's future earning capacity, the Arbitrator notes the record reveals no evidence was offered as to Petitioner's current earnings in his part-time jobs as a driver for Residence Inn and a driver for Renaissance Hotel. The Arbitrator gives minor weight to this factor. He finds that the facts weigh in favor of slightly increased permanency.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the record reveals that as a result of the accident, Petitioner underwent physical therapy, took prescription pain medication, received a set of bilateral diagnostic lumbar facet injections, a set of bilateral therapeutic lumbar facet injections, two sets of bilateral medial branch blocks, a radiofrequency ablation on the left at L2, 3, 4, 5 and at the dorsal root of L5, and a radiofrequency ablation on the right at L2, 3, 4, 5 and at the dorsal root of L5. Dr. Jain, the treating physician, wrote, on January 11, 2016, that Petitioner has been put on modified duty. The Arbitrator gives major weight to this factor. He finds that these facts weigh in favor of increased permanence.

Determination of permanent partial disability ("PPD") is not simply a calculation but is an evaluation of the five factors. The Arbitrator has carefully considered all five factors. By applying §8.1b and by considering the relevance and weight of all five factors, the Arbitrator finds that as a result of the November 25, 2014 accident, Petitioner has sustained a permanent loss of use of his person as a whole to the extent of 14%, pursuant to Section 8(d)2 of the Act.

Brian T. Cronin

Arbitrator

2-6-2019

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF ST. CLAIR)

☒ 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 Glasgow,

Petitioner,

vs. NO: 18 WC 21718

Christy Industrial Services,

Respondent.

20IWCC0201

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 5, 2019, 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.

20IWCC0201

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $21,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 24 2020
MP:yl
o 2/4/20
68

Marc Parker

Maria E. Portela

DISSENT

I disagree with the majority's decision. I would find that Petitioner failed to prove he sustained an accident arising out of and in the course of his employment and failed to prove his condition is causally related to the accident of April 26, 2018.

> It is the burden of every Petitioner before the Workers' Compensation Commission to establish with evidence every disputed issue litigated at trial, including issues establishing Respondent's liability for benefits. *Board of Trustees of the University of Illinois v. Industrial Comm'n.*, 44 Ill.2d 207 at 214, 254 N.E. 2d 522 (1969), *Edward Don v. Industrial Comm'n.,* 344 Ill.App3d 643, 801 N.E.2d 18 (2003). A claimant must establish her current condition of ill-being is causally related to her asserted accident. *Sisbro, Inc. v. Industrial Comm'n.*, 207, Ill.2d 193, 203 (2003*); Land and Lakes Co. v. Industrial Comm'n.,* 359 Ill.App.3d 582, 591-92 (2nd Dist. 2005).

The credible evidence shows Petitioner failed to prove he sustained a work-related accident. Jason Twiggs, Superintendent, testified on behalf of Respondent. He worked in the same cyclone as Petitioner every day Petitioner was on site. During the 6 days Petitioner with Mr. Twiggs, Petitioner never advised him of any work-related injury.

In fact, Petitioner called Mr. Twiggs on April 27, 2018, advising he would not be in because of shoulder soreness. (RX1) Petitioner told Mr. Twiggs he was lifting his son's dirt bike into the

back of a pickup. (T.109-110) Petitioner's own testimony corroborates his statement to Mr. Twiggs. He testified he told Mr. Twiggs he hurt his arm somehow with the bikes or the motorcycles. (T. 34) Petitioner continued to text Mr. Twiggs and advised him he wasn't going to make it in because of shoulder fatigue. (T.98) Mr. Twiggs advised Petitioner he was looking to be finished with the job and needed to be getting rid of guys. (T. 98) Petitioner was advised he'd be receiving a check in the mail. (T. 98) As Petitioner had not reported a work injury between April 20 - April 26, 2018, while he was still working, or April 27, 2018, when he called in sick, or during his text communications with Mr. Twiggs after April 27, there was no accident investigation or drug test performed. (RX1) Petitioner did not seek medical treatment until after the lay-off.

On May 14, 2018, Petitioner submitted an e-mail through Respondent's website stating he hurt his shoulder at the job and needed medical attention. (RX1)

Greg O'Brien, Project Manager, testified on behalf of Respondent. Mr. O'Brien testified that he completed an Investigation Report after being notified Petitioner was claiming a work-related injury. (T. 80) Mr. O'Brien wrote on page 2, "...that several employees report that his shoulder was hurt at home lifting his son's dirt bike." (T. 83) (RX1) Mr. O'Brien testified he spoke to those employees himself, specifically, "Jason, Dennis, Ron O'Toole and Tommy Stephens." (T. 83) Jason Twiggs completed the witness statement on page 1 of the Incident Investigation Form and stated, "Scott Glasgow stated on April 26, 2018, that he had injured himself lifting his son's dirt bike into his pickup truck. He did not come to me for medical attention." (RX1) Likewise, Dennis Woodruff completed witness 2 statement on the investigation form and stated, "Scott Glasgow said he hurt himself at home." (RX1) Petitioner corroborated this statement himself admitting at arbitration he told Mr. Woodruff he hurt his shoulder somewhere else. (T. 36)

Mr. O'Brien further testified he saw Petitioner at the worksite during those 6 days and Petitioner neither reported an injury to his shoulder nor asked to be changed to a different position. (T. 80)

Based on Petitioner's statements to multiple co-workers made during the 6 days he worked for Respondent before he was laid off, corroborated by Petitioner himself, the simple inference is that Petitioner injured his right shoulder lifting his son's dirt bike.

Despite telling multiple co-workers he injured his shoulder lifting his son's dirt bike into a pickup truck, Petitioner incredibly denied injuring his right shoulder outside of work. He admitted his son does race but they had a trailer for the bikes and customarily he did not put the bikes in the bed of the pickup truck. The Arbitrator noted Petitioner's credibility was in question due to the prior inconsistent statements but indicated those statements were due to potential future work activities.

Petitioner's justification for telling his co-workers his accident happened lifting dirt bikes is simply not credible. Petitioner testified if he reported a work-related accident, he might be "labeled" or may not be called back to jobs they had. (T. 35) However, Petitioner admitted he did

not actually know how Respondent would react. (T. 35) Furthermore, Petitioner called in sick on April 27 and continued to text Mr. Twiggs advising he would not be in. If Petitioner was concerned about being "labeled", surely calling in sick on a two week job would cause Respondent to apply a "label" if Petitioner's rationale is to be believed. It was not until after Petitioner was laid off that Petitioner said he injured his shoulder at work. Petitioner's change in stories depending on when it benefited him, at a minimum, casts doubt on his credibility. Absent credible testimony, Petitioner has not proven his case by a preponderance of the evidence. The credible evidence shows Petitioner injured his right shoulder lifting his son's dirt bike into the back of a pickup truck. Therefore, the decision should be reversed.

Assuming *arguendo* Petitioner is credible, the evidence does not support a finding Petitioner sustained a compensable accident under a repetitive trauma theory or his condition was caused by work activities. A claimant who alleges injury based on repetitive trauma must show that the injury is work related and not the result of the normal degenerative aging process. *Peoria County Belwood Nursing Home v. Industrial Comm'n.*, 115 Ill.2d 524, 530, 505 N.E.2d 1026, 106 Ill.Dec. 235 (1987). A claimant who seeks an award of benefits under a repetitive trauma theory is held to the same standard of proof as a claimant seeking benefits for a sudden, traumatic injury. *Durand v. Indus. Comm'n.*, 224 Ill.2d 53, 64 (2006). In repetitive trauma cases, the claimant generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability. *Nunn v. Industrial Comm'n.,* 157 Ill.App.3d 470, 477, 510 N.E.2d 502, 109 Ill.Dec 634 (1987). "In those cases where the courts sustained a theory of repetitive trauma, the claimant in each one conclusively established a repetitive job task. In each case, the claimant performed the same task in a repetitive fashion on a daily basis." *Williams v. Industrial Comm'n*, 244 Ill. App. 3d 204, 211, 614 N.E.2d 177, 181, 185 Ill. Dec. 43, 47 (1st Dist. 1993).

It is undisputed Petitioner began working as a bricklayer for Respondent on April 20, 2018, and worked until April 26, 2018, the accident date. Before he began working for Respondent in April 2018, Petitioner felt weakness and soreness in his right shoulder. (T. 30) Petitioner testified that after the first day of work, his arm was very sore and weak. (T. 31) Petitioner's own testimony shows he was symptomatic before he began working for Respondent and complained of the same symptoms after one day of working for Respondent.

In addition, Respondent offered the medical opinion of Dr. Kostman, Respondent's Section 12 physician, who reviewed Petitioner's work activities. Dr. Kostman was provided a history by Petitioner of using a 15 pound pneumatic gun for 10 hours over 3-4 days, with a break for lunch. (RX7, p. 10) Petitioner also advised he was operating off of a 50-150 PSI pressure, reaching and holding the device with his arms at 90 degrees of flexion at the elbow and that he would raise his arms from 0 to 45 degrees of forward flexion to do the tamping process. (RX7, p. 10) His report noted the MRI findings, degenerative changes and absence of biceps within the joint, and opined that was consistent with a chronic rotator cuff tear. Dr. Kostman reviewed the witness statements of Petitioner reporting an injury lifting a dirt bike onto a pickup truck. (RX6) He noted Petitioner's complaints of shoulder pain and weakness in the right shoulder after lengthy use of a pneumatic

ram tool. He further noted Petitioner frequently manipulates dirt bikes and "he has had some degree of right shoulder pain over the last two years with reaching away from his body when manipulating these." (RX, p. 18)

After receiving a history from Petitioner, reviewing documentation, medical records and diagnostic studies, Dr. Kostman opined that Petitioner's right shoulder condition was a chronic rotator cuff tear and long head biceps tear. (RX7, p. 16) Dr. Kostman further opined the development of the tears were not consistent with the activities described of April 26, 2018, but were of a longstanding history of shoulder pain over two years as Petitioner described to him. (RX7, p. 19) He further opined that using a pneumatic device and the positions described is not consistent with the development of a rotator cuff tear. (RX6)

Dr. Kostman believed reaching overhead with any heavy activities could aggravate Petitioner's chronic rotator cuff tear but, he noted, that was not what Petitioner described to him. (RX7, p. 45) Thus Dr. Kostman opined Petitioner's condition was not caused by his work activities.

In contrast, the opinion of Richard Howard, D.O., Petitioner's Section 12 examiner, is based on an inaccurate history. He testified he understood Petitioner was working overhead more than half a day. (PX3, p. 23) However, Mr. Twiggs' testified he performed all of the overhead work in the cyclone because he was more experienced, and he was faster. (T. 96) Mr. Twiggs' unbiased testimony is more credible and reliable than Petitioner's testimony thus the basis for Dr. Howard's opinion is flawed.

Also, Dr. Howard noted Petitioner advised him the pneumatic gun was supposed to be operating at 70-80 PSI's but was actually running at 150 PSI's. (PX2) Mr. Twiggs testified that the PSI on the pneumatic gun Petitioner was using is run at 80 to 85 PSI's. (T. 92) Mr. Twiggs further testified that the guns do not run at 150 PSI's, because it would "blow the heads off them". (T. 93) Again, Mr. Twiggs' testimony is more credible than Petitioner's and Dr. Howard's opinion is based on an inaccurate history.

Finally, Dr. Howard's causation opinion is based on an inaccurate history regarding how long Petitioner was bricklaying. Dr. Howard testified, "...And I would also add that for his age, being a bricklayer, that he's in what I'd call a high risk group. In my 30 years of clinical experience, if I look at bricklayers who are in their 40's or 50's, if I were to take all of them and go scan them, more than half would have tears of varying degrees…just because of the nature of their work." (PX3, p. 31) This opinion presumes a career of bricklaying. However, Petitioner, 48 years old at the time of his exam, was not a bricklayer during his entire career. Petitioner worked as a bricklayer for five years, from 2000-2005, at which time he ceased bricklaying and worked as a counselor. (T. 11) Then he resumed bricklaying in spring 2018, after a 13 year break, and *2 months* before his date of accident. (T. 52) Dr. Howard's causation opinion is based on an inaccurate history and thus it is unpersuasive.

Petitioner's credibility is clearly at issue given the statements most contemporaneous to the alleged injury and the variance in histories to medical providers and examiners. I would find that Petitioner failed to meet his burden to prove he sustained an accident that arose out of and in the course of employment and he failed to prove his condition was caused by his work activities under a repetitive trauma theory. Therefore, I respectfully dissent.

Kathryn A. Doerries

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

GLASGOW, SCOTT
Employee/Petitioner

Case# **18WC021718**

CHRISTY INDUSTRIAL SERVICES
Employer/Respondent

20IWCC0201

On 6/5/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.25% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0810 BECKER HOERNER & YSURSA PC
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5196 CLAYBORNE SABO WAGNER LLP
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BELLEVILLE, IL 62221

STATE OF ILLINOIS)
)SS.
COUNTY OF ST. CLAIR)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Scott Glasgow
Employee/Petitioner

v.

Christy Industrial Services
Employer/Respondent

Case # 18 WC 021718

Consolidated cases: N/A

20IWCC0201

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville Illinois**, on **March 27, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of 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, **4/26/2018**, Respondent ***was*** operating under and subject 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 **$58,240.00**; the average weekly wage was **$1,120.00**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **1** child under 18.

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

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

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

ORDER

Petitioner sustained an accident that arose out of and in the course of his employment with Respondent causing injuries to his right arm and right shoulder. Those conditions of ill-being, as presented at the hearing, are causally related to the accident of April 26, 2018.

Petitioner's claim for prospective medical care, as recommended by Dr. Richard Howard, is awarded. The surgical procedure recommended for Petitioner's torn rotator cuff is hereby awarded.

Respondent shall pay to Petitioner a total of 29 weeks of temporary total disability representing the period of time of 5/16/2018 through 12/5/2018 at the rate of $746.67 per week in accordance with Section 8(a) of the Act.

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

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

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

Signature of Arbitrator

6/4/19
Date

ICArbDec19(b)

JUN 5 - 2019

20IWCC0201

STATE OF ILLINOIS)
)
COUNTY OF ST. CLAIR)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION, continuation
Scott Glasgow v. Christy Industrial Services
Case Number: 18 WC 021718

Findings of Fact and Conclusions of Law:

On March 27, 2019 the parties proceeded before the Arbitrator on Petitioner's Petitions under Sections 19(b) and 8(a). The issues in dispute were accident, causal connection, temporary total disability and future medical care.

Petitioner testified that he was 48 years old and had a Masters Degree in rehab counseling. He is also a licensed professional counselor and bricklayer.

Petitioner was not working at the time of hearing and had last worked in April 2018 for Respondent. He was a bricklayer for Respondent. He had returned to bricklaying for a couple of months prior to April 2018. He said that he had started working as a bricklayer in 2000, but attended college and graduate work while he was a bricklayer. He then began working as a counselor. In the spring of 2018, he decided to return to bricklaying. When asked why he returned to work as a bricklayer since he was a licensed counselor, he said that he needed to make more money. He thought he could earn twice his salary as a therapist. He also said that the burnout rate for substance abuse counselors or any counselors was quite high. Petitioner did not receive any workers' compensation benefits since May 2018. Currently he resides with his parents.

In April of 2018 Petitioner was working for Respondent in Baldwin. He was lining the interior of what was later classified as a cyclone furnace. The vessel was spherical in nature and was a confined space. He and others worked on the floor of the sphere and also on scaffolding erected in the sphere. The size of the vessel was about 15 foot tall by 12 foot wide. He worked with up to four other people inside the vessel.

His job was to ram material onto the walls of the inside of the sphere in order to insulate it. The work started at the top of the vessel and down to the floor of the vessel. He said that about 50% - 75% of his work was performed on scaffolds.

Petitioner described the material that he was placing on the wall as clay or a strong putty. It was soft when it was first exposed to the air but then would

harden. This material came in boxes and laborers cut sections of it about 4" x 8" and 1" thick. He would then apply the putty to the interior of the sphere with his hands or with a hammer and then would use a ram gun in order to affix the putty to the wall permanently. After the first day on the job he could no longer use his hands alone to put the putty on the inside of the sphere and had to use a hammer.

Petitioner used a pneumatic ram gun. It had a reciprocating action and was described as like a "tamper". The "tamper" portion of the ram gun would come out one end of the gun as he depressed a lever at the other end and would smash the putty on the walls. The "tamper" came out of the gun many times per minute. The speed of the tamper was similar to the speed of a jackhammer. He had to use the muscles of his arms in order to keep the ram gun from flying out of his hands. He testified that the device had a kickback to it, similar to that of a shotgun. He was not always able to brace the ram gun against his body or shoulder because of the various positions that he had to take inside the vessel. He used the ram gun with his arms while holding it away from his body on those occasions. Petitioner testified that on many occasions he had to hold the ram gun at shoulder height to tamp material that was above shoulder height. His right hand was at the back of the tamper and his left hand was at the front.

Petitioner began this job on April 20, 2018. He worked six days, 10 hours a day, through April 26, 2018. About 90% of his time was spent inside the vessel using or preparing to use the ram gun. He stated that he would spend 25%-50% of his time putting the putty on the wall and then 50%-75% of the day ramming the putting into the wall with the ram gun.

When Petitioner started work for Respondent on April 20, 2018 he was not experiencing any aching, pain or discomfort in his right arm or shoulder. Before April 2018 he saw Dr. Varanasi, his family doctor. He had been his family doctor for about 20 years. He saw the doctor on almost a monthly basis because he was taking a scheduled drug for attention deficit disorder. He stated that whenever he saw the doctor, he would tell him about all the complaints and symptoms that he would have at each visit and that the doctor would examine him. The Petitioner said that the medications that were prescribed by the doctor were filled at Walgreens.

Petitioner admitted that the records from Walgreens that were offered into evidence showed that beginning in 2016 he was prescribed Hydrocodone almost every month by Dr. Varanasi. He received this medication due to complaints of pain in his low back and legs. This was verified by the records of Dr. Varanasi who noted prior diagnoses of low back pain, RSD of the leg and an ankle injury. He denied that Dr. Varanasi ever prescribed Hydrocodone for his right arm or shoulder before April 2018.

Petitioner did have a problem with his left arm before April 2018. This was with the biceps muscle. The Petitioner testified, and the records of Dr. Varanasi confirmed, that he complained of his left upper extremity in February, March and April 2018. He said that as he was using a rachet with his left hand, he felt as if he had a "Charlie horse" in his left biceps. Later he noticed that his left biceps had an abnormality in it that seemed to bunch up near his elbow. Dr. Varanasi examined him and thought that he tore a tendon in the biceps muscle. He did not order any x-rays, CT scans or other diagnostic studies for his arm. Dr. Varanasi did not place him on any physical restrictions nor did he give him any medication for that condition. When Petitioner went to work for the Respondent, it did not request that he undergo a physical examination.

Petitioner testified that he had some discomfort in his right shoulder before April 2018. This was documented by Respondent's examining physician, Dr. Chris Kostman. He had aches and pains throughout the course of his life and referred to any difficulty with his right shoulder as being sore or somewhat weak. He did not see any doctor for his right arm or shoulder before April 2018. The records of Dr. Varanasi do not contain any complaints with regard to his right arm or shoulder before April 2018.

Petitioner said that after he worked the first day for Respondent on April 20, 2018, his right arm and shoulder was very sore and weak. As he continued to work, he said that his arm got sorer, weaker and he lost range of motion. He never experienced any sensations like this before April 2018. He testified that it interfered with his personal life in that he could not reach behind his back to dry himself after taking a shower or clean himself after using the restroom.

Petitioner was scheduled to return to work on 04/27/2018, but chose not to do so. He thought that a day of rest would help his arm and he knew the job was coming to an end. On the morning of 04/27/2018 he called Jason Twiggs. He told Jason that he had somehow hurt his arm and shoulder with motorcycles. He thought he told Jason that he was tying down a motorcycle on the back of his truck. He indicated that he could have told Jason he was lifting a dirt bike. Petitioner gave Mr. Twiggs that history because he had just returned to bricklaying and it was his experience that having an injury that soon after returning to work as a bricklayer might prevent him from being called to other jobs.

Petitioner recalled having a conversation with a co-worker named Dennis Woodruff. He might have told Mr. Woodruff that he hurt his shoulder with a motorbike as well. The Petitioner had sons and they did race motorbikes almost every weekend.

Petitioner said after few days not working after 04/26/2018, his right arm and shoulder pain remained. He was hopeful that it would, but his arm was still very week and debilitating. He knew he would have to seek treatment. He was

going to call Jason when he realized this. Jason told him that he was going to be gone on vacation. Therefore, he called Respondent directly and spoke to a phone operator who told him that needed to speak to "Charlie". He tried his extension and left a voicemail message. He never was able to speak with Charlie but did email the company about his difficulty with his arm and shoulder after working at Baldwin. He said that he thought his arm was going to get better, and he did not want to make a big deal out of it. When he realized that it was not going to get better on its own, he knew that he had to report the real reason for the onset of his symptoms. He told Respondent that he thought it was due to the use of the ram gun. He did not want to claim it as a work related injury because of his fear of reduced future employment.

Petitioner's sons' dirt bikes were not normally lifted into the back of a truck. He said that he has a trailer with ramps and that his boys are the ones who normally load and unload the dirt bikes and other equipment.

Petitioner sought care at Barnes Care in St. Louis because Respondent referred him there. His first visit was on May 16, 2018. He told the doctor of the use of the ram gun and the onset of his pain and disability. The records of Barnes Care confirm this. The doctor attending him placed him on restrictions of a light duty nature and told him to undergo an MRI of his right shoulder. Petitioner said that he was not aware of any light duty for a bricklayer.

The MRI was performed and Petitioner returned to Barnes Care. The doctor told him that he would need to have surgery. The doctor stated a referral would be made for him to an orthopedist specialist. When Petitioner did not hear from a specialist, he called and was told that the visit had not been authorized by his employer. He was still on limited duty at that time.

Petitioner saw Dr. Richard Howard at his attorney's request in September 2018. Petitioner was also examined by Dr. Chris Kostman at Respondent's request. In Dr. Kostman's report he stated that information was sent to him indicating that Petitioner injured his arm and shoulder by lifting an ATV into the back of a pickup truck. Petitioner said that he does not own an ATV and would never try to lift one of those into the bed of his pickup truck.

While Petitioner has been off work, he has sought work based on his counseling skills. He has not been able to obtain any employment and has not received any job offers.

Petitioner testified that since he last worked, he noticed some change in his shoulder. The pain has lessened, but he has difficulties with range of motion and strength. The only medical insurance Petitioner had was Medicaid. He asked that the Arbitrator order Respondent to provide him with surgery that was recommended by both Doctors Howard and Kostman.

Petitioner never filed a workers' compensation claim before and never had any biceps problem in his right arm. After he worked for Respondent, he noticed problems with his right biceps muscle. It seemed to be the same problem as his left arm.

On cross examination Petitioner testified that he had been a member of Bricklayers Local 8 since about 2000. He said that he worked full time as a bricklayer from 2000 – 2005 and achieved Journeyman status. He then stopped bricklaying and did not return to bricklaying until a couple of months before April 2018. He had only had one other job in 2018 bricklaying and that was for about two weeks at a refinery in Wood River. He did use a pneumonic ram at that site, but not on a daily basis.

Petitioner testified that the length of the ram gun was less than two feet. He thought it weighed about 10 pounds. He was not sure what PSI the gun ran at but he did know that 75 pounds was one of the pressure readings. He said there had been a discussion with Respondent about getting smaller ram guns, but the individuals who had those would not give them up. He spent about 50% of his day putting the putty on the wall and 50% of his day tamping the putty into place. He stated that he did tamp putty material above his shoulder. Petitioner denied that he hurt his arm lifting a dirt bike.

Petitioner testified that when he saw Dr. Kostman he was honest with him, but there seemed to be communication problem with the doctor. He tried to show the doctor how he used the gun, but said that Dr. Kostman was not very patient with him. He thought that Dr. Kostman believed that what he (Petitioner) was telling him (Dr. Kostman) was not fitting what the doctor wanted to hear. The doctor seemed to be frustrated with him.

Mr. Greg O'Brien testified for Respondent. He was the project manger for Respondent at the time of Petitioner's employment. He said he met Petitioner for a safety meeting on April 19, 2018. Mr. O'Brien described the pneumonic ram gun as a cylinder with an air hose at the end of it. It has a lever action on the side and a tamper on the front end. He thought that the whole mechanism was about 15" long and weighed about 7 pounds. He said that the recommended PSI for operation of the ram gun was up to 90 pounds. He testified the vessel in which Petitioner worked was 10' in diameter and 10' long. Each vessel had two bricklayers and one laborer inside applying material to the interior. The vessels were called cyclone burners for a coal-fired power plant.

Mr. O'Brien testified that work started at 7:00 am and then laborers would cut slabs of ram putty. The bricklayer would stick that to the wall and use the ram gun to pound it into place. A scraper was used to remove any excess putty. He testified that there would not be any putty applied directly overhead, but up to about the one o'clock position on the sides of the walls.

Mr. O'Brien did receive an email from Petitioner about injuring his shoulder at work. He recalled that it stated that he hurt his shoulder using the ram gun. He received the email on May 14, 2018. Mr. O'Brien said that the job was supposed to last about two weeks. He estimated that 80% of the cyclone burner would need to be covered with the refectory clay.

On cross examination Mr. O'Brien testified that he had used a ram gun and that it had a kick-back to it. He said that after he used the ram gun his hands were very sore. He said he was not able to brace it against his body at all times. He agreed with Petitioner that the ram gun would have to be used at shoulder height or above due to of the shape of the vessel. He agreed that he would describe the speed of the head of the ram gun as equivalent to a tamping device.

Mr. Jason Twiggs testified for Respondent. He was the superintendent of the job at Baldwin. He was a bricklayer by trade. He has not had any contact with Petitioner since the work project. He agreed that the project was supposed to last about two weeks at Baldwin.

Mr. Twiggs testified that he worked in the same vessel as Petitioner. They were installing "plastic ram" to the interior surfaces of the cyclone. Laborers cut the putty and the bricklayer applied the putty to the wall, initially with his hands. They would then use the ram gun to keep the putty in place. That process would be done repetitively throughout the day. The ram gun was about 12" – 15" in length and weighed about 8 pounds. It was pneumatic and was supposed to run at the 80 – 85 pound per square inch of pressure parameter. About 50% of Petitioner's time would be devoted to placing the putty on the walls and 50% of his time would be for tamping the putty into place with the ram gun. Mr. Twiggs testified that he did most of the overhead work. Petitioner did not say anything to Mr. Twiggs about injuring his arm on the job but did tell him that he would not be at work on April 27, 208 because his arm felt fatigued. He stated that Petitioner told him on one occasion that he injured his shoulder helping his son lift a motorbike into the back of a pickup.

On cross examination Mr. Twiggs agreed that there was no light duty work for a bricklayer unless they were a non-working superintendent. He said it would take a number of years to reach that level. Mr. Twiggs had no complaints with regard to the work that was performed by Petitioner or by his effort. He said the ram gun did have a reciprocating action and that it came out several times per minute. When Mr. Twiggs used a ram gun, his hands and forearms would be very fatigued. He stated that using a ram gun by holding it with the hands away from the body was not unusual. He agreed that putty would have to be applied in the vessel up to about the eleven o'clock position on the wall. Petitioner did do some shoulder height work. He stated that there was a joke among the workers that using the ram gun might not allow them to hold a beer

after work because it fatigued the hands greatly. He said that bricklayers tried to avoid using the ram gun because it was harder work.

Mr. Twiggs testified that no one told him that Petitioner lifted an ATV and injured his shoulder. The only thing that he heard that Petitioner lifted was a dirt bike.

On 05/16/2018 Petitioner went to Barnes Care Midtown for an initial evaluation upon referral by Respondent. He complained of pain in his right shoulder and denied prior injuries to the shoulder. The doctor noted that he had received an email from an adjuster who stated that members of the work team at the Baldwin plant told her that Petitioner injured his shoulder elsewhere. Petitioner told the doctor that he was primarily working overhead with a pneumatic ram gun, that was heavy and required two hands to operate. The ram gun had a substantial vibration and kick-back. He began noticing pain in his right shoulder after working on the project. He said that at the end of the six days he had some difficulty moving his arm. His symptoms had not changed after he stopped working. After examination the doctor diagnosed stiffness in the right shoulder and stated that "within a reasonable degree of medical certainty the occupational repetitive motion is undetermined prevailing factor in causing work injury". He recommended an MRI/arthrogram and released the petitioner to work, provided that he not lift more than 20 pounds, not push or pull more than twenty pounds and not reach out or reach above himself more than one hour a day.

On 05/24/2018 Petitioner underwent the MRI and it revealed tears of the supraspinatus and infraspinatus tendons with retraction of the tendon fibers. The AC joint was somewhat widened. Contrast material exited the joint.

On 05/29/2018 Petitioner returned to Barnes Care. The doctor agreed with the radiologist's interpretation and suggested that he see an orthopedic surgeon. Restrictions remained the same.

Respondent did not authorize an evaluation by an orthopedic surgeon and Petitioner did not see any other physician for his condition of ill-being until he saw Dr. Richard Howard at his attorney's request on 09/17/2018. Dr. Howard testified that he was an orthopedic surgeon who treated hand and upper extremity injuries. He saw about 150 patients a week and did about 15 surgeries per week. He also performed independent medical examinations at the request of employers and employees. About 90% of those evaluations were at the request of the employer in workers' compensation cases.

When Dr. Howard saw Petitioner, he told him that he was inside of a large tank using a ram gun that shot putty up against a wall. He said there was some kick-back with that activity similar to shooting a gun. He was shooting the ram gun in a lot of different directions. It was his understanding that Petitioner

used both hands to operate the gun. He complained primarily of shoulder symptoms. He told the doctor that he had some prior shoulder pain. It was the doctor's understanding that the surface of the vessel had to be coated from the top to the bottom. Examination showed loss of range of motion, weakness with supraspinatus tests and weakness with rotating externally. Petitioner could not really hold the weight of his arm straight out to the side. He thought these findings were indicative of a large rotator cuff tear. The doctor reviewed the MRI and it showed a large, retracted rotator cuff tear. There was no evidence of muscle atrophy. He testified there are four tendons that form the shoulder and that two of them had been torn. The doctor thought the tear was "mostly acute". He asserted that a large tear would normally lead to some degree of atrophy if it is chronic in nature because it doesn't take very long for muscles to atrophy. He said that would be very apparent on an MRI scan. The doctor testified that Petitioner had a very large rotator cuff tear but no atrophy. Therefore, he thought that the tear was acute. The doctor stated that Petitioner's work activities could have been a cause or one of the causes of the rotator cuff tear. He stated that this was based upon the history provided to him, his physical examination and the MRI findings. He recommended that he undergo a rotator cuff repair. He concluded that Petitioner was able to work at that time, but could not lift more than 10 pounds, not climb and not perform any overhead work. The doctor testified that even if Petitioner had some type of biceps tendon problem in the right arm before April 2018, it would not impact his opinion regarding medical causation.

Dr. Howard testified the fact that Petitioner's rotator cuff tear was retracted did not indicate that it was a chronic condition. He said that retraction is a feature of a chronic tear, but not the only feature. He said other features included muscle atrophy or fat infiltration of the muscles in the shoulder, which can be detected on the MRI. The doctor testified that even if Petitioner had some shoulder pain off and on before April 2018, it would not impact his opinion with regard to medical causation.

On cross examination, Dr. Howard testified that when he stated that Petitioner worked "overhead" in the vessel, he meant that the Petitioner was aiming the ram gun overhead. He thought Petitioner was holding the gun at about chest level to shoot it up. In that position, the Petitioner's arms would be in an abducted position. He thought that more than half of his day was spent using the ram gun.

Dr. Howard further testified on cross examination that for there to be muscle atrophy due to a rotator cuff tear, there must be a number of months that pass from the time of the tear to the time of the examination. He testified that there would be fat streaking in the muscles if the tear was more than 6 months to 12 months old. He said that an acute tear is usually more disabling and has a "more dramatic presentation" than a chronic rotator cuff tear. The doctor stated that lifts and falls were the primary cause of rotator cuff tears. In those

situations, more often than not, the tears are chronic with an overlying acute change. That is, a person could have a chronic rotator cuff tear with no symptoms and then after a fall can have a dramatic change in function. He was asked to define the term "chronic", and he stated that he had no clear definition of that term, but that his use of the term "acute" meant that there was an identifiable event and function changed abruptly. He said that is an acute tear and everything else is chronic. In Petitioner's case he thought that he probably did not have a completely normal tendon before he began working for Respondent and as a result of working with the ram gun with two hands and taking repeated impacts that went through the shoulder. He admitted that one would not anticipate that such work activities would cause a rotator cuff tear, but if an individual had an abnormal tendon before such activities, then it certainly could aggravate the condition. Dr. Howard testified that a bricklayer of Petitioner's age would be in a high risk group for a rotator cuff problem. He said that in his 30 years of experience, if MRIs were performed of all bricklayers in their 40s and 50s, more than half of them would have rotator cuff tears of varying degrees without symptoms. He stated there was no loss of bulk of the infraspinatus and supraspinatus muscles when he reviewed the MRI, which would indicative of an acute onset of his shoulder condition.

Respondent had Petitioner evaluated by Dr. William Chris Kostman, an orthopedic surgeon, on 12/05/2018. Dr. Kostman testified that he performed surgeries on upper and lower extremities. He also performed independent medical examinations and record reviews as part of his practice. When he saw Petitioner on 12/05/2018 Petitioner told him that he had been working in a boiler area and putting putty on walls and packing it using a tamping gun. Petitioner told him the gun weighed about 15 pounds and operated at 50 – 150 PSI pressure. The gun had a lever to activate the tamper and Petitioner held the other end of the device with his left hand. He testified that he would hold the gun with his elbow at about 90 degrees of flexion and would rotate his arms from 0–45 degrees of forward flexion to do the tamping process. He said that Petitioner performed his activity 10 hours a day over three to four days and developed right shoulder pain. He testified that lifting, pushing and pulling exacerbated his symptoms, as did reaching away from his body.

Dr. Kostman stated that Petitioner told him he had some degree of shoulder pain before April 2018 and Petitioner had a deformity in his right biceps area about a month before April 2018. Petitioner had no treatment for those conditions and the shoulder pain had been off and on for over a couple of years with activities. He had never seen a physician for that problem or had any type of treatment. Dr. Kostman testified that the activities of a bricklayer would be fairly physical in nature.

Dr. Kostman's' physical examination revealed a proximal biceps deformity that was consistent with a tear of the long head of the biceps tendon. He had loss of range of motion and loss of strength with external rotation and forward flexion

on the right. He had a positive Hawkin's test on the right side and a positive impingement test on the right side. He performed x-rays that revealed he had a type II acromion, moderate A/C arthritis and mild glenohumeral degenerative changes. His review of the MRI of 05/24/2018 revealed a large, retracted rotator cuff with some humeral head migration. He also had some degenerative changes and absence of the biceps tendon within the joint. He said that was consistent with a chronic rotator cuff tear. He testified that the size of the tear, the retraction, the weakness in the surrounding muscles, some of the degenerative changes and the position of the humeral head lead him to believe it was a chronic tear. He said such tears are normally 6 months to greater than a year old. He did agree that surgery would be acceptable in Petitioner's case.

The doctor further testified that he had received information that an alleged witness stated that Petitioner had told him he had lifted an ATV and injured his shoulder. Petitioner denied this. Petitioner also denied that he injured his shoulder lifting a dirt bike or motorcycle. Based upon his evaluation, it was his opinion that his work activities in April 2018 were not consistent with the development of his rotator cuff tear. He thought that it was due to a long standing history of shoulder pain over two years. He testified that activities that involved reaching and lifting overhead could cause someone who has a rotator cuff tear to become symptomatic. Such activities could make a rotator cuff tear worse. It would be considered "worse" if the individual was more symptomatic with certain activities such as reaching away from his body and lifting. Based on the history provided to him and that he obtained elsewhere and his examination of Petitioner, the rotator cuff tear that he saw when he examined the Petitioner was not related to the work activities of April 2018.

Dr. Kostman on cross examination stated that Petitioner was not necessarily using his arms next to his body when he was working inside the vessel. He said that if one cannot hold one's arms next to the body when using a device such as this, it would be more difficult to hold the object. Dr. Kostman thought that the Petitioner would have to apply the putty in all areas of the vessel. He said that depending upon the Petitioner's position and how he could reach certain areas that were shoulder height or above, it could alter his opinion with regard to the position that he assumed the Petitioner's arms were in at all times. He said Petitioner could have had to extend his arm more than 45 degrees as discussed previously. He acknowledged that the ram gun was pneumatic in nature and would have a push back. Dr. Kostman agreed that a biceps tendon tear could occur without a tear of the rotator cuff. Dr. Kostman was not aware of any records that showed any examination or treatment of Petitioner's right shoulder before May of 2018 and saw no evidence that Petitioner was not able to perform his duties as a bricklayer before April 2018.

Dr. Kostman was asked on cross examination the basis for his determination that the Petitioner had a chronic tear, and he agreed it was because of retraction, weakness, degenerative changes, the tear of the long head of the

biceps tendon out of the joint and migration of the humeral head. He denied there were any other reason for determining it was chronic in nature. He did state that an individual can have a large rotator cuff tear due to an acute trauma. When asked if there was any evidence of muscle atrophy upon his review of the MRI, he said that there was. When asked why that was not noted in his report, he said that he reviewed the MRI scan again and detected some muscle atrophy, although it was not noted in his report. He also said that there was evidence of fatty streaking of the muscle in the supraspinatus, but again that was not contained in his initial report. When asked why it was not contained in his initial report, he said there was no reason. He stated that even if Petitioner did lift a dirt bike, it did not cause his rotator cuff tear because it was chronic in nature. He also said that he was familiar with ATV's and that he owned one. He testified no human could lift an ATV into the back of a pickup truck. He testified that if conservative care did not improve Petitioner's shoulder condition, surgery would be necessary. With regard to Petitioner's ability to work, he testified that if Petitioner was able to work before April 2018 as a bricklayer with his rotator cuff tear, he could do so after working in April 2018.

On further cross examination the doctor stated that the goal of treating an individual with a condition of ill-being is to return them to function in a high level as possible. He agreed that Petitioner's symptoms after working in April 2018 with regard to his right shoulder were worse than they were before that date. The doctor further stated that if Petitioner was reaching overhead with heavy activities, he could aggravate his rotator cuff tear with that activity and cause him to have symptoms as it related to his chronic rotator cuff tear. He admitted that he knew of no prior positive physical findings with regard to the Petitioner's right arm nor any other MRI study before April 2018. He agreed that an individual could have an acute onset of symptoms with a chronic rotator cuff tear, but not necessarily alter the physical structure of the large, chronic rotator cuff tear. He said that reaching away from one's body is more difficult and puts more stress on the shoulder.

Medical records from Dr. Varanasi, Petitioner's treating physician for many years prior to April 2018, were admitted into evidence. A review of those records does not indicate that Petitioner had any complaints with regard to his right arm or right shoulder prior to May 2018. The Petitioner did have some upper extremity complaints prior to April 2018, but it was to his left arm. The records revealed that in February 2018 Dr. Varanasi stated that Petitioner had a tear of the biceps tendon in his left arm. He once again discussed this in March and April 2018. The records contain no physical findings relative to the right arm before April 2018, treatment to the right arm before that date, referral to any orthopedic surgeons prior to that date or any specialized radiological studies.

Based upon the information as outlined above, the Arbitrator makes the following rulings on the issues presented at the time of hearing:

With regard to **"C" – "Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?"**, the Arbitrator finds that Petitioner *did* sustain an accident via repetitive trauma with regard to his right shoulder while employed by Respondent from 04/20/2018 – 04/26/2018. All witnesses, including those presented by Respondent, agreed that Petitioner's job consisted primarily of applying putty to the inside of a vessel and then using a ram gun to permanently affix the putty to the inside of the vessel. Approximately half of the day would be spent applying the putty and the other half would be using the ram gun to keep it in place. All witnesses testified that the ram gun used 50 – 90 pounds of force in order to operate, that it had a kick-back to it and that the device would be used with the arms away from the body placing greater stress on the upper extremity and shoulder area. Further, the witnesses agreed that during the 6 days the Petitioner worked, they were 10 hour days. As a result of his work activities, Petitioner was exposed to a risk of injury to his shoulder greater than a member of the general public based upon the use of the ram gun.

There was testimony concerning Petitioner's statements to his supervisor and to at least one other co-worker regarding the onset of his right shoulder pain and limitations. Mr. Twiggs testified that when Petitioner contacted him after April 26, 2018, he told Mr. Twiggs that he injured his shoulder while helping his son lift a dirt bike into the back of his pickup truck. Mr. Bailey testified that although Petitioner advised him that he had injured his shoulder through the use of the ram gun, he had also received statements from Mr. Twiggs and others that Petitioner injured his shoulder lifting a dirt bike. The Petitioner admitted to making these statements, but asserted that he did so as he had only recently returned to the profession of bricklaying after being a licensed counselor for over 10 years. The Petitioner testified that he had been a bricklayer in 2000 – 2005, and was attending college and post graduate studies during that period of time. As a result, he obtained a Masters Degree in vocational rehabilitation and also became a licensed counselor in the State of Illinois. He performed in that profession for over 10 years. It had only been in the first part of 2018 that Petitioner returned to work as a bricklayer. He testified that he did so because the income he could derive would be much greater than that of a counselor. Further, he testified that substance abuse counselors suffer a degree of burnout because of the nature of their positions. Petitioner had only worked one job in 2018 before he went to work for Respondent. He had never worked with Respondent before. He testified that he was fearful that if he reported his shoulder condition as work related, he would not be called back to work for Respondent for any other job in the future. He further testified that as a bricklayer he had suffered aches and pains due to employment related activities in the past, and was hopeful that, as on other occasions, his shoulder pain and disability would lessen with rest. When it did

not do so, he realized that he should seek medical attention and therefore reported the true nature of the onset of his condition of ill-being to Respondent. Histories to the medical providers and examining physicians were all consistent with his testimony at trial.

With regard to the lifting of the dirt bike, Petitioner denied that this actually occurred. He did admit that his sons had dirt bikes that they raced almost every weekend, but that they had a trailer for the dirt bikes and that they could be pushed up ramps. He stated that it was not his custom to lift dirt bikes into the bed of his pickup truck. In addition, the Arbitrator notes that Dr. Kostman received some information from Respondent or its representative asserting that Petitioner injured his shoulder lifting an ATV into the back of a pickup truck. All witnesses, including Dr. Kostman, agreed that it would be impossible to lift an ATV into the back of a pickup truck. Further, Mr. Biggs, Petitioner's supervisor, testified that he knew of no one who claimed that Petitioner had lifted an ATV into the back of a pickup truck.

Therefore, although the Petitioner's credibility was certainly called into question, the Arbitrator finds that the reasons given for his prior, inconsistent statements were due to the nature of his potential work activities in the future and the result of his desire to earn a living for his family greater than the living he had as a counselor.

Therefore, taking all the evidence into consideration, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that he sustained an accident arising out of and in the course of his employment with Respondent on April 26, 2018.

With regard to the issue of **"F" – "Is Petitioner's current condition of ill-being causally related to the injury?"**, the Arbitrator finds that Petitioner's current condition of ill-being with regard to his right shoulder *is* related to the work activities he performed for Respondent from April 20 – April 26, 2018. Petitioner's occupation as a bricklayer, as noted by the witnesses, is physical in nature and subjects such individuals to the stresses and strains of that type of work. Although Petitioner stated that he had some aches and pains in his shoulder before April 2018, this would not be unusual with regard to the nature of his employment. Further, there is no medical information contained in any of the records or depositions that confirms that Petitioner underwent any examination, evaluation, treatment, or sophisticated radiological studies for any condition related to his right shoulder before April 2018. Indeed, Dr. Varanasi saw Petitioner almost monthly beginning in 2016 and his records contain no reference to any complaints with regard the right shoulder before April 2018. There was testimony that Petitioner thought he had sustained an injury to his right biceps before April 2018, but the records of Dr. Varanasi also confirm that although Petitioner did have a biceps tendon issue before April 2018, but it was to his left arm. This was initially discover by Dr. Varanasi in

February 2018 and mentioned once again in March and April 2018 visits. Further, there was no testimony or medical documentation indicating that Petitioner was restricted in working in any way with regard to his right shoulder before April 2018.

It was also clear from the testimony of the Petitioner and the medical documentation that even if he had aching, pain or discomfort in his right shoulder before April 2018, it was certainly worsened by his activities that he performed for Respondent through April 26, 2018. All medical examinations revealed some degree of objective findings regarding potential injury to the rotator cuff and an MRI confirmed that both the infraspinatus and supraspinatus muscles and tendons had been injured and were not functioning properly. Therefore, these findings confirm Petitioner's complaints of pain, discomfort, lack of strength and lack of mobility in his right shoulder. None of these things were documented prior to April 2018. In addition, Petitioner's condition of ill-being did not return to the "baseline" he had in April 2018. His symptoms remained increased since April 2018. As a result, both Dr. Howard and Dr. Kostman agreed that Petitioner was a candidate for surgery, both objectively and subjectively. He was not a candidate for such surgery prior to April 2018 as he had minimal complaints. Both Dr. Howard and Dr. Kostman testified that the use of a ram gun in the manner described by Petitioner could have caused an increase in his symptom thus leading to his current condition of ill-being and the need for further treatment.

There was evidence presented by Respondent through the testimony of Dr. Kostman that there was MRI evidence confirming that Petitioner's rotator cuff tear was chronic in nature and not due to any acute trauma. Dr. Kostman testified initially that there were several factors upon his review of the MRI that caused him to believe that Petitioner's condition of ill-being was chronic in nature and was not affected by his employment. In his report, he did not mention that he found muscle atrophy upon his review of the MRI, nor did he find any evidence of fatty infiltration of the muscles in the shoulder upon his initial review of the MRI. Dr. Howard had testified before Dr. Kostman that evidence of atrophy of the musculature or fatty infiltration of the muscles of the shoulder would be radiographic evidence of a chronic rotator cuff tear. On cross examination, when asked to identify the factors that he took into consideration in determining if there was a chronic rotator, Dr. Kostman also added testimony regarding subsequent review of the MRI films before his deposition which lead him to believe that there was atrophy of the musculature and fatty infiltration of the muscles of the shoulder, thus adding to his conclusion that the tear was chronic in nature. He admitted that those findings were not contained in his original report and that there was no reason that he could not have placed such findings in his report. As a result, the Arbitrator must question those particular findings of Dr. Kostman, particularly as he was utilizing them as a foundation for his opinion that Petitioner sustained no additional injury as a result of his employment with Respondent.

Therefore, taking all the evidence into consideration, the Arbitrator finds that Petitioner *has* proven by preponderance of the evidence that there was a relationship between his work activities of April 2018 and the condition of ill-being with regard to his right shoulder and right rotator cuff.

With regard to the issue of **"L" – "What temporary benefits are in dispute? TTD"**, the Arbitrator finds that Respondent shall pay to Petitioner the sum of $746.67 per week in temporary total disability benefits from May 16, 2018 through December 5, 2018, a total of 29 weeks of disability, as Petitioner was unable to work from May 16, 2018 through the date of his independent medical examination with Dr. Kostman of December 5, 2018. When Petitioner saw a physician with Barnes Care in St. Louis on 05/16/2018, the doctor stated that he could return to work, with restrictions. Those restrictions remained the same when the Petitioner returned to see the doctors at Barnes Care on 05/31/2018. When Petitioner saw Dr. Howard on 09/17/2018, he also stated that Petitioner could return to work, with significant restrictions. Both Petitioner and Mr. Twiggs, his superintendent who is also a bricklayer for over 20 years, testified that there was no light duty for bricklayers unless they happen to be employed as a non-working superintendent. Petitioner was unable to work as a non-working superintendent because of his lack of years of service with the bricklayers. Dr. Kostman testified that since Petitioner was able to work with his rotator cuff tear that he assumed existed before April 2018, he could work with the same injury when he saw him on December 5, 2018.

Although Petitioner testified that he sought work within his restrictions, primarily as a counselor for which he had been previously trained, his search for alternative employment was certainly lacking in effort and numbers of contacts.

Therefore, taking off of the evidence into consideration, the Arbitrator finds that Petitioner *has* proven by a preponderance of the evidence that he was temporarily and totally disabled as a result of his condition of ill-being from 05/16/2018 – 12/05/2018, a total of 29 weeks.

With regard to the issue of **"K" – "Is Petitioner entitled to any perspective medical care?"**, the Arbitrator finds that treatment as recommended by Dr. Richard Howard, namely a rotator cuff surgery on the right shoulder, is awarded. The evidence indicates that Petitioner has a massive rotator cuff tear, has objective findings of such a tear and has complaints of lack of range of motion, weakness and inability to use the arm in a normal manner that warrant such a surgery. Although Dr. Kostman stated that conservative efforts could be utilized, given the nature and extent of Petitioner's rotator cuff tear, the Arbitrator finds that Petitioner can seek surgical treatment without the need for such conservative care.

Therefore, taking all of the evidence into consideration, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that he has shown that he is in need of further medical treatment on his right shoulder, namely a surgical repair of his rotator cuff.

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Melisa Queiro,

Petitioner,

vs.

JBS USA,

Respondent.

No. 17 WC 032832
(consolidated with No. 18 WC 5418)

20IWCC0202

DECISION AND OPINION ON REVIEW

Petition for Review having been timely filed by Petitioner and notice given to all parties, the Commission, after considering the nature and extent of Petitioner's right hand disability, and being advised of the facts and law, modifies the August 15, 2019 Decision of the Arbitrator, as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

This case was consolidated for trial with 18 WC 5418, which alleged a different date of accident and a different injured body part. That appeal will be addressed in a separate Commission decision. The consolidated cases were tried on March 26, 2019 with the sole issue being the nature and extent of Petitioner's injuries. In Case No. 17 WC 32832, the Arbitrator awarded Petitioner permanent partial disability for her repetitive stress injuries: 10% loss of use of her right hand for carpal tunnel, radial tunnel, and posterior interosseous nerve entrapment syndromes and 15% loss of use of her right arm for epicondylitis. On review, Petitioner asserts that the right hand award was insufficient. The Commission agrees.

Petitioner worked for Respondent for six years; at the time of this injury, her job involved cutting frozen hog jowls, which required her to use a straight knife in her right hand. Petitioner came under the care of Dr. Brett Wolters at Springfield Clinic who diagnosed right carpal tunnel syndrome after an EMG/NCS was performed. He eventually performed a right carpal tunnel release, radial tunnel release, and posterior interosseous nerve decompression on January 27, 2017. Immediately after surgery, Petitioner noted numbness and an inability to straighten her right fourth and fifth fingers. Dr. Wolters restricted her use of the right arm and hand and referred her to occupational hand therapy.

At her March 3, 2017 appointment, Dr. Wolters added a diagnosis of right third, fourth, and fifth digit nerve palsy of a branch of the posterior interosseous nerve, based upon Petitioner's inability to straighten those fingers. Petitioner was advised to continue therapy, but her pain and cramping persisted. Testing on April 6, 2017 revealed diminished grip strength contralaterally with approximately 50% loss of grip strength in her right hand as compared to her left. Petitioner reported pain at her anterior wrist with flexion and a loss of range of motion at the right wrist and long, ring and small fingers at this visit. Dr. Wolters ordered continued physical therapy and allowed her to continue working with restrictions until May 10, 2017, when she was released to return to work full duty.

Petitioner returned to Dr. Wolters' office for a follow up visit on July 12, 2017 and reported that she had been assigned repetitive work using her right hand to cut off animals' tails with a knife. This work caused pain, tenderness and electric sensations in her right forearm. Dr. Wolters ordered additional physical therapy and advised Petitioner to use a forearm strap and sleeve. He encouraged Petitioner to seek a job change but did not impose work restrictions. On September 15, 2017, Dr. Wolters noted that Petitioner complained of increased forearm pain whenever she performed meat carving tasks, so he encouraged her to restrict herself from excessive meat carving, to wear a splint, and to use anti-inflammatories when necessary. Dr. Wolters repeated his suggestion that Petitioner seek another position. No medical opinion to the contrary was submitted into evidence.

After her release from treatment and her return to work, Petitioner was moved from the jowl cutting position to a Cryovac job, which did not require repetitious right arm movement. Petitioner subsequently transferred to a management position in the laundry, which initially paid $.40 per hour less than her Cryovac position but did not require repetitious use of either arm or hand. The laundry position provides Petitioner with the potential to earn more in the future than she would had she remained in the Cryovac position. However, no evidence was submitted regarding any increase in Petitioner's pay compared to her pre-injury position.

At the arbitration hearing, Petitioner testified that she continues to suffer from hand numbness at night, limited use of her right hand, and a feeling of electricity if she overuses her hand. She relieves these sensations by rubbing her hands together and taking Aleve or Ibuprofen.

After discussing Petitioner's treatment, job changes, and status at the time of hearing, the Arbitrator considered the five factors, pursuant to §8.1(b) and assigned the following weights to them:

(i) **Disability impairment rating:** *significant weight.* Respondent's §12 examiner, Dr. Fletcher, found a 5% impairment of Petitioner's right upper extremity.

(ii) **Employee's occupation:** *greater weight.* At the time of hearing, Petitioner was performing a management position in the laundry which did not require her to utilize a knife in the performance of her job duties.

(iii) **Age of employee at time of injury:** *greater weight.* At the time of her injury, Petitioner was only 34 years old with many work years ahead of her, during which she must deal with her disability.

(iv) **Future earning capacity:** *some weight.* Petitioner testified that she voluntarily moved to the management position in the laundry, despite the initial reduction of

$.40 per hour, but with the potential to earn more than she would have in her previous jobs.

(v) **Evidence of disability corroborated by treating medical records:** *significant weight.* Petitioner underwent three procedures—right carpal tunnel release, radial tunnel release, and posterior interosseous nerve decompression. Petitioner continues to experience symptoms post-operatively and testified that she still has numbness at night, is limited in her use of her hand and arm and continues to feel an electric sensation if she overuses her forearm.

After considering all five factors, the Arbitrator awarded Petitioner 10% loss of use of the right hand. The Commission agrees with the Arbitrator regarding the weight assigned to the various factors but finds that a combined evaluation of the factors requires a higher permanent partial disability award given Petitioner's young age and inability to perform jobs requiring repetitive use of her dominant right hand. Moreover, although the Arbitrator noted the possibility of Petitioner earning more in the position she held at the time of the hearing, no actual increase was evident. Thus, in consideration of the record as a whole, the Commission finds that Petitioner suffered a 15% loss of use of the right hand.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $363.30/week for a period of 66.45 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to Petitioner to the extent of 15% loss of use of the right hand (28.5 weeks) and 15% loss of use of the right arm (37.95 weeks).

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $24,200.00. 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 24 2020

Marc Parker

Barbara N. Flores

mp/dak
o-3/5/20
068

20IWCC0202

Concurrence in Part and Dissent in Part

I respectfully concur in part and dissent in part from the Decision of the majority. The Arbitrator awarded Petitioner a total of 56.95 weeks of PPD representing loss of the use of 10% of the right hand and of 15% of the right arm. The Majority affirmed the loss of 15% of the arm award but increased the hand award to loss of 15% of the right hand. I would have affirmed and adopted the Decision of the Arbitrator. Therefore, I concur in the Majority's affirmance of the arm award and dissent from the Majority's increase of the hand award.

The Arbitrator evaluated the five statutory factors that the Commission must consider in awarding PPD. She noted that Dr. Fletcher performed an impairment rating based on AMA Guides. He assessed Petitioner's impairment at 5% of the right arm. In so doing, he noted that he found no objective deficit in the functionality of her hand and that Petitioner's subjective assessment of her impairment was in excess of her physical condition. The Arbitrator also considered Dr. Fletcher's findings, as well as Petitioner's last visit to her treating surgeon, Dr. Wolters, in assessing the evidence of disability corroborated in the medical records. In his final note, Dr. Wolters found Petitioner had full strength and range of motion in her hand. In addition, the Arbitrator considered Petitioner's young age (34) and found that she would have to live with any impairment for a lengthy future working life. On the issue of her occupation, the Arbitrator noted that Petitioner was released to return to work as a butcher, but voluntarily transferred to a position in management. Finally, on the issue of possible diminution of Petitioner's future earning potential, the Arbitrator stressed that although Petitioner currently earned $.40 less in the managerial job, she testified that she voluntarily took the new position to further her career and to hopefully earn more income in the future.

On review, the Majority appears to have increased the PPD award for the right hand basically because she had three surgeries to that hand. In my opinion, the Arbitrator's analysis of the statutory factors used to determine PPD was appropriate. Because part of the analysis involves assessing the credibility of Petitioner in determining the extent of her permanent disability, I see no reason for the Commission to substitute its opinion for that of the Arbitrator who observed the Petitioner's testimony. In addition, the Commission is mandated to award PPD based on a claimant's actual disability and reduction of functionality. In my opinion, simply because multiple procedures were performed is not in and of itself a sufficient basis to increase a PPD award; it is akin to increasing a PPD award for pain and suffering, from which the Commission is precluded.

For the reasons stated above, I would have affirmed and adopted the Decision of the Arbitrator. Therefore, I concur in the Majority's affirmance of the arm award and dissent from the Majority's increase of the hand award. Therefore, I respectfully dissent.

Deborah L. Simpson

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

QUEIRO, MELISA
Employee/Petitioner

Case# **17WC032832**

18WC005418

JBS USA
Employer/Respondent

20IWCC0202

On 8/15/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2934 BOSHARDY LAW OFFICE PC
JOHN V BOSHARDY
1610 S 6TH ST
SPRINGFIELD, IL 62703

2461 NYHAN BAMBRICK KINZIE & LOWRY
JASON H PAYNE
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602-4195

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

MELISA QUEIRO
Employee/Petitioner

v.

JBS USA
Employer/Respondent

Case # **17** WC **32832**

Consolidated cases: **18 WC 005418**

20IWCC0202

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 Hemenwa**, Arbitrator of the Commission, in the city of **Springfield**, on **March 26, 2019**. By stipulation, the parties agree:

On the date of accident, **August 2, 2016**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**31,486.00**, and the average weekly wage was $**605.50**.

At the time of injury, Petitioner was **34** years of age, ***single*** with **1** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner the sum of **$363.30**/week for a further period of **56.95** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **10% loss of use of the right hand (19 weeks) and 15% loss of use of the right arm (37.95 weeks)**.

Respondent shall pay Petitioner compensation that has accrued from **September 15, 2017,** through **March 26, 2019**, 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

August 12, 2019
Date

AUG 15 2019

20IWCC0202

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT

MELISA QUEIRO
Employee/Petitioner

v.

Case #: **17 WC 32832**
& 18 WC 005418

JBS USA
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner filed two Applications for Adjustment of Claim: (1) 17 WC 32832, injury to right hand and elbow, date of accident August 2, 2016; and (2) 18 WC 005418, injury to left shoulder, date of accident January 19, 2018. The cases were consolidated for purposes of arbitration; however, they involve distinct and separate body parts and are therefore addressed in separate Arbitration Decisions. The parties stipulated that the only issue in dispute is the nature and extent of Petitioner's permanent partial disability.

On August 2, 2016, Petitioner was 34 years old, single, and had one dependent child. Her average weekly wage was $605.50. Her job with Respondent was cutting hog jowls, which involved using a straight knife in her right hand. She had been employed by Respondent for approximately six years. She is right-hand dominant. Petitioner testified that she initially saw the plant doctor with MOHA for her complaints, and was placed on restrictions and referred to physical therapy. She ultimately came under the care of Wolters of Springfield Clinic.

On October 21, 2016, Dr. Wolters examined Petitioner and diagnosed her with right elbow lateral epicondylitis and possible right elbow posterior interosseous nerve entrapment syndrome. He recommended work restrictions and an MRI of the right elbow. PX5. The MRI was completed at Passavant Area Hospital on November 14, 2016. PX6. Dr. Wolters reviewed the MRI on November 18, 2016, and interpreted same as demonstrating mild right lateral epicondylitis and olecranon bursitis. He recommended an EMG/NCS of the right upper extremity. PX5. The EMG/NCS was completed on December 9, 2016, and revealed mild right carpal tunnel syndrome. Petitioner returned to Dr. Wolters, who diagnosed mild right carpal tunnel syndrome, right radial tunnel syndrome, and mild right lateral epicondylitis. He did not

believe that the lateral epicondylitis was significantly symptomatic, and recommended a right carpal tunnel and radial tunnel release. PX5.

On January 27, 2017, Petitioner underwent surgery by Dr. Wolters. The procedures included right carpal tunnel release, radial tunnel release, and posterior interosseous nerve decompression. Petitioner's right arm was placed in a sling and she was released to return to work the next day with the restriction of no use of her right arm. PX5.

Petitioner testified, and Dr. Wolters' records reflect, that immediately after surgery she still had numbness and was unable to straighten her fourth and fifth fingers. On January 31, 2017, Dr. Wolters noted that the nurses at work had apparently been wrapping her radial tunnel incision in Coban, which she was wearing in the office that day. Dr. Wolters advised that the Coban was essentially turning into a tourniquet, due to the swelling, and that she was no longer to use it. He ordered a custom splint and arm sleeve for her to wear instead. PX5.

On February 10, 2017, Petitioner returned to Dr. Wolters and reported that she still could not move her fingers, but that her pain was under better control and the swelling was better. She believed the wrist splint helped protect her hand and wrist. On examination, there was tenderness to palpation over both incisions, but both incisions were well approximated. Wrist range of motion was painful, and she continued to have difficulty extending her right third, fourth, and fifth fingers. Dr. Wolters referred her to occupational hand therapy. He noted that she no longer had to use the sling, but still could not use her right hand at work. PX5.

Petitioner attended occupational therapy at Passavant Area Hospital from February 20, 2017, through March 2, 2017. PX8. She also attended physical therapy at Apex Physical Therapy from January 31, 2017, through May 9, 2017. PX7.

On March 3, 2017, Petitioner returned to Dr. Wolters and reported that the pain in her forearm was completely gone and the numbness in her hand was better, but she still had lack of finger extension and weakness of the fourth and fifth digits. She continued to use her hand splint and was attending hand therapy. She did not believe the current hand therapy was any different than that she was receiving at Respondent's onsite facility. Examination confirmed Petitioner's complaints with regard to weakness and lack of extension in the fingers. Dr. Wolters added a diagnosis of right third, fourth, and fifth digit nerve palsy of a branch of the posterior interosseous nerve. He recommended an EMG/NCS and continued no use of the right hand. He noted that her symptoms of radial tunnel were completely better. PX5. The Arbitrator notes, however, that during testimony, Petitioner denied telling Dr. Wolters that she was pain free.

Physical therapy records from March 6, 2017, three days after Petitioner's follow up with Dr. Wolters, noted that her pain continued to be at a 6/10. She continued to experience intermittent cramps in the palm of her right hand, and she gained only marginal improvement in straightening or lifting her ring or small finger. PX7.

Physical therapy records from April 6, 2017, indicated that Petitioner complained of pain at the anterior wrist with flexion, rated at 5/10. Range of motion measurements continued to

show loss of range of motion at the wrist and long, ring, and small right fingers. Grip strength testing revealed approximately 50% loss of grip strength as compared to the left hand. PX7.

On April 7, 2017, Petitioner returned to Dr. Wolters and reported she was doing much better. She had near full strength of her right hand, very mild weakness mainly of the right finger, and no pain in her forearm. On examination, there was full range of motion of the elbow and wrist, no tenderness to palpation over forearm incision, mild tenderness over the carpal tunnel incision, very minimal weakness of the right ring finger extension, and otherwise full extension of the right wrist. Dr. Wolters no longer recommended the nerve testing, as the symptoms with regard to the nerve palsy were gone. He recommended continued light duty, with restrictions of limited repetitive use of the right hand and no lifting over 25 pounds with the right arm, and continued physical therapy. PX5.

On May 10, 2017, Petitioner returned to Dr. Wolters and reported mild discomfort when she pressed up with her right hand. She no longer had pain throughout the forearm, had no numbness in her hand, and had very little to no weakness of her right fingers. On examination, she had full strength with wrist dorsiflexion and finger extension at the MCP joints and PIP joints of the right hand, and normal sensation about the right hand. Dr. Wolters released her to return to work full duty and instructed her to return in two months. PX5.

On July 12, 2017, Petitioner returned to Dr. Wolters and advised that she had been put on a job where she was doing repetitive work with her right hand with a knife cutting tails off of animals. She reported that the work activities caused a lot of pain and tenderness in her forearm, and she experienced electric type sensations in the forearm. She denied any numbness or tingling, but felt that the arm was swollen and tender to touch. She stated should would be applying for a different job that would not require her to use her forearm repetitively. On examination, she had full strength of the wrist and hand and equal grip strength bilaterally. There was severe point tenderness to palpation over the anterior lateral aspect of the right upper forearm extending towards the right lateral epicondyle. Range of motion of the elbows and shoulders was full bilaterally. Dr Wolters recommended additional physical therapy, as well as use of a forearm strap and the sleeve. He did not give any work restrictions, but encouraged Petitioner to try and transfer to different positions when doing repetitive activities. PX5.

Petitioner attended physical therapy sessions at Apex Physical Therapy from July 14, 2017, through September 14, 2017. On September 14 she reported that her pain was "not bad" and rated it at 3/10. She was performing her regular job bagging hams, and was only limited when performing knife work. The therapist noted full strength in the elbow and wrist. Range of motion and strength were within normal limits. Petitioner reported that she was not able to work pain-free with a knife, but was able to perform her normal job of bagging hams "just fine". PX9.

On September 15, 2017, Petitioner returned to Dr. Wolters and reported that whenever she performed meat carving with her hands, she had increased pain in the right forearm in both the medial and the dorsal aspects. She had no significant numbness or tingling in the hand and could use her wrist without difficulty. On examination of the right arm and elbow, there was tenderness over the dorsal compartment of the right forearm, full range of motion of the right elbow, and mild tenderness over the medial epicondyles. On examination of the right hand and

wrist, there was negative cubital tunnel Tinel's, and full dorsiflexion strength of the wrist. Petitioner was advised to continue with conservative management of her forearm and to restrict herself from excessive meat carving. She was instructed to use anti-inflammatories as needed, and to wear the wrist splint with any increased pain in her forearm. She was released from care at that time. PX5.

On June 29, 2018, Petitioner was evaluated by Dr. David Fletcher for an AMA Impairment Rating. Dr. Fletcher testified by way of deposition on February 5, 2019. He testified that as part of the evaluation process, he reviewed Petitioner's medical records, and had her complete a QuickDASH and a pain disability questionnaire. Her QuickDASH score was 65.9, or moderately severe. Her pain drawing showed pins and needles sensation and pain in her right forearm from her elbow to her wrist. Her pain rating was 7/10. RX1.

Dr. Fletcher testified that the physical examination of Petitioner's right upper extremity was completely normal, except for the presence of the surgical scars. All provocative tests for ongoing nerve entrapment were negative. When asked whether he believed there was a correlation between Petitioner's QuickDASH score and the physical examination, he answered "probably not." He testified that her subjective complaints seemed high compared to her physical examination findings. He believed that because Petitioner was treating for a *left* upper extremity problem at the time, that that could have influenced the scores. He testified that grip strength testing was a little bit inconsistent, and he concluded that the grip strength test results were non-physiological. Dr. Fletcher testified as to the specifics of how he assigned an AMA Impairment Rating of 5% upper extremity, even with the severe QuickDASH score. RX1.

On cross-examination, Dr. Fletcher acknowledged that Petitioner complained to him that she continued to have tingling and numbness in her forearm to the elbow, and that her elbow and hand would ache with use. He admitted that when he examined Petitioner she had swelling about her right forearm, and that swelling around a nerve could cause pain. He agreed that on examination he noted tenderness over the radial tunnel. Dr. Fletcher testified that the grip strength tests were equivocal, but not a "flat" grip strength test, which would indicate malingering or symptom magnification. He noted that Petitioner had the same equivocal test on the left, uninjured, hand. Dr. Fletcher acknowledged that the percentages of impairments used in the 6th Edition Guides were created by the Editors, without any other influence. RX1.

Petitioner testified that after sustaining this injury, she was placed in the Cryovac job, which did not require repetitious right arm movement. She ultimately bid to own that job, which paid more than her previous position of cutting jowls. She sustained an injury to her left arm as a result of her work in the Cryovac job, which is addressed in the case consolidated for hearing with the case herein. Eventually, she bid for a job in the laundry, which does not require repetitious use of either arm or hand. It is a management position and provided her with an opportunity to earn more in the future than if she had remained in the Cryovac position. She testified that when she bid for the job, she initially earned $.40 per hour less than she would have earned in the Cryovac position.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. The parties stipulated that the only issue in dispute was the nature and extent of the injury. 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)**, Respondent submitted an impairment rating performed by Dr. Fletcher using the AMA Guides 6th Edition. Dr. Fletcher found 5% impairment of the right upper extremity. He acknowledged that Petitioner reported right hand numbness and weakness, pins and needles to her right hand and elbow, aching of her right hand and elbow, and had a moderate to severe QuickDASH score of 65.9. However, he found no abnormalities on physical examination except for the surgical scars. He testified that there was probably not a correlation between Petitioner's physical examination findings and her QuickDASH score, and that her subjective complaints appeared high compared to her physical examination. He noted that there was a question about the reliability of the grip strength testing, as it was not considered maximum effort.

The Arbitrator recognizes that permanent partial disability and impairment as defined by the AMA Guides are not the same. The Arbitrator makes note of this distinction when assessing the weight given to Dr. Fletcher's impairment rating 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 in the jowl cutting area at the time of the accident and was eventually released to full duty work. Dr. Wolters recommended that she apply for other jobs which did not require repetitive meat cutting. She transferred to a Cryovac job after her injury, and thereafter bid to stay in the job. She later bid for a job in Laundry, which she currently held at the time of arbitration. She testified that this was a management position, which provided her with an opportunity to earn more in the future than if she had remained in the Cryovac position. However, when she first started in the Laundry position, she earned $.40 less per hour than when she was in Cryovac. She testified that there are times she will assist with knife sharpening, but otherwise she is not utilizing a knife in the performance of any job duties. The Arbitrator places greater weight on this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 34 years old at the time of the accident. She is a young individual and has many work years ahead of her, during which she must deal with her disability Over time, her condition could improve, stay the same, or get worse. The Arbitrator places greater weight on this factor.

In regard to factor **(iv) the employee's future earning capacity**, Petitioner testified that she bid from the jowls cutting job, which was a grade 3 job, to the Cryovac position, which was a grade 5 job, and which paid more than the jowls cutting position. Petitioner then voluntarily bid to a management position in the laundry, which initially will pay $.40 per hour less than the

Cryovac position. However, Petitioner testified that this was a voluntary job change and that she could have remained in the Cryovac position. Petitioner also testified that the laundry position provides her with an opportunity to make more money in the future than if she had remained in the Cryovac position, which is not a management position. The Arbitrator concludes that any impact on Petitioner's earning capacity was voluntary and will be temporary. The Arbitrator places some weight on this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical record**, the Arbitrator notes that Petitioner underwent surgery which included three procedures—right carpal tunnel release, radial tunnel release, and posterior interosseous nerve decompression. She continued to experience symptoms postoperatively, which were addressed conservatively with physical therapy and splinting. The final physical therapy report from September 14, 2017, noted that Petitioner's range of motion and strength were within normal limits. The Arbitrator notes that in Dr. Wolters' final office record of September 15, 2017, he noted that Petitioner had full range of motion of the right elbow, negative cubital tunnel Tinel's test on the right hand, and full dorsiflexion strength of the right wrist. Petitioner did report that whenever she performed meat carving with her hands, she continued to have increased pain in the right forearm in both the medial and the dorsal aspects. Dr. Fletcher's examination nine months later, on June 29, 2018, found no objective abnormalities except for the surgical scarring. He testified that the physical examination did not correlate with Petitioner's subjective complaints. The Arbitrator places significant weight on this factor.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration and based on the record in its entirety, the Arbitrator finds that Petitioner has sustained a 10% loss of use of the right hand (19 weeks) and a 15% loss of use of the right arm (37.95 weeks) pursuant to Section 8(e) of the Act. The parties stipulated that Petitioner's average weekly wage was $605.50. The Arbitrator finds her permanent partial disability rate is $363.30.

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

Melisa Queiro,
Petitioner,
vs.

NO: 18WC005418
(consolidated with No. 17WC32832)

JBS USA,
Respondent.

20IWCC0203

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 15, 2019, 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 24 2020

Marc Parker

Barbara N. Flores

Deborah Simpson

o030520
MP/jrc
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

QUEIRO, MELISA
Employee/Petitioner

Case# **18WC005418**

17WC032832

JBS USA
Employer/Respondent

20IWCC0203

On 8/15/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2934 BOSHARDY LAW OFFIC PC
JOHN V BOSHARDY
1610 S 6TH ST
SPRINGFIELD, IL 62703

2461 NYHAN BAMBRICK KINZIE & LOWRY
JASON PAYNE
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602-4195

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

MELISA QUEIRO
Employee/Petitioner

v.

JBS USA
Employer/Respondent

Case # **18** WC **005418**

Consolidated cases: **17 WC 32832**

20IWCC0203

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 **Springfield**, on **March 26, 2019**. By stipulation, the parties agree:

On the date of accident, **January 19, 2018**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**33,631.28**, and the average weekly wage was $**659.44**.

At the time of injury, Petitioner was **36** years of age, ***single*** with **1** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner the sum of $395.66/week for a further period of **20** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **4% loss of use of the body as a whole.**

Respondent shall pay Petitioner compensation that has accrued from **September 14, 2018,** through **March 26, 2019**, 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

August 12, 2019
Date

AUG 15 2019

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT

MELISA QUEIRO
Employee/Petitioner

v.

Case #: 18 WC 005418
& 17 WC 32832

JBS USA
Employer/Respondent

20IWCC0203

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner filed two Applications for Adjustment of Claim: (1) 17 WC 32832, injury to right hand and elbow, date of accident August 2, 2016; and (2) 18 WC 005418, injury to left shoulder, date of accident January 19, 2018. The cases were consolidated for purposes of arbitration; however, they involve distinct and separate body parts and are therefore addressed in separate Arbitration Decisions. The parties stipulated that the only issue in dispute is the nature and extent of Petitioner's permanent partial disability.

On January 19, 2018, Petitioner was 36 years old, single, and had one dependent child. Her average weekly wage was $659.44. She testified that while treating for her right hand and right elbow in case 17 WC 32832, she was transferred to the Cryovac position. The job involved repeatedly pushing meat into plastic bags. In that position, she used her left arm more than her right arm, and she developed problems in her left shoulder, for which she sought treatment with the plant medical department.

On March 14, 2018, Petitioner presented to Dr. Robert Gordon, the plant doctor from Midwest Occupational Health Associates. She reported pain in the left shoulder/left upper arm region and numbness and tingling of the left upper extremity, which she attributed to operating the Cryovac machine. Following examination, Dr. Gordon diagnosed her with rotator cuff tendinitis/bursitis, and prescribed Mobic and Flexeril. He noted that Petitioner had been taken off of the Cryovac job. PX2.

Petitioner returned to MOHA on April 5, 2018, and was seen by Advanced Practice Nurse Sandra Elliot. She reported no improvement and in fact noted that the shoulder hurt worse. Her range of motion was consistent, but decreased from normal. She reported that her

symptoms increased significantly when she worked in Cryovac, and that when she was able to rotate to another job her symptoms were not as bad. On examination, there was moderate tenderness to the anterior aspect, moderate tenderness to the glenohumeral area, mildly decreased range of motion, and mildly positive empty can test. Petitioner's supervisor was present for the appointment, and discussed her job duties. He stated that Petitioner would be moved to wiping condensation duties. APRN Elliott recommended Petitioner bid off the Cryovac job, and she was agreeable. Petitioner was instructed to stop taking the Meloxicam and to start Relafen instead. She was referred for x-rays and to physical therapy. PX2. Left shoulder x-rays were performed at Passavant Area Hospital on April 9, 2018, and were normal. PX3.

On April 11, 2018, Petitioner presented for an initial physical therapy evaluation at Apex Physical Therapy. She reported a consistent history of injury. There was noted weakness and decreased range of motion. She attended nine therapy sessions throughout April 2018. PX4.

Petitioner returned to MOHA on April 19, 2018, and was again seen by APRN Elliott. She reported no improvement in symptoms and was having trouble sleeping due to shoulder pain. She had continued weakness, numbness, and tinging in the left upper extremity. On examination, there was moderate tenderness to the anterior aspect of the left shoulder and left glenohumeral region. Range of motion was somewhat improved. Strength was decreased, hand grip was decreased, and empty can test was positive. Petitioner was instructed to continue current job duties with wiping condensation, and to continue with Relafen, Flexeril, and physical therapy. An MRI was ordered at that time. PX2.

On April 25, 2018, Petitioner underwent a left shoulder MRI. It revealed (1) supraspinatus infraspinatus mild tendinosis without evidence of significant tearing; and (2) "SLAP tear—likely old with granulation tissue". PX5.

On April 26, 2018, Petitioner was seen by Dr. Gordon, who reviewed the MRI findings with her and recommended referral to orthopedics. PX2.

On May 9, 2018, Petitioner presented to Dr. Brett Wolters at Springfield Clinic, who had previously treated her right elbow and wrist conditions under case 17 WC 32832. On examination, there was a mildly positive Whipple test on the left. Apprehension and Speed's tests were positive. Dr. Wolters reviewed the MRI and noted rotator cuff tendinopathy, mild acromial clavicular joint osteoarthritis, and a degenerative SLAP tear. He diagnosed (1) rotator cuff tendinopathy/impingement syndrome; (2) internal contracture secondary to impingement syndrome; (3) mild acromioclavicular joint osteoarthritis; and (4) possible degenerative SLAP tear. He recommended a cortisone injection and continuation of physical therapy and Flexeril. It is unclear from the record whether the cortisone injection was administered that day. PX6.

Petitioner attended physical therapy at Apex throughout the month of May 2018. PX4.

On June 13, 2018, Petitioner returned to Dr. Wolters and reported some improvement with therapy, but continued significant pain at night. She noted she had vacuumed a few days prior, which caused increased pain. She was currently working in the laundry and was doing reasonably well with that. On examination, there was pain with Neer Hawkins impingement

testing, and significant pain with passive abduction of the shoulder. There was mild pain with Speed's testing and mild pain over the AC joint. Dr. Wolters recommended continued conservative treatment with physical therapy and medication, and a "repeat" cortisone injection if not better at follow up in six weeks. PX6.

Petitioner attended physical therapy throughout the months of June and July 2018. PX4.

On July 25, 2018, Petitioner returned to Dr. Wolters and reported continued pain in the left shoulder, without relief through physical therapy. She noted that the previous cortisone injection did not improve her symptoms significantly except for the first five days. She also reported numbness and tingling in the left arm. On examination, there was significant pain with Neer and Hawkins impingement testing. Strength and sensation were mildly decreased on the left. Carpal tunnel compression test on the left was mildly positive. Treatment options were discussed, including living with the condition and undergoing surgery. Petitioner advised she did not want any additional cortisone injections and believed she was just going to have to live with the pain. Dr. Wolters explained that some people responded well to subacromial decompression surgery and some did not. He noted, "I recommended that she consider the option of surgery. She will think about this." He recommended an EMG/NCS due to her complaints of numbness, with follow up after the testing. PX6. During arbitration, Petitioner testified that she was not told by Dr. Wolters that he was recommending surgery.

On August 28, 2019, Petitioner underwent an EMG/NCS by Dr. John Watson. There was no evidence of a left upper extremity medial or ulnar neuropathy and no evidence of brachial plexopathy or cervical radiculopathy. PX7.

On September 14, 2018, Petitioner returned to Dr. Wolters and reported she was feeling somewhat better. It was noted she was working in the laundry area. She continued to report some minimal numbness in her left hand, but noted it was much improved. She reported pain with overhead activities on the left shoulder. The normal EMG/NCS results were discussed. On examination, there was pain with Neer Hawkins impingement testing, but strength was normal. Assessment was left shoulder impingement syndrome, AC joint osteoarthritis, and possible SLAP tear, and resolving left hand numbness. Petitioner underwent a repeat cortisone injection in the left subacromial space. Work restrictions were to be addressed through MOHA, and Petitioner was released from Dr. Wolters' care at that time. There was no mention of the need or recommendation for surgery. PX6. The Arbitrator notes this is the last treatment record.

Petitioner testified that she had not returned to Dr. Wolters since he released on September 14, 2018, and that she did not have any appointments to see him.

Petitioner testified that after sustaining her right elbow and wrist injury, addressed in the case consolidated for hearing with the case herein, she was placed in the Cryovac job, which did not require repetitious right arm movement. She ultimately bid to own that job, which paid more than her previous position of cutting jowls. She then sustained the left arm injury addressed in the instant case, as a result of her work in the Cryovac job. Eventually, she bid for a job in the laundry, which does not require repetitious use of either arm or hand. It is a management position and provided her with an opportunity to earn more in the future than if she had remained

in the Cryovac position. She testified that when she bid for the job, she initially earned $.40 per hour less than she would have earned in the Cryovac position. Regarding her current symptoms, Petitioner testified that if she uses her left shoulder, it bothers her. She continues to have pain with lifting her left arm over her head and when she sleeps on it.

CONCLUSIONS OF LAW

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

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

In regard to factor **(ii) the occupation of the injured employee**, the record reveals that at the time of her first accident, addressed in the case consolidated for hearing with the case herein, she was placed in the Cryovac job, which did not require repetitious right arm movement. She thereafter bid to stay in the job. She later bid for a job in Laundry, which she currently held at the time of arbitration. She testified that this was a management position, which provided her with an opportunity to earn more in the future than if she had remained in the Cryovac position. However, when she first started in the Laundry position, she earned $.40 less per hour than when she was in Cryovac. Petitioner testified that she could have remained in her previous position, but chose to bid to the management position in Laundry. The Arbitrator places greater weight on this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 36 years old at the time of the accident. She is a young individual and has many work years ahead of her, during which she must deal with her disability Over time, her condition could improve, stay the same, or get worse. The Arbitrator places greater weight on this factor.

In regard to factor **(iv) the employee's future earning capacity**, Petitioner testified that she bid from the previous jowls cutting job, which was a grade 3 job, to the Cryovac position, which was a grade 5 job, and which paid more than the jowls cutting position. Petitioner then voluntarily bid to a management position in the laundry, which initially will pay $.40 per hour less than the Cryovac position. However, Petitioner testified that this was a voluntary job change and that she could have remained in the Cryovac position. Petitioner also testified that the laundry position provides her with an opportunity to make more money in the future than if she had remained in the Cryovac position, which is not a management position. The Arbitrator concludes that any impact on Petitioner's earning capacity was voluntary and will be temporary. The Arbitrator places some weight on this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical record**, the Arbitrator notes that Petitioner treated for shoulder complaints for approximately eight months. She underwent approximately four months of physical therapy and two injections. The Arbitrator notes that in Dr. Wolters' final office record of September 14, 2018, he noted that she continued to have pain with impingement testing, but strength was normal. Assessment at that time was left shoulder impingement syndrome, AC joint osteoarthritis, and possible SLAP tear, and resolving left hand numbness. There was no mention of the need or recommendation for surgery. Petitioner testified that she had not returned to Dr. Wolters since that time, but that she continued to experience pain with lifting her left arm over her head and when she sleeps on it. The Arbitrator notes that Petitioner's testimony is generally consistent with her treating medical records. The Arbitrator places significant weight on this factor, particularly in light of the two injections.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration and based on the record in its entirety, the Arbitrator finds that Petitioner has sustained a 4% loss of use of the body as a whole (20 weeks) pursuant to Section 8(d)2. The parties stipulated that Petitioner's average weekly wage was $659.44. The Arbitrator finds her permanent partial disability rate is $395.66.

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

RICKY WIELAND,

Petitioner,

vs. NO: 11 WC 42764

COUNTY OF PEORIA,

Respondent.

20IWCC0204

DECISION AND OPINION ON §19(h) AND §8(a) PETITION

This case comes before the Commission on Petitioner's §19(h) and §8(a) Petition, filed on March 17, 2015 and heard before Commissioner Luskin on June 11, 2018, alleging a material increase in his disability resulting in additional permanent disability and claiming additional medical expenses following the previous arbitration hearing, which was held on December 21, 2012.

To summarize the history of this case, Petitioner sustained a right hip injury at work on March 10, 2011. He underwent a right total hip replacement on January 23, 2012. After a hearing on December 21, 2012, the Arbitrator issued a decision on March 14, 2013, finding causation and awarding temporary total disability benefits and medical expenses. The Arbitrator also awarded "50% loss of use of the right leg minus a credit for 12.78% paid previously." *Arb.Dec. at 6.* On June 9, 2014, the Commission issued a Decision, which affirmed and adopted the Arbitrator's decision.

Subsequently, the "Stryker" hardware that had been implanted in Petitioner's hip was recalled and Petitioner was having progressive pain along with elevated cobalt and chromium levels in his blood. *T.20, Px2, Px3.* Petitioner filed a Petition under Sections 19(h) and 8(a) on March 17, 2015. He underwent a revision hip surgery with implantation of new hardware on July 2, 2015. *Px2.*

20IWCC0204

We note that the §8(a) medical portion of the petition is no longer at issue. Petitioner's brief states, "Medical and TTD were paid in full for the second surgery." *Petitioner's Brief at 1.* Likewise, Respondent's brief states, "The medical bills submitted by the Petitioner's attorney in front of the Honorable Commissioner Luskin have been paid subject to the fee schedule by the Respondent in this case." *Respondent's Brief at 5-6.* Therefore, we are limiting this Decision to the §19(h) petition, which alleges a material increase in Petitioner's disability and requests additional permanent disability of 15% loss of use of the right leg. In contrast, Respondent argues that "Petitioner's complaints were exactly the same as he had at the first hearing" and that he failed to prove a "material increase in his disability." *Respondent's Brief at 7 and 8.*

The Commission first points out that Petitioner's accident occurred on March 10, 2011. Since this was before September 1, 2011, the five permanent partial disability factors in §8.1b of the Act do not apply and the Commission is not required to address those factors.

To compare Petitioner's current complaints with those at the arbitration hearing, we first look to the Arbitrator's March 14, 2013 decision, which was affirmed and adopted by the Commission on June 9, 2014. Regarding nature and extent, the Arbitrator wrote:

> Petitioner testified that while he has returned to work on a full duty basis, he notices a substantial decrease in his physical abilities relating to his right hip. He testified that when he sits for any extended period of time, his hip begins to ache and he needs to shift positions. Likewise, if he stands for too long, he has pain in his hip and while he is able to walk without assistance, any substantial distances causes his hip to ache. He notices that changes in weather cause pain in his hip, and that he has pain and stiffness in the morning which [sic: sentence/paragraph ends abruptly]
>
> Petitioner's testimony about his hip is credible and substantiates a permanent partial disability of 50% loss of use of the right leg minus a credit for 12.78% paid previously. *Arb.Dec. at 6.*

In the Findings of Fact section, the Arbitrator also wrote:

> Prior to his injury, Petitioner was an avid outdoorsman participating in hunting and fishing through the year. He climbed deer stands, used "waders" in the water, hiked in and out of hunting areas, and launched and retrieved his boat as part of these activities. In addition, Petitioner testified that he worked overtime on a regular basis, took care of his home and yard without assistance, and walked for long distances without pain. *Arb.Dec. at 3.*

The Commission finds that there are many similarities between Petitioner's complaints at the time of the 2012 arbitration hearing and those he testified to having at the current §19(h) hearing. For example, Petitioner is still working full duty and has similar complaints of right hip achiness, difficulty standing and walking, inability to use "waders" while fishing, etc. However, there are a few differences, which we address in more detail.

First, there is a difference between the medical records then and now and, particularly, regarding the development of sciatic pain. On May 23, 2012, Petitioner saw Mark Lauffer, PA-C, who wrote that Petitioner was "back at work without any problems." Petitioner denied any pain and "is able to do most everything he wants." Petitioner had excellent range of motion of the hip and walked without any gait disturbance. However, at the December 21, 2012 arbitration hearing, Petitioner testified that he had various problems and symptoms, which were not corroborated by the treating medical records. The Arbitrator's permanency award reflected consideration of these non-corroborated complaints, which was appropriate at the time because this is a pre-September 1, 2011 case and the five factors in §8.1b did not apply.

Petitioner's last visit to Mr. Lauffer, PA-C, prior to the §19(h) hearing, was on September 28, 2016. This record indicates that Petitioner had achiness as well as some sciatic pain, which he noticed after being on concrete floors all day. Petitioner also complained that he "cannot walk much or long distances due to the sciatica like pain," which is more laterally and posteriorly in his buttock region. Petitioner still had full and excellent range of motion of the right hip and he walked independently with no gait disturbance.

Petitioner's brief claims that "his physical therapist stated that this pain was due to the hip having to be revised a second time and that Petitioner should consider injections for his relief." *Petitioner's Brief at 4*. However, it appears that this note was written by Dr. Akeson's Physician's Assistant, Mark Lauffer. Regarding Petitioner's "continued discomfort in his hip," Mr. Lauffer wrote, "I think just due to being a revisional surgery, he may have just continued aches in that hip but everything looks fine, however." Mr. Lauffer suggested Petitioner could consider therapy for strengthening or a referral "for some injections around the sciatic region" which may help "with some of this."

The question we have, however, is whether Mr. Lauffer actually opined that Petitioner's sciatic symptoms were causally related to his revision surgery? When the note is read closely, he actually said the "continued aches in that hip" are due to the revisional surgery. However, he never made such a clear connection with the sciatic and leg symptoms. We find that this note does not rule out some other unrelated lumbar condition as the cause of Petitioner's new sciatic symptoms.

Another aspect of Petitioner's "sciatic" problem is that, on May 30, 2014, before Petitioner's revision surgery, he complained to Dr. Akeson about activity-related pain **anteriorly** and laterally at the hip and some in the gluteal area. About four months after his revision surgery, Petitioner told his physical therapist, on November 18, 2015, that he was walking and continued to perform his exercises. There was no mention of any sciatic pain. This note also indicates that Petitioner returned to hunting and "has even dragged a couple of deer out of the woods." Petitioner was discharged and told to follow up prn. Therefore, there was a period of time after Petitioner's surgery that he did not have any sciatic pain, which would indicate that there could be another cause of his new symptoms. Furthermore, on September 28, 2016, Mr. Lauffer documented lateral and **posterior** pain along with pain in the buttock region.

The Commission is also skeptical about the severity of Petitioner's sciatic complaints

because of the gap in treatment of over 20 months between September, 28, 2016 and the §19(h) hearing on June 11, 2018. If this new symptom truly constituted a "material increase in disability," we question why Petitioner did not return to have the injections for sciatic pain that Mr. Lauffer recommended.

The second difference in Petitioner's condition is, at the original arbitration hearing, Petitioner testified that he did not take any medication for his hip. *T.12/21/12 at 34.* At the §19(h) hearing, he testified that he now takes 3 or 4 over-the-counter Ibuprofen about 3 or 4 days a week. *T.27.* However, we find that Petitioner failed to prove that his use of this medication is related to his revision hip surgery and work accident as opposed to a different source of his new sciatic pain.

Third, Petitioner testified that he is now unable to keep his wallet in his right pocket because his leg will go numb when he sits. *T.23.* Again, we find that Petitioner has not proven that this is related to his revision hip surgery.

Fourth, Petitioner testified that he does not really walk anymore and has gained weight. *T.23.* He testified that after the first surgery he was walking every day and weighed "220, 230" but now he weighs over 290 pounds. *T.22.* However, the records show that Petitioner also weighed 285 pounds at the time of the original work injury. *See 3/10/11 IWIRC record.* It is true that Petitioner lost weight after his first hip replacement and weighed 230 pounds as of May 8, 2015, prior to his revision surgery on July 2, 2015. However, Petitioner was still recorded as weighing 242 pounds when he last saw Mark Lauffer on September 28, 2016. We did not find a recent medical record to support Petitioner's §19(h) hearing testimony that he now weighs 290 pounds. Regardless, even if he does weigh that much, it is commensurate to what he weighed before his work injury. Furthermore, even if Petitioner is unable to walk due to pain, we still find that Petitioner failed to prove that this new sciatic problem is causally related to his work injury and revision hip surgery.

Turning to Respondent's brief, it includes "Points and Authorities" for its "Burden of Proof" section. It indicates that there are other cases and decisions cited on pages 6 and 11. However, there are no cases cited on page 6 and there is no page 11. Respondent does cite to a Commission decision on page 7, *Lamborn v. Bridgestone*, (6 IWCC 1203; 2006 Ill. Wrk. Comp. LEXIS 1219), for the proposition that, "The possibility of additional surgery was taken into consideration when the petitioner was [sic] received an original award of 55% of a leg in that case. In *Lamborn*, the petitioner underwent a surgery to his knee after the first trial." *Respondent's Brief at 7.*

In *Lamborn*, the Commission specifically noted that Dr. Novotny's pre-arbitration report indicated that the petitioner "may require additional reconstructive surgery in the future." In other words, the petitioner's original permanency award already contemplated the possibility of a future surgery. In contrast, there is no evidence in the case at bar that it was contemplated that Petitioner would need a revision hip replacement surgery in the future. It appears that this only became necessary because Petitioner's original hardware was recalled and he was having problems with it. Therefore, we find that Respondent's reliance on *Lamborn* is not on point.

20IWCC0204

Analyzing Petitioner's claim of a material increase in disability, we note that prior to the five-factor-analysis instituted in §8.1b, the number of surgeries a petitioner underwent was a factor the Commission considered in determining a permanency award. Therefore, we find that under a pre-§8.1b permanency analysis, Petitioner is entitled to an additional award of 5% loss of use of the right leg under §8(e)12 of the Act. We find that Petitioner failed to prove that his new sciatic symptoms are causally related to his work accident.

Petitioner's average weekly wage was previously adjudicated to be $911.00. Based on this, his permanent partial disability benefit rate is $546.60 per week.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition under §19(h) is hereby granted, in part.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $546.60 per week for a period of 10.75 weeks, as provided in §8(e)12 of the Act, for the reason that Petitioner has proven a material increase in his disability under §19(h) of the Act to the extent of an additional 5% loss of use of the right leg.

The party commencing 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 24 2020

Maria E. Portela

D. Douglas McCarthy

Kathryn A. Doerries

SE/
O: 3/10/20
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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMIE SCHMITT,

Petitioner,

vs. NO: 17 WC 37190

MEMORIAL HOSPITAL,

Respondent.

20IWCC0205

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, medical expenses, and credit for overpayment of temporary total disability benefits, 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 parties stipulated that Petitioner's period of temporary total disability (TTD) was 2-6/7 weeks from September 15, 2017 through October 5, 2017, and that Respondent had paid $1,746.24 in TTD benefits. In the Findings section, the Arbitrator wrote, "The parties stipulated TTD and TPD benefits were paid in full." However, it is not clear from the decision that there was an overpayment of TTD benefits. We note that Petitioner's Statement of Exceptions on Review stipulates that Respondent is entitled to a credit of $911.80 for an overpayment of TTD benefits. Therefore, we modify the decision to reflect this credit.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable and necessary medical services as identified in Petitioner's Exhibit 8, excepting

20IWCC0205

those incurred in connection with the MRI spectroscopy, 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 for prospective medical treatment including, but not limited to, the disc replacement surgery recommended by Dr. Matthew Gornet.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $911.80 for the overpayment of temporary total disability benefits under Section 8(b) of the Act.

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

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

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

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

DATED: MAR 2 7 2020

Maria Elena Portela
Maria E. Portela

D. Douglas McCarthy

Kathryn A. Doerries
Kathryn A. Doerries

SE/
O: 3/10/20
49

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

SCHMITT, JAMIE
Employee/Petitioner

Case# **17WC037190**

17WC037197
17WC037196

MEMORIAL HOSPITAL
Employer/Respondent

20IWCC0205

On 6/18/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.13% 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:

0656 GLASS & KOREIN LLC
MICHAEL H KOREIN
7012 W MAIN ST
BELLEVILLE, IL 62223

1679 MATHIS MARIFIAN & RICHTER LTD
DEANNA L LITZENBURG
23 PUBLIC SQ SUITE 300
BELLEVILLE, IL 62222

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Jamie Schmitt
Employee/Petitioner

Case # 17 WC 37190

v.

Consolidated cases: 17 WC 37197

Memorial Hospital
Employer/Respondent

20IWCC0205

17 WC 37196

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on May 22, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0205

FINDINGS

On the date of accident, September 1, 2017, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $18,395.78; the average weekly wage was $438.09.

On the date of accident, Petitioner was 38 years of age, single with 2 dependent child(ren).

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

Respondent shall be given a credit of $1,746.24 for TTD, $3,267.10 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $5,013.34. The parties stipulated TTD and TPD benefits were paid in full.

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 8, excepting those incurred in connection with the MRI spectroscopy, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the disc replacement surgery recommended by Dr. Matthew Gornet.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

June 15, 2019
Date

JUN 18 2019

Findings of Fact

Petitioner filed three Applications for Adjustment of Claim which alleged she sustained accidental injuries arising out of and in the course of her employment by Respondent. In case 17 WC 37190, the Application alleged Petitioner sustained an accident on September 1, 2017, while "helping lift a patient" and sustained an injury to her "low back." In case 17 WC 37197, the Application alleged Petitioner sustained an accident on October 30, 2017, when she was "catching patient who was falling" and sustained a "low back injury." In case 17 WC 37196, the Application alleged Petitioner sustained an accident on December 7, 2017, while "lifting patient onto bed" and sustained a "low back injury" (Arbitrator's Exhibit 2).

In cases 17 WC 37190 and 17 WC 37196, Respondent stipulated Petitioner sustained a work-related accident, but in case 17 WC 37197, Respondent disputed Petitioner sustained a work-related accident. In all three cases, Respondent disputed liability on the basis of causal relationship. The three cases were previously consolidated and were tried in a 19(b) proceeding. Petitioner sought an order for payment of medical bills as well as prospective medical treatment. Petitioner and Respondent stipulated that temporary total disability and temporary partial disability benefits had been paid in full (Arbitrator's Exhibit 1).

As aforestated, the three accidents all involved low back injuries sustained by Petitioner as she was attempting to lift/move patients. Petitioner testified she previously received treatment for low back and right SI joint symptoms between August, 2012, and April, 2013. That medical treatment was received in regard to another workers' compensation claim against a different employer which was settled. Petitioner also testified she received treatment for low back symptoms between July, 2015, and November, 2016, with right and left leg pain, more right than left. Petitioner stated she received conservative treatment including injections and, by November, 2016, the symptoms had completely resolved.

Petitioner became employed by Respondent in December, 2016, as a patient care technician. Petitioner's job duties included lifting/moving patients. Petitioner stated she had no low back or leg symptoms from the time she began working for Respondent in December, 2016, until the accident of September 1, 2017.

Medical records for treatment received prior to the accident of September 1, 2017, were received into evidence at trial. Petitioner was treated at SIHF Healthcare (hereinafter referred to as "SIHF"), from September 24, 2012, through May 27, 2014, because of a variety of health issues. When seen on September 24, 2012, Petitioner had complaints of right thigh pain, but it was noted she had back pain associated with a work injury. When Petitioner was subsequently evaluated on March 6, 2013, primarily for neck/shoulder symptoms, it was noted Petitioner was off work because of a work injury involving the low back and SI joint. Petitioner was subsequently seen on a number of occasions through May 27, 2014, for a variety of reasons including sunburn, fatigue, obesity, heart issues, sore throat, etc. There was no mention of Petitioner having low back or radiating leg pain (Petitioner's Exhibit 1).

Petitioner was subsequently seen at SIHF on October 26, 2015, and complained of chronic low back pain which had been present for three months. Petitioner stated the pain was on the right

side of her back and went down the back of her right leg. The record noted Petitioner had been previously diagnosed with an L4-L5 herniation and had received SI injections. Petitioner was again seen on December 3, 2015, and an MRI was ordered (Petitioner's Exhibit 1).

The MRI was performed on December 8, 2015. According to the radiologist, the MRI revealed a left posterior disc protrusion at L3-L4 and peripheral annular tears and a tiny central disc protrusion at L4-L5 with facet joint degenerative changes (Petitioner's Exhibit 1).

Petitioner was subsequently seen at SIHF on April 1, 2016, and was diagnosed with lumbar radiculopathy with symptoms on the right even though the MRI had findings on the left. Petitioner was again seen at SIHF on September 7, and November 2, 2016, for low back pain. When seen on November 2, 2016, Petitioner advised she had received injections after her last visit and was "pain free." Further, Petitioner was not having any problems lifting/moving residents at work. The medical record of that date noted Petitioner's lumbar radiculopathy had resolved (Petitioner's Exhibit 1).

Petitioner was again seen at SIHF on February 6, 2017, but for throat pain. Low back pain and lumbar radiculopathy were listed as problems; however, Petitioner had no complaints regarding same at that time. Further, examination of the lumbar and SI joints revealed no tenderness (Petitioner's Exhibit 1).

On September 1, 2017, Petitioner was transferring a patient with another employee. Petitioner estimated the patient weighed 380 to 400 pounds. The patient's knees gave out which caused Petitioner to sustain an onset of severe low back pain with radiation down both legs, more on the left than right.

Petitioner initially sought medical treatment on September 12, 2017, in Employee Health Services. At that time, Petitioner advised she sustained an injury to her left shoulder and low back and experienced radiation into both legs. The record of that date noted that the physician (whose name not indicated) who evaluated Petitioner had previously examined Petitioner on August 29, 2016, and did not approve her being hired because she had significant pre-existing orthopedic problems. He/she opined that if Petitioner was hired, she should not perform patient lifting/transfers. Petitioner was referred to Dr. Patricia Hurford, a physiatrist (Petitioner's Exhibit 4).

Dr. Hurford evaluated Petitioner on September 26, 2017. At that time, Petitioner complained of low back pain and bilateral leg symptoms. Dr. Hurford noted Petitioner had a prior history of SI joint symptoms on the right, but Petitioner had not had any problems since having injections over one year prior. Dr. Hurford opined Petitioner had sustained a lumbar strain injury with severe low back symptoms and bilateral radicular complaints, but without objective findings of radiculopathy. Dr. Hurford prescribed medication, ordered physical therapy and an MRI and also imposed work/activity restrictions (Petitioner's Exhibit 6).

The MRI was performed on September 28, 2017. According to the radiologist, there was lumbar disc degeneration, but no disc herniations; however, annular bulges were noted at L3-L4 and L4-L5 (Petitioner's Exhibit 5).

Dr. Hurford subsequently saw Petitioner on October 5, 2017, and reviewed the MRI scan. She opined the MRI was unremarkable and opined Petitioner had sustained a severe strain injury. She recommended further conservative treatment and continued work/activity restrictions (Petitioner's Exhibit 6).

On October 13, 2017, Petitioner was seen at SIHF. At that time, Petitioner complained of low back pain, shooting pain down both legs, left greater than right, numbness/pins and needles sensations in her legs and groin area, and "Charlie horses" in her inner thighs. Petitioner was diagnosed with an unspecified back injury and directed to follow-up with Dr. Hurford (Petitioner's Exhibit 1).

Petitioner testified she reinjured her back on October 30, 2017. Petitioner was on light duty at that time; however, when a patient started to fall, Petitioner caught the patient and experienced an onset of right-sided low back pain. As aforestated, Respondent disputed Petitioner sustained a work-related accident on October 30, 2017, primarily because there was no injury report. However, Petitioner called Employee Health Service on October 30, 2017, and reported she had sustained a work-related injury that day. Petitioner was seen there the following day, October 31, 2017, and was directed to return to Dr. Hurford (Petitioner's Exhibit 4).

Dr. Hurford saw Petitioner on November 15, 2017. At that time, Petitioner advised Dr. Hurford of the accident of October 30, 2017, and she had experienced an aggravation of her symptoms. Dr. Hurford ordered a CT myelogram (Petitioner's Exhibit 6).

The CT myelogram was performed on November 22, 2017. According to the radiologist, the CT myelogram revealed circumferential disc bulges at L3-L4 and L4-L5 with moderate spinal canal stenosis (Petitioner's Exhibit 6).

Dr. Hurford saw Petitioner on December 4, 2017, and reviewed the CT myelogram. She opined it was not substantially different than any of the prior diagnostic studies. Dr. Hurford opined Petitioner had sustained work-related injuries on September 1, 2017, and October 30, 2017, and diagnosed her with a lumbar sprain, spondylosis of the lumbar joint and parasthesias. Dr. Hurford opined Petitioner was at MMI, could work without restrictions and recommended Petitioner return to her primary care physician for treatment of her pre-existing spine condition (Petitioner's Exhibit 6).

On December 7, 2017, Petitioner was in the process of moving a patient onto a bed. At that time, Petitioner experienced an onset of low back pain which radiated into both legs. Petitioner reported the accident to Respondent the same day and was seen in Employee Health Service the following day. At that time, Petitioner advised she had sustained a re-injury to her low back and legs. In regard to Dr. Hurford's recommendation she see her primary care physician, Petitioner advised this was not possible because her primary care physician would not see her because of the involvement of workers' comp (Petitioner's Exhibit 4).

Petitioner subsequently sought medical treatment from Dr. Matthew Gornet, an orthopedic surgeon. Dr. Gornet initially evaluated Petitioner on February 9, 2018. At that time, Petitioner complained of low back pain in both sides, pain in both buttocks/hips and down both legs.

Petitioner informed Dr. Gornet of the accident of September 1, 2017, and that she had been treated by Dr. Hurford who had opined that she was at MMI and could work without restrictions. Petitioner also informed Dr. Gornet that she was treated for SI joint pain in 2013 in 2015 and had received injections (Petitioner's Exhibit 7).

Dr. Gornet reviewed the MRI scans of September 28, 2017, and December 8, 2015. He opined the MRI of September 28, 2017, was of moderate/poor quality, but did reveal an annular tear at L4-L5. When compared to the prior MRI of December 8, 2015, Dr. Gornet opined there was a change in its overall appearance. Dr. Gornet opined Petitioner's condition was related to her work injury, prescribed medication, imposed work/activity restrictions and referred Petitioner to Dr. Helen Blake for epidural steroid injections. Dr. Gornet also ordered a high resolution MRI scan (Petitioner's Exhibit 7).

Petitioner was seen by Dr. Helen Blake on March 6, and March 20, 2018. On those occasions, Dr. Blake performed epidural steroid injections at L4-L5 on the left and L5-S1 on the left, respectively (Petitioner's Exhibit 7).

The MRI ordered by Dr. Gornet was performed on April 19, 2018. According to the radiologist, the MRI revealed a small left protrusion at L3-L4 near the left L3 nerve root and a small annular tear abnormality at L4-L5 (Petitioner's Exhibit 7).

Dr. Gornet saw Petitioner on April 19, 2018, and reviewed the MRI scan. He opined the majority of Petitioner's pain was probably because of the findings at L4-L5. He noted Petitioner had received steroid injections, which did not give her any significant relief. Petitioner still complained of low back pain in both sides, both buttocks/hips with tingling in her legs. Dr. Gornet reaffirmed his opinion that Petitioner's symptoms were related to the work injury of September 1, 2017. He recommended Petitioner undergo a CT discogram from L3-S1 as well as an MRI spectroscopy from L3-S1. He continued to impose light duty restrictions, but noted Petitioner was no longer working for Respondent, but working for her husband in a light duty capacity (Petitioner's Exhibit 7).

The discogram and MRI spectroscopy were performed on May 4, 2018. The discogram revealed a provocative disc at L4-L5 with annular tear. The MRI spectroscopy revealed abnormal chemical levels at L4-L5. The report of the MRI spectroscopy contained the following: "Investigational device. Limited by Federal Law to investigational use only." (Petitioner's Exhibit 7).

At the direction of Respondent, Petitioner was examined by Dr. Michael Chabot, an orthopedic surgeon, on May 14, 2018. In connection with his examination of Petitioner, Dr. Chabot reviewed medical records and diagnostic studies provided to him by Respondent. Dr. Chabot opined Petitioner sustained strain injuries as a result of the three work-related accidents, but his findings on examination were normal. He disagreed with Dr. Gornet's interpretation of the MRIs and did not observe any evidence of changes indicative of an injury to a disk. He opined Petitioner was at MMI and her symptoms had returned to a baseline level. However, Dr. Chabot also noted Petitioner was not a good candidate to work as a CNA unless there was significant lifting and patient transfer restrictions imposed. He opined Petitioner had chronic low back pain,

chronic SI dysfunction and morbid obesity. He imposed work/activity restrictions, but opined they were not based on any of the work accidents Petitioner had sustained (Respondent's Exhibit 1; Deposition Exhibit 2).

In regard to the prior medical treatment Petitioner had received, Dr. Chabot opined it was all reasonable and necessary, with exceptions of the epidural steroid injections, CT discogram and MRI spectroscopy. In regard to the MRI spectroscopy, Dr. Chabot noted it was for investigational use only and not appropriate for making clinical recommendations (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Gornet subsequently saw Petitioner on June 4, 2018, and reviewed the discogram and MRI spectroscopy. At that time, Dr. Gornet recommended Petitioner undergo disc replacement surgery at L4-L5. Because of Petitioner's weight, he recommended she lose weight, exercise and remain on light duty (Petitioner's Exhibit 7).

Dr. Chabot received additional medical records, primarily the results of the discogram and MRI spectroscopy, and prepared a supplemental report dated June 12, 2018. He reaffirmed his opinion that the MRI spectroscopy was not medically necessary. He also opined Petitioner was not a surgical candidate as it related to the three work-related accidents (Respondent's Exhibit 1; Deposition Exhibit 3).

Dr. Gornet saw Petitioner on August 6, 2018, and reviewed Dr. Chabot's report (which appears to of been Dr. Chabot's initial report of May 14, 2018). Dr. Gornet agreed Petitioner had pre-existing conditions, but that the accident aggravated the underlying conditions and probably produced a new injury (Petitioner's Exhibit 7).

Dr. Chabot was deposed on October 26, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Chabot's testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. Specifically, Dr. Chabot testified Petitioner had sustained back strains/sprains as a result of the accidents of September 1, 2017, October 30, 2017, and December 7, 2017, had a history of chronic low back pain with radiculopathy, chronic SI joint degeneration, chronic sacroiliitis and morbid obesity. Dr. Chabot testified Petitioner had reached MMI and returned to her baseline level. He also stated Petitioner should not return to work as a CNA, but could work in a light duty capacity with lifting restrictions (Respondent's Exhibit 1; pp 16-18).

In regard to the treatment Petitioner had previously received, Dr. Chabot testified the epidural steroid injections were not warranted because they are performed to address radicular symptoms which Petitioner did not have. He testified the discogram was not appropriate because it is an invasive procedure which can cause damage to the disc spaces. In regard to the MRI spectroscopy, he testified this procedure was not appropriate because it is not a validated diagnostic procedure and should not be used to determine whether surgery is indicated (Respondent's Exhibit 1; pp 18-20).

On cross-examination, Dr. Chabot was interrogated about his review of the medical records which predated the first accident of September 1, 2017. While the record of October 26, 2015,

noted Petitioner had a history of chronic low back pain for the preceding three months, there was no history of any low back or SI joint symptoms from April, 2013, through October 26, 2015. Further, Dr. Chabot agreed Petitioner last sought treatment for low back symptoms in November, 2016, at which time she was pain free. Dr. Chabot also agreed Petitioner had been working full duty as a CNA prior to the accident of September 1, 2017 (Respondent's Exhibit 1; pp 33, 38, 44).

Dr. Gornet last saw Petitioner on February 21, 2019, and he reviewed Dr. Chabot's report of June 12, 2018. Dr. Gornet stated Dr. Chabot's opinion regarding the use of MRI spectroscopy was inaccurate and misleading and that the test clearly indicated Petitioner had painful chemicals present at the L4-L5 level (Petitioner's Exhibit 7).

At trial, Petitioner testified she ceased working for Respondent after the accident of December 7, 2017. In February, 2018, Petitioner began working for her husband as an office manager. She stated the restrictions imposed by Dr. Gornet had been accommodated. Petitioner still has low back and leg pain, more on the left than right. She wants to proceed with the disc replacement surgery as recommended by Dr. Gornet.

Conclusions of Law

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

The Arbitrator concludes Petitioner's current condition of ill-being is causally related to the accident of September 1, 2017.

In support of this conclusion the Arbitrator notes following:

There was no dispute Petitioner sustained a work-related accident on September 1, 2017, which caused an onset of severe full back pain with radiation into both legs, left more than right.

Petitioner sustained a prior low back injury which periodically caused low back and SI symptoms. However, when seen on November 2, 2016, Petitioner was "pain free" and able to perform all of her job duties which included lifting/moving patients.

Petitioner was able to perform all of her job duties from the time she was hired by Respondent in December, 2016, until she sustained the accident on September 1, 2017.

Petitioner's primary treating physician, Dr. Gornet, has examined Petitioner on multiple occasions, reviewed various diagnostic tests, and has opined her condition is related to the accident of September 1, 2017.

Respondent's Section 12 examiner, Dr. Chabot, opined Petitioner's pre-existing condition returned to baseline and that she was at MMI; however, he also opined Petitioner should not work as a CNA because of her underlying condition. He also agreed Petitioner was symptom free in November, 2016, and was able to work without restrictions from the time she was hired in December, 2016, until she sustained the accident of September 1, 2017.

The Arbitrator notes that Respondent's physician who examined Petitioner on August 29, 2016, (which was prior to her being employed by Respondent) opined Petitioner should not have been hired because of her pre-existing orthopedic problems and Petitioner should not be performing patient lifting/transfers. This physician seemed to have anticipated Petitioner would sustain a work-related injury.

Based upon the preceding, the Arbitrator finds the opinion of Dr. Gornet to be more persuasive than that of Dr. Chabot in regard to causality.

The Arbitrator also finds the subsequent accidents of October 30, 2017, and December 7, 2017, to be exacerbations of the injury Petitioner sustained on September 1, 2017.

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary, with the exception of the MRI spectroscopy, and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 8, excepting those incurred in connection with the MRI spectroscopy, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In support of this conclusion the Arbitrator notes the following:

The only medical services in dispute are those provided or ordered by Dr. Gornet. Because of the Arbitrator's conclusion of law in disputed issue (F), the treatment provided by or ordered by Dr. Gornet is causally related to the accident of September 1, 2017, even though the MRI spectroscopy was found to be not medically necessary.

The Arbitrator was not persuaded by Dr. Chabot's opinion that the epidural steroid injections and discogram were medically unnecessary. However, the Arbitrator was not persuaded that the MRI spectroscopy was a necessary diagnostic procedure to determine whether Petitioner should undergo disc replacement surgery.

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

The Arbitrator concludes Petitioner is entitled to prospective medical treatment including, but not limited to, the disc replacement surgery recommended by Dr. Gornet.

In support of this conclusion the Arbitrator notes the following:

Petitioner has had extensive conservative treatment without any significant reduction of her low back and leg symptoms. Dr. Gornet has recommended disc replacement surgery at L4-L5.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMIE SCHMITT,
Petitioner,

vs.

NO: 17WC 37196

MEMORIAL HOSPITAL,
Respondent.

20IWCC0206

DECISION AND OPINION ON REVIEW

Timely Petition for Review under section 19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, and credit for overpayment of temporary total disability benefits, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 18, 2019, 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 27 2020
o031020
MEP/jrc
049

Maria Elena Portela
Maria E. Portela

D. Douglas McCarthy
D.Douglas McCarthy

Kathryn A. Doerries
Kathryn A. Doerries

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

SCHMITT, JAMIE
Employee/Petitioner

Case# **17WC037196**

17WC037190
17WC037197

MEMORIAL HOSPITAL
Employer/Respondent

20IWCC0206

On 6/18/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.13% 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:

0656 GLASS & KOREIN LLC
MICHEAL H KOREIN
7012 W MAIN ST
BELLEVILLE, IL 62223

1679 MATHIS MARIFIAN & RICHTER LTD
DEANNA L LITZENBURG
23 PUBLIC SQ SUITE 300
BELLEVILLE, IL 62222

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Jamie Schmitt
Employee/Petitioner

v.

Memorial Hospital
Employer/Respondent

Case # 17 WC 37196

Consolidated cases: 17 WC 37190

17WC37197

20IWCC0206

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on May 22, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, December 7, 2017, Respondent was operating under and subject 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 $18,395.78; the average weekly wage was $438.09.

On the date of accident, Petitioner was 38 years of age, single with 2 dependent child(ren).

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $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, all benefits are awarded under case number 17 WC 37190.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

June 15, 2019
Date

JUN 18 2019

Findings of Fact

Petitioner filed three Applications for Adjustment of Claim which alleged she sustained accidental injuries arising out of and in the course of her employment by Respondent. In case 17 WC 37190, the Application alleged Petitioner sustained an accident on September 1, 2017, while "helping lift a patient" and sustained an injury to her "low back." In case 17 WC 37197, the Application alleged Petitioner sustained an accident on October 30, 2017, when she was "catching patient who was falling" and sustained a "low back injury." In case 17 WC 37196, the Application alleged Petitioner sustained an accident on December 7, 2017, while "lifting patient onto bed" and sustained a "low back injury" (Arbitrator's Exhibit 2).

In cases 17 WC 37190 and 17 WC 37196, Respondent stipulated Petitioner sustained a work-related accident, but in case 17 WC 37197, Respondent disputed Petitioner sustained a work-related accident. In all three cases, Respondent disputed liability on the basis of causal relationship. The three cases were previously consolidated and were tried in a 19(b) proceeding. Petitioner sought an order for payment of medical bills as well as prospective medical treatment. Petitioner and Respondent stipulated that temporary total disability and temporary partial disability benefits had been paid in full (Arbitrator's Exhibit 1).

As aforestated, the three accidents all involved low back injuries sustained by Petitioner as she was attempting to lift/move patients. Petitioner testified she previously received treatment for low back and right SI joint symptoms between August, 2012, and April, 2013. That medical treatment was received in regard to another workers' compensation claim against a different employer which was settled. Petitioner also testified she received treatment for low back symptoms between July, 2015, and November, 2016, with right and left leg pain, more right than left. Petitioner stated she received conservative treatment including injections and, by November, 2016, the symptoms had completely resolved.

Petitioner became employed by Respondent in December, 2016, as a patient care technician. Petitioner's job duties included lifting/moving patients. Petitioner stated she had no low back or leg symptoms from the time she began working for Respondent in December, 2016, until the accident of September 1, 2017.

Medical records for treatment received prior to the accident of September 1, 2017, were received into evidence at trial. Petitioner was treated at SIHF Healthcare (hereinafter referred to as "SIHF"), from September 24, 2012, through May 27, 2014, because of a variety of health issues. When seen on September 24, 2012, Petitioner had complaints of right thigh pain, but it was noted she had back pain associated with a work injury. When Petitioner was subsequently evaluated on March 6, 2013, primarily for neck/shoulder symptoms, it was noted Petitioner was off work because of a work injury involving the low back and SI joint. Petitioner was subsequently seen on a number of occasions through May 27, 2014, for a variety of reasons including sunburn, fatigue, obesity, heart issues, sore throat, etc. There was no mention of Petitioner having low back or radiating leg pain (Petitioner's Exhibit 1).

Petitioner was subsequently seen at SIHF on October 26, 2015, and complained of chronic low back pain which had been present for three months. Petitioner stated the pain was on the right

side of her back and went down the back of her right leg. The record noted Petitioner had been previously diagnosed with an L4-L5 herniation and had received SI injections. Petitioner was again seen on December 3, 2015, and an MRI was ordered (Petitioner's Exhibit 1).

The MRI was performed on December 8, 2015. According to the radiologist, the MRI revealed a left posterior disc protrusion at L3-L4 and peripheral annular tears and a tiny central disc protrusion at L4-L5 with facet joint degenerative changes (Petitioner's Exhibit 1).

Petitioner was subsequently seen at SIHF on April 1, 2016, and was diagnosed with lumbar radiculopathy with symptoms on the right even though the MRI had findings on the left. Petitioner was again seen at SIHF on September 7, and November 2, 2016, for low back pain. When seen on November 2, 2016, Petitioner advised she had received injections after her last visit and was "pain free." Further, Petitioner was not having any problems lifting/moving residents at work. The medical record of that date noted Petitioner's lumbar radiculopathy had resolved (Petitioner's Exhibit 1).

Petitioner was again seen at SIHF on February 6, 2017, but for throat pain. Low back pain and lumbar radiculopathy were listed as problems; however, Petitioner had no complaints regarding same at that time. Further, examination of the lumbar and SI joints revealed no tenderness (Petitioner's Exhibit 1).

On September 1, 2017, Petitioner was transferring a patient with another employee. Petitioner estimated the patient weighed 380 to 400 pounds. The patient's knees gave out which caused Petitioner to sustain an onset of severe low back pain with radiation down both legs, more on the left than right.

Petitioner initially sought medical treatment on September 12, 2017, in Employee Health Services. At that time, Petitioner advised she sustained an injury to her left shoulder and low back and experienced radiation into both legs. The record of that date noted that the physician (whose name not indicated) who evaluated Petitioner had previously examined Petitioner on August 29, 2016, and did not approve her being hired because she had significant pre-existing orthopedic problems. He/she opined that if Petitioner was hired, she should not perform patient lifting/transfers. Petitioner was referred to Dr. Patricia Hurford, a physiatrist (Petitioner's Exhibit 4).

Dr. Hurford evaluated Petitioner on September 26, 2017. At that time, Petitioner complained of low back pain and bilateral leg symptoms. Dr. Hurford noted Petitioner had a prior history of SI joint symptoms on the right, but Petitioner had not had any problems since having injections over one year prior. Dr. Hurford opined Petitioner had sustained a lumbar strain injury with severe low back symptoms and bilateral radicular complaints, but without objective findings of radiculopathy. Dr. Hurford prescribed medication, ordered physical therapy and an MRI and also imposed work/activity restrictions (Petitioner's Exhibit 6).

The MRI was performed on September 28, 2017. According to the radiologist, there was lumbar disc degeneration, but no disc herniations; however, annular bulges were noted at L3-L4 and L4-L5 (Petitioner's Exhibit 5).

Dr. Hurford subsequently saw Petitioner on October 5, 2017, and reviewed the MRI scan. She opined the MRI was unremarkable and opined Petitioner had sustained a severe strain injury. She recommended further conservative treatment and continued work/activity restrictions (Petitioner's Exhibit 6).

On October 13, 2017, Petitioner was seen at SIHF. At that time, Petitioner complained of low back pain, shooting pain down both legs, left greater than right, numbness/pins and needles sensations in her legs and groin area, and "Charlie horses" in her inner thighs. Petitioner was diagnosed with an unspecified back injury and directed to follow-up with Dr. Hurford (Petitioner's Exhibit 1).

Petitioner testified she reinjured her back on October 30, 2017. Petitioner was on light duty at that time; however, when a patient started to fall, Petitioner caught the patient and experienced an onset of right-sided low back pain. As aforestated, Respondent disputed Petitioner sustained a work-related accident on October 30, 2017, primarily because there was no injury report. However, Petitioner called Employee Health Service on October 30, 2017, and reported she had sustained a work-related injury that day. Petitioner was seen there the following day, October 31, 2017, and was directed to return to Dr. Hurford (Petitioner's Exhibit 4).

Dr. Hurford saw Petitioner on November 15, 2017. At that time, Petitioner advised Dr. Hurford of the accident of October 30, 2017, and she had experienced an aggravation of her symptoms. Dr. Hurford ordered a CT myelogram (Petitioner's Exhibit 6).

The CT myelogram was performed on November 22, 2017. According to the radiologist, the CT myelogram revealed circumferential disc bulges at L3-L4 and L4-L5 with moderate spinal canal stenosis (Petitioner's Exhibit 6).

Dr. Hurford saw Petitioner on December 4, 2017, and reviewed the CT myelogram. She opined it was not substantially different than any of the prior diagnostic studies. Dr. Hurford opined Petitioner had sustained work-related injuries on September 1, 2017, and October 30, 2017, and diagnosed her with a lumbar sprain, spondylosis of the lumbar joint and parasthesias. Dr. Hurford opined Petitioner was at MMI, could work without restrictions and recommended Petitioner return to her primary care physician for treatment of her pre-existing spine condition (Petitioner's Exhibit 6).

On December 7, 2017, Petitioner was in the process of moving a patient onto a bed. At that time, Petitioner experienced an onset of low back pain which radiated into both legs. Petitioner reported the accident to Respondent the same day and was seen in Employee Health Service the following day. At that time, Petitioner advised she had sustained a re-injury to her low back and legs. In regard to Dr. Hurford's recommendation she see her primary care physician, Petitioner advised this was not possible because her primary care physician would not see her because of the involvement of workers' comp (Petitioner's Exhibit 4).

Petitioner subsequently sought medical treatment from Dr. Matthew Gornet, an orthopedic surgeon. Dr. Gornet initially evaluated Petitioner on February 9, 2018. At that time, Petitioner complained of low back pain in both sides, pain in both buttocks/hips and down both legs.

Petitioner informed Dr. Gornet of the accident of September 1, 2017, and that she had been treated by Dr. Hurford who had opined that she was at MMI and could work without restrictions. Petitioner also informed Dr. Gornet that she was treated for SI joint pain in 2013 in 2015 and had received injections (Petitioner's Exhibit 7).

Dr. Gornet reviewed the MRI scans of September 28, 2017, and December 8, 2015. He opined the MRI of September 28, 2017, was of moderate/poor quality, but did reveal an annular tear at L4-L5. When compared to the prior MRI of December 8, 2015, Dr. Gornet opined there was a change in its overall appearance. Dr. Gornet opined Petitioner's condition was related to her work injury, prescribed medication, imposed work/activity restrictions and referred Petitioner to Dr. Helen Blake for epidural steroid injections. Dr. Gornet also ordered a high resolution MRI scan (Petitioner's Exhibit 7).

Petitioner was seen by Dr. Helen Blake on March 6, and March 20, 2018. On those occasions, Dr. Blake performed epidural steroid injections at L4-L5 on the left and L5-S1 on the left, respectively (Petitioner's Exhibit 7).

The MRI ordered by Dr. Gornet was performed on April 19, 2018. According to the radiologist, the MRI revealed a small left protrusion at L3-L4 near the left L3 nerve root and a small annular tear abnormality at L4-L5 (Petitioner's Exhibit 7).

Dr. Gornet saw Petitioner on April 19, 2018, and reviewed the MRI scan. He opined the majority of Petitioner's pain was probably because of the findings at L4-L5. He noted Petitioner had received steroid injections, which did not give her any significant relief. Petitioner still complained of low back pain in both sides, both buttocks/hips with tingling in her legs. Dr. Gornet reaffirmed his opinion that Petitioner's symptoms were related to the work injury of September 1, 2017. He recommended Petitioner undergo a CT discogram from L3-S1 as well as an MRI spectroscopy from L3-S1. He continued to impose light duty restrictions, but noted Petitioner was no longer working for Respondent, but working for her husband in a light duty capacity (Petitioner's Exhibit 7).

The discogram and MRI spectroscopy were performed on May 4, 2018. The discogram revealed a provocative disc at L4-L5 with annular tear. The MRI spectroscopy revealed abnormal chemical levels at L4-L5. The report of the MRI spectroscopy contained the following: "Investigational device. Limited by Federal Law to investigational use only." (Petitioner's Exhibit 7).

At the direction of Respondent, Petitioner was examined by Dr. Michael Chabot, an orthopedic surgeon, on May 14, 2018. In connection with his examination of Petitioner, Dr. Chabot reviewed medical records and diagnostic studies provided to him by Respondent. Dr. Chabot opined Petitioner sustained strain injuries as a result of the three work-related accidents, but his findings on examination were normal. He disagreed with Dr. Gornet's interpretation of the MRIs and did not observe any evidence of changes indicative of an injury to a disk. He opined Petitioner was at MMI and her symptoms had returned to a baseline level. However, Dr. Chabot also noted Petitioner was not a good candidate to work as a CNA unless there was significant lifting and patient transfer restrictions imposed. He opined Petitioner had chronic low back pain,

chronic SI dysfunction and morbid obesity. He imposed work/activity restrictions, but opined they were not based on any of the work accidents Petitioner had sustained (Respondent's Exhibit 1; Deposition Exhibit 2).

In regard to the prior medical treatment Petitioner had received, Dr. Chabot opined it was all reasonable and necessary, with exceptions of the epidural steroid injections, CT discogram and MRI spectroscopy. In regard to the MRI spectroscopy, Dr. Chabot noted it was for investigational use only and not appropriate for making clinical recommendations (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Gornet subsequently saw Petitioner on June 4, 2018, and reviewed the discogram and MRI spectroscopy. At that time, Dr. Gornet recommended Petitioner undergo disc replacement surgery at L4-L5. Because of Petitioner's weight, he recommended she lose weight, exercise and remain on light duty (Petitioner's Exhibit 7).

Dr. Chabot received additional medical records, primarily the results of the discogram and MRI spectroscopy, and prepared a supplemental report dated June 12, 2018. He reaffirmed his opinion that the MRI spectroscopy was not medically necessary. He also opined Petitioner was not a surgical candidate as it related to the three work-related accidents (Respondent's Exhibit 1; Deposition Exhibit 3).

Dr. Gornet saw Petitioner on August 6, 2018, and reviewed Dr. Chabot's report (which appears to of been Dr. Chabot's initial report of May 14, 2018). Dr. Gornet agreed Petitioner had pre-existing conditions, but that the accident aggravated the underlying conditions and probably produced a new injury (Petitioner's Exhibit 7).

Dr. Chabot was deposed on October 26, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Chabot's testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. Specifically, Dr. Chabot testified Petitioner had sustained back strains/sprains as a result of the accidents of September 1, 2017, October 30, 2017, and December 7, 2017, had a history of chronic low back pain with radiculopathy, chronic SI joint degeneration, chronic sacroiliitis and morbid obesity. Dr. Chabot testified Petitioner had reached MMI and returned to her baseline level. He also stated Petitioner should not return to work as a CNA, but could work in a light duty capacity with lifting restrictions (Respondent's Exhibit 1; pp 16-18).

In regard to the treatment Petitioner had previously received, Dr. Chabot testified the epidural steroid injections were not warranted because they are performed to address radicular symptoms which Petitioner did not have. He testified the discogram was not appropriate because it is an invasive procedure which can cause damage to the disc spaces. In regard to the MRI spectroscopy, he testified this procedure was not appropriate because it is not a validated diagnostic procedure and should not be used to determine whether surgery is indicated (Respondent's Exhibit 1; pp 18-20).

On cross-examination, Dr. Chabot was interrogated about his review of the medical records which predated the first accident of September 1, 2017. While the record of October 26, 2015,

noted Petitioner had a history of chronic low back pain for the preceding three months, there was no history of any low back or SI joint symptoms from April, 2013, through October 26, 2015. Further, Dr. Chabot agreed Petitioner last sought treatment for low back symptoms in November, 2016, at which time she was pain free. Dr. Chabot also agreed Petitioner had been working full duty as a CNA prior to the accident of September 1, 2017 (Respondent's Exhibit 1; pp 33, 38, 44).

Dr. Gornet last saw Petitioner on February 21, 2019, and he reviewed Dr. Chabot's report of June 12, 2018. Dr. Gornet stated Dr. Chabot's opinion regarding the use of MRI spectroscopy was inaccurate and misleading and that the test clearly indicated Petitioner had painful chemicals present at the L4-L5 level (Petitioner's Exhibit 7).

At trial, Petitioner testified she ceased working for Respondent after the accident of December 7, 2017. In February, 2018, Petitioner began working for her husband as an office manager. She stated the restrictions imposed by Dr. Gornet had been accommodated. Petitioner still has low back and leg pain, more on the left than right. She wants to proceed with the disc replacement surgery as recommended by Dr. Gornet.

Conclusions of Law

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

The Arbitrator concludes Petitioner's current condition of ill-being is not related to the accident of December 7, 2017.

In support of this conclusion the Arbitrator notes following:

As noted in the Arbitrator's Decision in case 17 WC 37190, the Arbitrator found Petitioner's current condition of ill-being to be related to the accident of September 1, 2017.

In regard to disputed issues (J) and (K) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's Decision in case 17 WC 37190.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMIE SCHMITT,
Petitioner,

vs.

NO: 17WC 37197

20IWCC0207

MEMORIAL HOSPITAL,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under section 19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, and credit for overpayment of temporary total disability benefits, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 18, 2019, 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 27 2020
o031020
MEP/jrc
049

Maria Elena Portela
Maria E. Portela

D Douglas McCarthy
D. Douglas McCarthy

Kathryn A. Doerries
Kathryn A. Doerries

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

SCHMITT, JAMIE
Employee/Petitioner

Case# **17WC037197**

17WC037190
17WC037196

MEMORIAL HOSPITAL
Employer/Respondent

20IWCC0207

On 6/18/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.13% 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:

0656 GLASS & KOREIN LLC
MICHAEL H KOREIN
7012 W MAIN ST
BELLEVILLE, IL 62223

1679 MATHIS MARIFIAN & RICHTER LTD
DEANNA L LITZENBURG
23 PUBLIC SQ SUITE 300
BELLEVILLE, IL 62222

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Jamie Schmitt
Employee/Petitioner

v.

Memorial Hospital
Employer/Respondent

Case # 17 WC 37197

Consolidated cases: 17 WC 37190, 17 WC 37196

20IWCC0207

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on May 22, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, October 30, 2017, Respondent was operating under and subject 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 $18,395.78; the average weekly wage was $438.09.

On the date of accident, Petitioner was 38 years of age, single with 2 dependent child(ren).

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $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, all benefits are awarded under case number 17 WC 37190.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

June 15, 2019
Date

JUN 18 2019

Findings of Fact

Petitioner filed three Applications for Adjustment of Claim which alleged she sustained accidental injuries arising out of and in the course of her employment by Respondent. In case 17 WC 37190, the Application alleged Petitioner sustained an accident on September 1, 2017, while "helping lift a patient" and sustained an injury to her "low back." In case 17 WC 37197, the Application alleged Petitioner sustained an accident on October 30, 2017, when she was "catching patient who was falling" and sustained a "low back injury." In case 17 WC 37196, the Application alleged Petitioner sustained an accident on December 7, 2017, while "lifting patient onto bed" and sustained a "low back injury" (Arbitrator's Exhibit 2).

In cases 17 WC 37190 and 17 WC 37196, Respondent stipulated Petitioner sustained a work-related accident, but in case 17 WC 37197, Respondent disputed Petitioner sustained a work-related accident. In all three cases, Respondent disputed liability on the basis of causal relationship. The three cases were previously consolidated and were tried in a 19(b) proceeding. Petitioner sought an order for payment of medical bills as well as prospective medical treatment. Petitioner and Respondent stipulated that temporary total disability and temporary partial disability benefits had been paid in full (Arbitrator's Exhibit 1).

As aforestated, the three accidents all involved low back injuries sustained by Petitioner as she was attempting to lift/move patients. Petitioner testified she previously received treatment for low back and right SI joint symptoms between August, 2012, and April, 2013. That medical treatment was received in regard to another workers' compensation claim against a different employer which was settled. Petitioner also testified she received treatment for low back symptoms between July, 2015, and November, 2016, with right and left leg pain, more right than left. Petitioner stated she received conservative treatment including injections and, by November, 2016, the symptoms had completely resolved.

Petitioner became employed by Respondent in December, 2016, as a patient care technician. Petitioner's job duties included lifting/moving patients. Petitioner stated she had no low back or leg symptoms from the time she began working for Respondent in December, 2016, until the accident of September 1, 2017.

Medical records for treatment received prior to the accident of September 1, 2017, were received into evidence at trial. Petitioner was treated at SIHF Healthcare (hereinafter referred to as "SIHF"), from September 24, 2012, through May 27, 2014, because of a variety of health issues. When seen on September 24, 2012, Petitioner had complaints of right thigh pain, but it was noted she had back pain associated with a work injury. When Petitioner was subsequently evaluated on March 6, 2013, primarily for neck/shoulder symptoms, it was noted Petitioner was off work because of a work injury involving the low back and SI joint. Petitioner was subsequently seen on a number of occasions through May 27, 2014, for a variety of reasons including sunburn, fatigue, obesity, heart issues, sore throat, etc. There was no mention of Petitioner having low back or radiating leg pain (Petitioner's Exhibit 1).

Petitioner was subsequently seen at SIHF on October 26, 2015, and complained of chronic low back pain which had been present for three months. Petitioner stated the pain was on the right side of her back and went down the back of her right leg. The record noted Petitioner had been previously diagnosed with an L4-L5 herniation and had received SI injections. Petitioner was again seen on December 3, 2015, and an MRI was ordered (Petitioner's Exhibit 1).

The MRI was performed on December 8, 2015. According to the radiologist, the MRI revealed a left posterior disc protrusion at L3-L4 and peripheral annular tears and a tiny central disc protrusion at L4-L5 with facet joint degenerative changes (Petitioner's Exhibit 1).

Petitioner was subsequently seen at SIHF on April 1, 2016, and was diagnosed with lumbar radiculopathy with symptoms on the right even though the MRI had findings on the left. Petitioner was again seen at SIHF on September 7, and November 2, 2016, for low back pain. When seen on November 2, 2016, Petitioner advised she had received injections after her last visit and was "pain free." Further, Petitioner was not having any problems lifting/moving residents at work. The medical record of that date noted Petitioner's lumbar radiculopathy had resolved (Petitioner's Exhibit 1).

Petitioner was again seen at SIHF on February 6, 2017, but for throat pain. Low back pain and lumbar radiculopathy were listed as problems; however, Petitioner had no complaints regarding same at that time. Further, examination of the lumbar and SI joints revealed no tenderness (Petitioner's Exhibit 1).

On September 1, 2017, Petitioner was transferring a patient with another employee. Petitioner estimated the patient weighed 380 to 400 pounds. The patient's knees gave out which caused Petitioner to sustain an onset of severe low back pain with radiation down both legs, more on the left than right.

Petitioner initially sought medical treatment on September 12, 2017, in Employee Health Services. At that time, Petitioner advised she sustained an injury to her left shoulder and low back and experienced radiation into both legs. The record of that date noted that the physician (whose name not indicated) who evaluated Petitioner had previously examined Petitioner on August 29, 2016, and did not approve her being hired because she had significant pre-existing orthopedic problems. He/she opined that if Petitioner was hired, she should not perform patient lifting/transfers. Petitioner was referred to Dr. Patricia Hurford, a physiatrist (Petitioner's Exhibit 4).

Dr. Hurford evaluated Petitioner on September 26, 2017. At that time, Petitioner complained of low back pain and bilateral leg symptoms. Dr. Hurford noted Petitioner had a prior history of SI joint symptoms on the right, but Petitioner had not had any problems since having injections over one year prior. Dr. Hurford opined Petitioner had sustained a lumbar strain injury with severe low back symptoms and bilateral radicular complaints, but without objective findings of radiculopathy. Dr. Hurford prescribed medication, ordered physical therapy and an MRI and also imposed work/activity restrictions (Petitioner's Exhibit 6).

The MRI was performed on September 28, 2017. According to the radiologist, there was lumbar disc degeneration, but no disc herniations; however, annular bulges were noted at L3-L4 and L4-L5 (Petitioner's Exhibit 5).

Dr. Hurford subsequently saw Petitioner on October 5, 2017, and reviewed the MRI scan. She opined the MRI was unremarkable and opined Petitioner had sustained a severe strain injury. She recommended further conservative treatment and continued work/activity restrictions (Petitioner's Exhibit 6).

On October 13, 2017, Petitioner was seen at SIHF. At that time, Petitioner complained of low back pain, shooting pain down both legs, left greater than right, numbness/pins and needles sensations in her legs and groin area, and "Charlie horses" in her inner thighs. Petitioner was diagnosed with an unspecified back injury and directed to follow-up with Dr. Hurford (Petitioner's Exhibit 1).

Petitioner testified she reinjured her back on October 30, 2017. Petitioner was on light duty at that time; however, when a patient started to fall, Petitioner caught the patient and experienced an onset of right-sided low back pain. As aforestated, Respondent disputed Petitioner sustained a work-related accident on October 30, 2017, primarily because there was no injury report. However, Petitioner called Employee Health Service on October 30, 2017, and reported she had sustained a work-related injury that day. Petitioner was seen there the following day, October 31, 2017, and was directed to return to Dr. Hurford (Petitioner's Exhibit 4).

Dr. Hurford saw Petitioner on November 15, 2017. At that time, Petitioner advised Dr. Hurford of the accident of October 30, 2017, and she had experienced an aggravation of her symptoms. Dr. Hurford ordered a CT myelogram (Petitioner's Exhibit 6).

The CT myelogram was performed on November 22, 2017. According to the radiologist, the CT myelogram revealed circumferential disc bulges at L3-L4 and L4-L5 with moderate spinal canal stenosis (Petitioner's Exhibit 6).

Dr. Hurford saw Petitioner on December 4, 2017, and reviewed the CT myelogram. She opined it was not substantially different than any of the prior diagnostic studies. Dr. Hurford opined Petitioner had sustained work-related injuries on September 1, 2017, and October 30, 2017, and diagnosed her with a lumbar sprain, spondylosis of the lumbar joint and parasthesias. Dr. Hurford opined Petitioner was at MMI, could work without restrictions and recommended Petitioner return to her primary care physician for treatment of her pre-existing spine condition (Petitioner's Exhibit 6).

On December 7, 2017, Petitioner was in the process of moving a patient onto a bed. At that time, Petitioner experienced an onset of low back pain which radiated into both legs. Petitioner reported the accident to Respondent the same day and was seen in Employee Health Service the following day. At that time, Petitioner advised she had sustained a re-injury to her low back and legs. In regard to Dr. Hurford's recommendation she see her primary care physician, Petitioner advised this was not possible because her primary care physician would not see her because of the involvement of workers' comp (Petitioner's Exhibit 4).

Petitioner subsequently sought medical treatment from Dr. Matthew Gornet, an orthopedic surgeon. Dr. Gornet initially evaluated Petitioner on February 9, 2018. At that time, Petitioner complained of low back pain in both sides, pain in both buttocks/hips and down both legs. Petitioner informed Dr. Gornet of the accident of September 1, 2017, and that she had been treated by Dr. Hurford who had opined that she was at MMI and could work without restrictions. Petitioner also informed Dr. Gornet that she was treated for SI joint pain in 2013 in 2015 and had received injections (Petitioner's Exhibit 7).

Dr. Gornet reviewed the MRI scans of September 28, 2017, and December 8, 2015. He opined the MRI of September 28, 2017, was of moderate/poor quality, but did reveal an annular tear at L4-L5. When compared to the prior MRI of December 8, 2015, Dr. Gornet opined there was a change in its overall appearance. Dr. Gornet opined Petitioner's condition was related to her work injury, prescribed medication, imposed work/activity restrictions and referred Petitioner to Dr. Helen Blake for epidural steroid injections. Dr. Gornet also ordered a high resolution MRI scan (Petitioner's Exhibit 7).

Petitioner was seen by Dr. Helen Blake on March 6, and March 20, 2018. On those occasions, Dr. Blake performed epidural steroid injections at L4-L5 on the left and L5-S1 on the left, respectively (Petitioner's Exhibit 7).

The MRI ordered by Dr. Gornet was performed on April 19, 2018. According to the radiologist, the MRI revealed a small left protrusion at L3-L4 near the left L3 nerve root and a small annular tear abnormality at L4-L5 (Petitioner's Exhibit 7).

Dr. Gornet saw Petitioner on April 19, 2018, and reviewed the MRI scan. He opined the majority of Petitioner's pain was probably because of the findings at L4-L5. He noted Petitioner had received steroid injections, which did not give her any significant relief. Petitioner still complained of low back pain in both sides, both buttocks/hips with tingling in her legs. Dr. Gornet reaffirmed his opinion that Petitioner's symptoms were related to the work injury of September 1, 2017. He recommended Petitioner undergo a CT discogram from L3-S1 as well as an MRI spectroscopy from L3-S1. He continued to impose light duty restrictions, but noted Petitioner was no longer working for Respondent, but working for her husband in a light duty capacity (Petitioner's Exhibit 7).

The discogram and MRI spectroscopy were performed on May 4, 2018. The discogram revealed a provocative disc at L4-L5 with annular tear. The MRI spectroscopy revealed abnormal chemical levels at L4-L5. The report of the MRI spectroscopy contained the following: "Investigational device. Limited by Federal Law to investigational use only." (Petitioner's Exhibit 7).

At the direction of Respondent, Petitioner was examined by Dr. Michael Chabot, an orthopedic surgeon, on May 14, 2018. In connection with his examination of Petitioner, Dr. Chabot reviewed medical records and diagnostic studies provided to him by Respondent. Dr. Chabot opined Petitioner sustained strain injuries as a result of the three work-related accidents, but his findings on examination were normal. He disagreed with Dr. Gornet's interpretation of the MRIs

and did not observe any evidence of changes indicative of an injury to a disk. He opined Petitioner was at MMI and her symptoms had returned to a baseline level. However, Dr. Chabot also noted Petitioner was not a good candidate to work as a CNA unless there was significant lifting and patient transfer restrictions imposed. He opined Petitioner had chronic low back pain, chronic SI dysfunction and morbid obesity. He imposed work/activity restrictions, but opined they were not based on any of the work accidents Petitioner had sustained (Respondent's Exhibit 1; Deposition Exhibit 2).

In regard to the prior medical treatment Petitioner had received, Dr. Chabot opined it was all reasonable and necessary, with exceptions of the epidural steroid injections, CT discogram and MRI spectroscopy. In regard to the MRI spectroscopy, Dr. Chabot noted it was for investigational use only and not appropriate for making clinical recommendations (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Gornet subsequently saw Petitioner on June 4, 2018, and reviewed the discogram and MRI spectroscopy. At that time, Dr. Gornet recommended Petitioner undergo disc replacement surgery at L4-L5. Because of Petitioner's weight, he recommended she lose weight, exercise and remain on light duty (Petitioner's Exhibit 7).

Dr. Chabot received additional medical records, primarily the results of the discogram and MRI spectroscopy, and prepared a supplemental report dated June 12, 2018. He reaffirmed his opinion that the MRI spectroscopy was not medically necessary. He also opined Petitioner was not a surgical candidate as it related to the three work-related accidents (Respondent's Exhibit 1; Deposition Exhibit 3).

Dr. Gornet saw Petitioner on August 6, 2018, and reviewed Dr. Chabot's report (which appears to of been Dr. Chabot's initial report of May 14, 2018). Dr. Gornet agreed Petitioner had pre-existing conditions, but that the accident aggravated the underlying conditions and probably produced a new injury (Petitioner's Exhibit 7).

Dr. Chabot was deposed on October 26, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Chabot's testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. Specifically, Dr. Chabot testified Petitioner had sustained back strains/sprains as a result of the accidents of September 1, 2017, October 30, 2017, and December 7, 2017, had a history of chronic low back pain with radiculopathy, chronic SI joint degeneration, chronic sacroiliitis and morbid obesity. Dr. Chabot testified Petitioner had reached MMI and returned to her baseline level. He also stated Petitioner should not return to work as a CNA, but could work in a light duty capacity with lifting restrictions (Respondent's Exhibit 1; pp 16-18).

In regard to the treatment Petitioner had previously received, Dr. Chabot testified the epidural steroid injections were not warranted because they are performed to address radicular symptoms which Petitioner did not have. He testified the discogram was not appropriate because it is an invasive procedure which can cause damage to the disc spaces. In regard to the MRI spectroscopy, he testified this procedure was not appropriate because it is not a validated

diagnostic procedure and should not be used to determine whether surgery is indicated (Respondent's Exhibit 1; pp 18-20).

On cross-examination, Dr. Chabot was interrogated about his review of the medical records which predated the first accident of September 1, 2017. While the record of October 26, 2015, noted Petitioner had a history of chronic low back pain for the preceding three months, there was no history of any low back or SI joint symptoms from April, 2013, through October 26, 2015. Further, Dr. Chabot agreed Petitioner last sought treatment for low back symptoms in November, 2016, at which time she was pain free. Dr. Chabot also agreed Petitioner had been working full duty as a CNA prior to the accident of September 1, 2017 (Respondent's Exhibit 1; pp 33, 38, 44).

Dr. Gornet last saw Petitioner on February 21, 2019, and he reviewed Dr. Chabot's report of June 12, 2018. Dr. Gornet stated Dr. Chabot's opinion regarding the use of MRI spectroscopy was inaccurate and misleading and that the test clearly indicated Petitioner had painful chemicals present at the L4-L5 level (Petitioner's Exhibit 7).

At trial, Petitioner testified she ceased working for Respondent after the accident of December 7, 2017. In February, 2018, Petitioner began working for her husband as an office manager. She stated the restrictions imposed by Dr. Gornet had been accommodated. Petitioner still has low back and leg pain, more on the left than right. She wants to proceed with the disc replacement surgery as recommended by Dr. Gornet.

Conclusions of Law

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

The Arbitrator concludes Petitioner sustained an accidental injury arising out of and in the course of her employment by Respondent on October 30, 2017.

In support of this conclusion the Arbitrator notes the following:

Respondent's denial of accident was based primarily on the lack of an accident report. However, Petitioner reported the accident to Respondent the same day it occurred and the record in Respondent's Employee Health Service of October 31, 2017, contained the history of Petitioner having sustained a work-related accident the day before.

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

The Arbitrator concludes Petitioner's current condition of ill-being is not related to the accident of October 30, 2017.

In support of this conclusion the Arbitrator notes the following:

As noted in the Arbitrator's Decision in case 17 WC 37190, the Arbitrator found Petitioner's current condition of ill-being related to the accident of September 1, 2017.

In regard to disputed issues (J) and (K) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's Decision in case 17 WC 37190.

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Vivian D. Killebrew,

Petitioner,

vs.

NO: 18 WC 22527

Macy's,

Respondent.

20IWCC0208

DECISION AND OPINION ON REVIEW

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

I. FINDINGS OF FACT

The Commission hereby incorporates by reference the findings of fact contained in the arbitration decision, which delineate the relevant facts and analyses. However, as it pertains to penalties and fees, the Commission views the evidence differently than the Arbitrator and, thus, modifies the award accordingly.

The record establishes that Petitioner began working for Respondent in 1987. For the past 22 years leading up to the arbitration hearing, she held the title of Eileen Fisher Specialist. The record reflects that, prior to the date in question, Petitioner had no history of head, right hand or ankle injuries. Petitioner worked at the Water Tower location, where the Eileen Fisher store was located on the fourth of eight floors inside of Macy's. There is an employee-only lunchroom on the seventh floor that is accessible via escalators located in Macy's. Petitioner worked twenty-eight hours per week and testified that she used this escalator approximately ten times per shift. She had never seen a customer use the escalator ten times in one day. Customers did have access to Macy's from the first through the eighth floors.

20IWCC0208

On July 22, 2018, Petitioner was riding the Macy's escalator back to work after lunch when she heard a noise and put her right hand up to her right temple to brace herself. At that time a light fixture from the skylight ceiling hit her right hand at the thumb area. Petitioner's body then twisted to the left and she twisted her left ankle. The 1.5 square foot fixture was fifteen feet up in the air and weighed seven or eight pounds.

Petitioner sought medical care, complaining of right hand and left ankle pain, along with mild headaches, bilateral ringing in her ears and dizziness. She was ultimately diagnosed by Dr. Rubinstein with a grade I to II left ankle sprain, and significant aggravation of a pre-existing subluxation and arthritis at the carpometacarpal thumb joint.

On August 8, 2018, Petitioner presented to Dr. Kozlova, a neurologist. Petitioner's head complaints included light sensitivity, fatigue, a decline in memory and concentration, increased irritability, depression and insomnia. She was diagnosed with a mild to moderate traumatic brain injury ("TBI"). Recovery was expected within six to twelve months.

Petitioner underwent a Section 12 examination at Respondent's request with neurologist Dr. Glantz on October 17, 2018. Upon examination Dr. Glantz opined that Petitioner may have suffered a brief concussion but found no physiological basis for continued symptoms at this point. He opined that Petitioner had reached maximum medical improvement as early as one month after the accident and was capable of a full duty return to work.

Petitioner continued treating with Dr. Rubinstein, and on December 31, 2018 was returned to light duty, beginning January 12, 2019. At approximately the six-month mark, on January 9, 2019, Petitioner returned to Dr. Kozlova with persistent head symptoms. Dr. Kozlova again noted a six to twelve-month recovery outlook, with the possibility of mild residuals persisting longer. Dr. Kozlova noted that symptoms may worsen, and that studies suggest some forms of TBI have delayed progression. Dr. Kozlova opined that Petitioner's remaining symptoms at that time were likely to be lifelong and chronic. As of January 28, 2019, Dr. Rubinstein maintained Petitioner's light duty status at 28 hours of work per week. Petitioner was to follow up on March 4, 2019.

II. CONCLUSIONS OF LAW

The Commission affirms the findings of the Arbitrator regarding accident, causal connection, medical expenses, temporary total disability and the reimbursement of bank fees. However, regarding penalties and fees, the Commission views the evidence differently than the Arbitrator.

Respondent admitted that Petitioner's injuries occurred in the course of her employment but argued that they did not arise out of the employment. However, Respondent noted the three categories of risk to which an employee is exposed, including risks distinctly associated with employment, personal risks, and neutral risks that have no particular employment or personal characteristics. *Illinois Institute of Technology Research Institute v. Industrial Comm'n*, 314 Ill.App.3d 149 (2000). Respondent argued that under a neutral risk analysis the question is

20IWCC0208

whether the employee was exposed to a risk greater than that of the general public. The increased risk may be qualitative or quantitative. *Metro. Water Reclamation Dist. of Greater Chi. v. Illinois Workers' Compensation Comm'n*, 407 Ill. App.3d 1010 (2011). While the Commission ultimately affirms the Arbitrator's rulings finding that Petitioner established that she sustained a compensable accident and a causal connection between her accident and condition of ill-being, we simultaneously acknowledge that it was not unreasonable or vexatious for Respondent to apply a neutral risk analysis to the facts of Petitioner's case at the time it denied benefits. Accordingly, the Commission reverses and vacates the Arbitrator's award of penalties and fees.

All else is affirmed and adopted.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner has met her burden of proof in relation to accident and causal connection to her current condition of ill-being related to her July 22, 2018 work accident.

IT IS ORDERED BY THE COMMISSION that the Arbitrator's awards of temporary total disability, medical expenses and reimbursement of bank fees be affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the award for penalties and fees pursuant to sections 16, 19(k) and 19(l) of the Act is hereby vacated.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit 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 $14,200.00. 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.

MAR 27 2020

DATED:
o: 3/9/20
BNF/wde
45

Barbara N. Flores

Deborah L. Simpson

Marc Parker

8 0 8 0 0 9 0 1 1 0 8

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

KILLEBREW, VIVIAN
Employee/Petitioner

Case# **18WC022527**

MACY'S
Employer/Respondent

20IWCC0208

On 5/16/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.35% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2739 SMOLER LAW OFFICE PC
ROBERT J SMOLER
30 N LASALLE ST SUITE 2140
CHICAGO, IL 60602

5001 GAIDO & FINTZEN
MALLORY ZIMET
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)

Vivian Killebrew,
Employee/Petitioner
v.
Macy's,
Employer/Respondent

Case # **18** WC **22527**

20IWCC0208

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Watts**, Arbitrator of the Commission, in the city of **Chicago**, on **February 6, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of 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 **$12.00 bank service charge**

FINDINGS

On the date of accident, **July 22, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**30,222.40**; the average weekly wage was $**581.20**.

On the date of accident, Petitioner was **60** years of age, ***single*** with **0** 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 $6,586.31 for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**6,586.31**.

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

ORDER

THE PETITIONER did have an accident that arose out of and in the course of Petitioner's employment by Respondent.

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

Temporary Total Disability - Respondent shall pay Petitioner temporary total disability benefits of $387.43/week for 25 5/7 weeks, commencing 07/23/2018 through 01/17/2019, as provided in Section 8(b) of the Act.

Medical benefits - Respondent shall pay reasonable and necessary medical services of $10,727.32, as provided in Sections 8(a) and 8.2 of the Act.

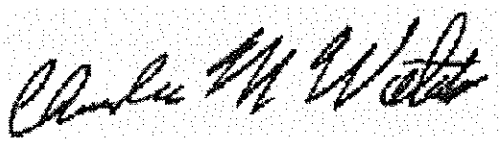
Penalties - Respondent shall pay to Petitioner penalties of $**2,826.32**, as provided in Section 16 of the Act; $**7,065.80**, as provided in Section 19(k) of the Act; and $**6,000.00**, as provided in Section 19(l) of the Act.

Other - The Respondent shall reimburse the Petitioner $12.00 in bank service charges incurred as the result of the stop payment on a TTD check.

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 13, 2019
Date

ICArbDec19(b)

MAY 16 2019

State of Illinois)
) SS:
County of COOK)

Before Illinois Worker's Compensation Commission

VIVIAN KILLEBREW,)
)
Petitioner,)
)
v.) No. 18 WC 022527
)
MACY'S,)
)
)
Respondent.)

ARBITRATOR'S 19()b DECISION

In support of the Arbitrator's decision, the Arbitrator finds the following facts:

The Petitioner was employed for the Respondent since 1987 at their Water Tower store. Her position has been in retail clothing sales in the Ilene Fisher division for the past 20 years. His physical duties require her to unpack boxes of clothes, lift boxes weighing twenty to thirty pounds, standing, bending, stooping and carrying. She works various hours but is provided a lunch hour if she works seven hours or more. Her division is located on the fourth floor. The lunch room is located on the seventh floor. Both elevators and escalators are provided in the store for customers and employees to use to move from floor to floor. She uses the escalators the majority of the time and will go up and down them many times during the day. She opined that she uses the escalators more than any particular customer would on a daily basis.

On July 22, 2015 she left her position on the fourth floor and traveled to the lunch room on the seventh floor on the escalators. When she was heading back to her work station on the fourth floor she again used the escalators to return. As she was on the down escalator from the sixth floor to the fifth floor she was struck by a light fixture that fell from its position in the ceiling fifteen feet above her on to her. She put her right hand up to block it from hitting her head

and it hit her right hand and her head with a heavy impact. She also twisted her left leg in turning to avoid the impact. She immediately felt stunned, blurry and in pain. She reported the accident and signed a report in HR.

She presented to the Emergency Department at Northwestern Hospital in Evanston. She provided a history of the accident at work that day and complained of her right hand, head and left ankle. She was treated with a scan of her head and x-rays of her right hand and left ankle and released in braces for both her hand and ankle.

She followed up with her primary care physician, Dr. Pandelis Banias, on July 25, 2018 complaining of her right hand, left ankle, headaches, bilateral ringing in her ears and dizziness. She was diagnosed with right ear contusion, dizziness, right wrist injury and left ankle injury. She was maintained off work and prescribed physical therapy.

She began a course of physical therapy at ATI on July 30, 2018.

She came under the care of her orthopedic surgeon, Dr. Scott Rubinstein, on August 1, 2018. She was casted for fracture of her right wrist. She was maintained off work. On August 3, 2018, Dr. Rubinstein referred her to Dr. Kozlova, a neurologist, for her head injury complaints.

She saw Dr. Kozlova for the first time on August 8, 2018 and diagnosed with a TBI and prescribed medications, brain MRI and off work. She had the brain MRI on August 9, 2018. She was re-casted on her right hand. She had an injection.

She is still under treatment with Dr. Rubinstein.

She completed a course of occupational and physical therapy for her hand, head and ankle.

She was released by Dr. Kozlova on January 9, 2019 and authorized to return to work and discharged from neurological care.

She attended an IME with Dr. Glantz, a neurologist, on October 17, 2018 which lasted a total of thirty minutes and was not provided an neurological written tests to take.

She returned to work as of January 18, 2019.

She has returned to her position with Macy's. She still has pain and throbbing in her right hand and right thumb and wears a brace. She has some weakness in her left ankle. She has been released from her neurologist but still has headaches, neck pain and balance issues and takes OTC medications.

She has had no prior nor subsequent injuries to her head, right hand and left ankle. She does home exercises provided by her therapist.

The Respondent provided no witnesses to testify at the hearing.

The Arbitrator finds in relationship to (C) whether an accident occurred that arose out of and in the course of the Petitioner's employment by Respondent:

The Arbitrator had the opportunity to observe the Petitioner on this matter when she testified. The Arbitrator concludes that the Petitioner was a very credible witness. The Petitioner's testimony was believable, and, as such, her statements are accepted as accurate.

The Petitioner testified to being injured on July 22, 2018 while returning from lunch inside the Macy's Water Tower Store. As she rode the escalators located inside the store, a light fixture fell from the ceiling striking her right hand, head and causing her to twist her left ankle. She underwent immediate medical treatment. The medical records corroborate her testimony about the accident.

The Respondent produced no evidence by way of documents or witnesses to dispute the Petitioner's testimony and the clear and convincing evidence of an accident arising out of and in

the course of her employment for the Respondent. In fact, it appears that the accident itself is not denied nor disputed as the Respondent is alleging, they are not liable as a matter of law. However, the only theory posited by the Respondent in law is that of neutral risk. This theory fails under these facts. Their argument is one reserved for those injuries clearly classified in the case law as applying to injuries over which the employer had not control and to which the general public is exposed to at the same level. However, the Respondent provided no case on point in this jurisdiction or any other jurisdiction in the other 49 States to support their theory. Further, the facts of this case would not apply to a neutral risk argument anyway. The Petitioner testified she uses the escalators many times over the course of day as it is almost her sole method of traveling throughout the store and more often than any customer would. This fact alone would remove the accident from any neutral risk argument. Further, the fact a ceiling fixture in the store fell and hit her causing her injuries is a clear defect in the employer's premises that in and of itself would render the accident to arise out of and in the course of her employment.

Therefore, the Arbitrator finds that the Petitioner established that she sustained a compensable accident on July 22, which arose out of and in the course of her employment with the Respondent and is entitled to benefits under the Act.

The Arbitrator finds in relationship to (F) whether the Petitioner's present condition of ill-being is causally related to the injuries:

The Petitioner's present condition of ill-being is related to her injury. The Petitioner testified, without contradiction, that after the accident she had pain in her right hand, left ankle and head. Her medical records corroborate her testimony.

Further, there are no prior nor subsequent nor intervening injuries to her right hand, left ankle or head. No evidence was ever produced at Arbitration as to any intervening injuries or

accidents separate from the job injury by way of impeachment, documents or testimony that would account for the need for her injuries.

Proof of the state of health of an employee prior to and down to the time of the injury, and the change immediately following the injury and continuing thereafter, is competent as tending to establish that the impaired condition was due to the injury. Kress Corp. v. Industrial Commission, 190 Ill. App. 3d. 72, 82 (1989).

Based on the evidence presented, the Arbitrator finds that the Petitioner established that her present condition of ill-being with regard to her right hand, left ankle and head and neck is causally related to her accident of July 22, 2018.

The Arbitrator finds in relationship to (J) whether the medical services that were provided to the Petitioner were reasonable and necessary:

The Petitioner submitted the following medical expenses at arbitration as PX 7-11:

1. Petitioner's medical bills from ATI Physical Therapy for dates of service from July 31, 2018 to January 04, 2019 in the amount of $8,501.42.
2. Petitioner's medical records from Midwest Medical M.D.'s for dates of service from October 29, 2018 in the amount of $378.90.
3. Petitioner's medical bills from Dr. Scott Rubenstein at Illinois Bone & Joint Institute for date of service October 29, 2018 in the amount of $609.00.
4. Petitioner's medical bills from Dr. Olga Kozlova at Chicago Neuro Diagnostics for dates of service from August 29, 2018 and October 11, 2018 in the amount of $1,250.00
5. Petitioner's out of pocket payment to Walgreens in the amount of $16.09 for the purchase of a prescribed cane.

These medical expenses, totaling $10,755.41, were supported by the testimony of the Petitioner and the treating doctors' medical records and bills. These medical expenses are found to be reasonable and necessary medical expenses.

Since the Arbitrator has concluded that the Petitioner did sustain a compensable accident, and that her present condition is causally related to that injury, the Respondent is hereby found liable for these bills. The Respondent shall, therefore, pay the appropriate amount to the Petitioner concerning these medical bills submitted into evidence, which are allowed pursuant to the medical fee schedule in Section 8.2 of the Act.

The Arbitrator finds in relationship to (L) Is Petitioner entitled to Temporary Total Disability benefits:

The Arbitrator finds the Petitioner was maintained off work during her recovery period from July 23, 2018 through January 17, 2019 as she returned to work on January 18, 2019, a period of 25 5/7 weeks at the rate of $387.43 per week.

The Arbitrator finds in relationship to (M) whether penalties or fees should be imposed upon the Respondent:

The Respondent failed to provide medical benefits and temporary total disability benefits pursuant to the Act. The Respondent disputed the accident at Arbitration even though they produced no evidence at Arbitration to support their dispute of the accident itself and no proper foundation in law to support their theory of defense. The Respondent's actions consisted of instituting proceedings which do not present a real controversy but are frivolous or merely for delay in payment of benefits and as such are vexatious. Although the Arbitrator finds the Respondent presented a theory of defense to the Petitioner's claim, the Respondent had the

opportunity after the testimony of the Petitioner and a review of the facts to assess the compensability of the claim and failed to do so and instead allowed the matter to proceed to arbitration hoping to gain a windfall. Their position has been found untenable based upon the preponderance of the evidence that the Petitioner's accident was compensable. The Respondent's position that this was a neutral risk is untenable. Further, the Arbitrator notes although TTD benefits were initially provided they were terminated without notice or warning when a TTD check that was already provided to the Petitioner was placed on a stop payment after the Petitioner had already deposited the funds in her account and for which she incurred a $12.00 stop payment bank charge.

The Petitioner is entitled to Penalties pursuant to 19(k) in the amount of 50% of the total disputed benefits awarded herein, of medical of $10,755.41 and TTD owed of $3,376.18 x 50%, which is $7,065.80.

The Petitioner is entitled to Attorney's Fees in the amount of 20% of the benefits awarded herein, $14,131.59 x 20%, which is $2,826.32.

The Petitioner is entitled to Penalties pursuant to 19(l) in the amount of $6,000.00.

The Arbitrator finds in relationship to (O) Other:

The Respondent shall pay to the Petitioner additionally $12.00 to reimburse a bank charge incurred when the Respondent stopped payment on a TTD check that had already been provided to the Petitioner and the funds deposited in her account without notice or warning that TTD was being terminated and the TTD check provided was being recalled by a stop payment order.

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

FREDERICK J. ZIEMANN,

Petitioner,

vs.

NO: 17 WC 005851

20IWCC0209

ELITE IRONWORKS, INC. and
THE ILLINOIS STATE TREASURER as EX OFFICIO CUSTODIAN
of the SECOND INJURY FUND,

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 benefit rates, earnings, causal connection, nature and extent, and Section 8(e)18/Liability of Second Injury Fund, 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 16, 2019, is hereby affirmed and adopted.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that 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.

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

DATED: MAR 27 2020
o020520
DDM/jrc
052

D. Douglas McCarthy

Stephen J. Mathis

DISSENT

I respectfully dissent. I find Petitioner failed to prove that he sustained the permanent and complete loss of use of his right foot. As such, I would award 75% loss use of the person as a whole pursuant to Section 8(d)2 of the Act.

As the majority aptly noted, Petitioner's ability to return to work is not relevant in establishing entitlement to benefits pursuant to Section 8(e)18 of the Act. The relevant consideration is Petitioner's ability to use the affected member. In the present matter, Petitioner reached maximum medical improvement as of June 20, 2018. T. 33. On July 2, 2018, Petitioner underwent a Functional Capacity Evaluation which found Petitioner functionally employable at a heavy physical demand level. PX5. Certainly, Petitioner demonstrated difficulty in stair climbing as well as walking continuously or on uneven surfaces. *Id.* Petitioner testified he was provided a filler (prosthetic) for use in his shoe to assist in walking. T. 26. Petitioner further testified he was able to walk in the same manner with or without the filler and uses a cane. T. 38. Petitioner testified he was unable to climb ladders or run. *Id.*

Petitioner suffered a severe career-ending injury, but such injury did not deprive him of the complete loss of use of his right foot. Therefore, I respectfully dissent.

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ZIEMANN, FREDERICK J
Employee/Petitioner

Case# **17WC005851**

ELITE IRONWORKS INC AND THE ILLINOIS STATE TREASURER AS EX OFFICIO CUSTODIAN OF THE SECOND INJURY FUND
Employer/Respondent

20IWCC0209

On 5/16/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.35% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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20IWCC0209

20IWCC0209

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

FREDERICK J. ZIEMANN
Employee/Petitioner

Case # **17** WC **05851**

v.

Consolidated cases: _____

ELITE IRONWORKS, INC. and THE ILLINOIS STATE TREASURER as EX OFFICIO CUSTODIAN of the SECOND INJURY 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 **Paul Cellini**, Arbitrator of the Commission, in the city of **Chicago**, on **October 15, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. [x] 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. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [x] What were Petitioner's earnings?
H. [x] What was Petitioner's age at the time of the accident?
I. [x] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Section 8(e)18 / Liability of Second Injury Fund**

FINDINGS 20IWCC0209

On **February 14, 2017**, Respondent ***was*** operating under and subject 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 $**100,360.00**; the average weekly wage was $**1,930.00**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**90,066.90** for TTD, $**0** for TPD, $**21,505.77** for maintenance, and $**98,430.00** for permanent partial disability, for a total credit of $**210,002.67**.

Respondent is entitled to a credit for all medical expenses paid under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner sustained accidental injuries arising out of and in the course of his employment with the Respondent on February 14, 2017.

The Arbitrator finds that the Respondent was operating under the Illinois Workers' Compensation Act on February 14, 2017, and that the Petitioner was an employee of the Respondent employer on that date.

The Arbitrator finds that the Petitioner provided timely notice to the Respondent under Section 6(c) of the Act.

The Arbitrator finds that the Petitioner's right foot and right knee injuries are causally related to the February 14, 2017 accident.

The Arbitrator finds that the Petitioner was 59 years old and married with no dependent children on February 14, 2017.

The Arbitrator finds that the Petitioner's earnings in the year prior to the accident were $100,360.00, and that his average weekly wage was $1,930.00.

Respondent shall pay reasonable and necessary medical expenses contained in Petitioner's Exhibit 9, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit towards any 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.

20IWCC0209

Respondent shall pay Petitioner permanent partial disability benefits of **$775.18 per week**, the maximum allowable statutory rate, for **21.5 weeks**, because the injuries sustained caused the loss of use of **10% of the right leg**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$775.18 per week**, the maximum allowable statutory rate, for **167 weeks**, because the injuries sustained caused the loss of use of **100% of the right foot**, as provided in Section 8(e) of the Act.

Because Petitioner had previously sustained 100% loss of the ***right eye*** and, as a result of this accident, has sustained 100% loss of the ***right foot***, Petitioner is eligible for statutory permanent total disability benefits of **$1,286.67** per week for life, commencing **June 21, 2018**, as provided in Section 8(e)18 of the Act.

Respondent shall pay Petitioner **$775.18** per week for **167** weeks, commencing **June 21, 2018**, for the loss of the second body part and, during this time, the Second Injury Fund shall pay Petitioner **$511.49** per week for **167** weeks, to equal the total PTD rate, as provided in Section 8(f) of the Act. Commencing **September 2, 2021**, the Second Injury Fund shall pay Petitioner **$1,286.67** per week for life.

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

Respondent Elite is entitled to credit against the Section 8(e) permanency awards totaling **$98,430.00** based on payments made to Petitioner prior to the date of hearing.

Respondent shall pay Petitioner compensation that has accrued from **February 14, 2017** through **October 15, 2018**, 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

May 14, 2019
Date

STATEMENT OF FACTS

MAY 16 2019

Petitioner, an ironworker since 1999, testified that he is a union journeyman working out of Local 63 in Chicago. He has been married for 28 years. A six-year employee of Respondent, Petitioner testified he sustained a serious injury to his right foot while working on 2/17/17. He was moving a cart with a load of steel when he hit a plate in the floor, causing the cart to tip over and the steel to slide off onto his right foot. The steel weighed about 2,000 pounds. Petitioner testified he was in excruciating pain. Someone from "construction" called the Respondent employer owner, Darren Enselman, and his father, Dave Enselman, to notify them of the injury. Petitioner was taken to Rush University Medical Center where he was admitted.

The 2/14/17 report from Rush notes x-ray and CT findings of multiple fractures in all of the toes of the right foot, including a displacement fracture of the distal phalanx and smaller vertical fracture of the distal proximal phalanx of the big toe and complete fracture of the distal phalanx of the fourth toe. Orthopedic treatment was rendered, and the right foot was splinted. Petitioner was admitted overnight for pain management and discharged the following day. On 2/24/17, Petitioner underwent open reduction and internal fixation surgery with Dr. Hamid on his right large toe and closed treatment of the other toes. He was discharged the same day. He was prescribed medications and placed in a non-weight bearing splint and was to follow-up on one week. It was noted that he likely would need further debridement surgery or even amputation once the foot had demarcated. (Px1).

Petitioner testified he followed up with Dr. Hamid on 3/2/17. Petitioner testified that his third toe had deteriorated with gangrene and he was given the option of amputating the toe or having a forefoot transmetatarsal amputation. On 3/3/17, Dr. Hamid noted that viability had been questionable at the last surgery, and the Petitioner had a fair amount of distal necrosis. He indicated the treatment plan was for amputation of the right third toe verse forefoot amputation. After discussion with and agreement from Petitioner, Dr. Hamid performed a recommended right transmetatarsal amputation of the right forefoot. The operative report noted the metatarsals were cut with a saw blade at an angle leaving an obtuse angled cut to the plantar foot. All necrotic tissue was excised. Petitioner was discharged on 3/6/17 with a plan for home health care to address his wounds, therapy and mobility. (Px1). This care was provided through Bright Star from 3/8/17 through 5/26/17. (Px3). The Petitioner was casted on 3/9/17 and a knee scooter was prescribed. (Px2). On 3/23/17, Dr. Hamid noted complaints of pain and nerve-like pain and indicated he wanted Petitioner to transition to a tall CAM boot and begin weightbearing. Lyrica was prescribed. (Px2).

On 4/6/17, Dr. Hamid prescribed physical therapy. (Px2). Petitioner testified he underwent therapy at Athletico in Crest Hill, Illinois, undergoing approximately 61 treatments through 11/9/17, when he was discharged. (Px5). Dr. Hamid noted that healing was slow and that there was a level of ongoing erythema but no specific finding of infection. Petitioner was strongly advised to discontinue smoking. (Px2).

Petitioner continued to regularly follow-up monthly with Dr. Hamid. He had further wound care treatment at Silver Cross Hospital between 5/31/17 and 7/12/17. (Px4). During this time, he was using the knee scooter, crutches and then a cane to assist with weight bearing and walking. By 6/14/17, Petitioner was showing signs of improved healing, and he had significantly reduced or discontinued his smoking. On 7/19/17, Petitioner was improving with therapy but had some ongoing drainage and pain and swelling with prolonged standing and ambulation. Dr. Hamid released Petitioner to light duty. (Px2).

As he increased his ambulation and weightbearing time in therapy, Petitioner testified that he began to develop right knee pain in the lower front of the kneecap, which he reported to the therapist at Athletico. He testified that he had no knee pain prior to the accident. On 8/16/17, Petitioner reported he was improved with occasional episodes of pain, specifically with activity, as well as brief episodes of nerve pain. He indicated he was able to

walk about 30 minutes using a cane and that he had obtained new shoes with a filler insert. Petitioner also reported some right knee pain that he attributed to walking differently since the surgery. A knee regimen was added to his physical therapy. Given the ongoing right knee pain, which he indicated was secondary to overuse due to the right foot injury, Dr. Hamid referred Petitioner to Dr. Yanke for a right knee evaluation on 9/27/17 and provided him with authorization for a disabled parking placard. (Px2)

On 10/25/17, Dr. Yanke indicated Petitioner's right knee x-rays showed early arthritis and a possible medial meniscus tear. He opined that Petitioner aggravated the preexisting condition and that this could be related to his gait abnormalities. While the report notes an injection was performed, a later report indicated it had not been authorized. (Px2). On 11/8/17, Petitioner reported soreness in the right foot with prolonged walking and intermittent "zingers" in the right foot. Petitioner indicated he remained off work as Respondent had no light duty available. He was provided with orthotics. (Px2). Petitioner testified he underwent therapy, again at Athletico, from 11/16/17 through 12/14/17, indicating this did not provide any significant right knee relief. On 11/15/17, Dr. Yanke injected the right knee and therapy was continued. An MRI was prescribed on 12/13/17, however Petitioner testified this could not be completed because he has metal in his head from a shotgun accident which resulted in the loss of his right eye. Dr. Yanke then on 12/27/17 recommended a CT scan, which took place on 1/30/18. On 1/10/18, Dr. Hamid continued Petitioner on sedentary work duties and indicated he would likely be considered at maximum medical improvement (MMI) one-year post-amputation. The right knee CT scan showed mild fissuring of the medial femoral condyle and minimal fissuring of the patellar apex cartilage with no evidence of other internal derangement, including the medial meniscus. Following his review of the CT scan on 2/14/18, Dr. Yanke indicated it showed some early arthritis and degenerative changes within the meniscus that could be contributing to his pain. He recommended right knee surgery but noted if the only pathology found involved arthritis, and not a lot of meniscal problems, Petitioner would be less likely to see improvement with the surgery. (Px2).

Surgery was performed by Dr. Yanke on 4/24/18 involving arthroscopic debridement and chondroplasty. The medial meniscus turned out to be intact and the final diagnosis was right medial compartment arthritis. On 6/20/18, Petitioner reported his knee was overall doing well with occasional anterior pain going down steps. Dr. Yanke diagnosed osteoarthritis of the right knee, indicating Petitioner was capable of full duty as to the right knee only, and otherwise recommended a functional capacity evaluation (FCE). He noted Petitioner might need a steroid injection in the future. Petitioner also saw Dr. Hamid on 6/20/18 and he noted Petitioner had mechanical pain with standing and walking and some irritation from his shoe filler rubbing on his residual foot. He opined that Petitioner had reached maximum medical improvement (MMI) as to the right foot and should remain off work pending the FCE, which would be needed to issue final restrictions. He also submitted Petitioner for a permanent handicapped placard. (Px2).

Petitioner also saw Dr. Yanke on 6/20/18. Dr. Yanke noted Petitioner indicated "he is doing well overall and he will experience occasional anterior pain in the right knee when ambulating down stairs." Dr. Yanke noted the Petitioner had arthritis in the knee but had reached MMI and was able to return to full duty relative to the right knee. (Px2).

On 7/2/18, the FCE therapist determined that Petitioner had provided a 100% consistency of effort. Testing indicated Petitioner was capable of work at the heavy physical demand level. The main limiting factors noted involved functional limitations related to decreasing balance, which was attributable to the right foot amputation. Standing, walking, carrying, climbing and squatting were limited by pain in the right foot. He had no specific limitations relative to solely the right knee. Petitioner testified that he was sore for two days after the examination, with a 7/10 to 8/10 pain level that evening, and a 5/10 level the next day. (Px5). Petitioner testified he has undergone no further medical treatment for his right knee or foot since 6/20/18.

Petitioner testified he currently has difficulty transferring his weight to his right leg/foot and loses his balance. He cannot balance on the right leg. He has to use the right heel to walk and testified he tilts his foot to the side so he lands on the heel. Petitioner testified he currently uses fillers that fill the front third of his shoe where the portion of his foot was removed, but that this irritates the remaining portion of his foot. He testified that he has constant pain. He further testified he cannot run, and his daily activities are limited. He described his walking as a "hobble", and noted that he cannot climb ladders and can only go upstairs sideways one at a time. He noted that his limitations are the same with or without the insert in his shoe. Petitioner also indicated that the condition of his right foot has slowed him down and caused him to gain weight. He testified that his weight has increased from approximately 185, when he was working, to 250 currently, which he attributes to inactivity due to the injury. Petitioner testified he had no prior right foot injuries before the 2/14/17 accident and that he has not re-injured the foot since then. He also noted that he has not had any other injuries to his right knee.

Petitioner testified that when he was 17 years of age he suffered a gunshot wound to his right eye. Due to the accident, his right eye was removed in 1973 and he was given a prosthetic eye. He therefore has no vision whatsoever in his right eye. He has treated with Dr. Danahey for his eye/vision since 2007, with Petitioner indicating he last saw him on 5/21/16. Some records from Dr. Danahay from 2007 to 2016 were submitted into evidence, and the records reflect that the Petitioner has had a prosthetic right eye going back to 1973. (Px6).

Petitioner testified that he has a GED and has limited computer skills, such as looking through eBay and ordering parts, but has had no computer training. After obtaining his GED in the 1970's Petitioner worked as a motorcycle mechanic for approximately 10 years, which involved prolonged standing, lifting up to 100 pounds, bending and squatting to change parts, tires and do whatever else needs to be done to the bikes. He then worked as a body and fender man, which involved similar physical activities. He next worked as an appliance repair man between 1995 and 1999, which involved standing/kneeling/lifting, when he started as an ironworker. He testified he has not kept up with the technology associated with motorcycles, body/fender work or appliance repair.

Petitioner testified that as an ironworker he rigged cranes, carried handrails, carried iron, climbed stairs, walked on uneven terrain, welded and worked out of a manlift. The only time he would sit as an ironworker would be while on a break or during lunch. There was constant walking, standing and climbing. He would wear a 40-pound tool belt on a daily basis. The tools he used regularly included a beater, two spuds, bullpen, and hardware, such as three-quarter nuts and bolts. On a daily basis, Petitioner testified he would lift at least 75 pounds and, typically, more than 100 pounds.

Currently, Petitioner testified that sitting with his leg up is the most comfortable position for his right foot, and he does this at least every couple of hours in his recliner. Petitioner noted that if he is unable to elevate his right leg, his right foot throbs and his lower right leg hurts. His right foot tightens up when the weather is colder. Petitioner testified that he generally wears gym shoes and doesn't think he would be able to wear a work boot. He testified that he uses a cane daily, especially when he is not in his house. He testified that the more he walks, the sorer his right lower extremity becomes, including his right foot, knee and hip. With regard to the right knee, Petitioner indicated that it is stiff and he can develop pain depending on how far he walks. He does drive occasionally, mainly around his hometown, but does not trust himself to drive in traffic. Petitioner testified that he has looked for work, including at a couple of wrecking yards, a mechanic shop and some car dealerships, but has not been offered a job. On cross-examination, he acknowledged he had not submitted any applications and has no prepared resume, and that he just spoke to the managers or owners of the prospective employers and that no positions were open. He testified that he does some chores around the house, including picking up the newspaper from the end of his driveway and taking the garbage out to the porch to put it in a garbage can. On

further cross, Petitioner agreed he was not restricted from lifting, noting there was nothing wrong with the rest of his body. He lost his right eye in a recreational setting, not at work. He testified he had no idea what types of jobs the Respondent might have available in an office setting, acknowledging he had never been to the office. He did not know if he was still considered an employee of the Respondent or not.

The Arbitrator notes that the Petitioner submitted two photos he took on 10/8/18 of the right foot amputation, and that they indicate a horizontal removal of all of the toes and the forefoot from approximately where the base of the 5th toe would be to approximately three inches from where the tip of the right big toe would have been. This is based on a comparison to the left foot, which is depicted side-by-side with the right. (Px7 & 8).

Petitioner's claimed causally related medical expenses were submitted into evidence as Px9.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (A), WAS THE RESPONDENT OPERATING UNDER AND SUBJECT TO THE ILLINOIS WORKERS' COMPENSATION OR OCCUPATIONAL DISEASES ACT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Respondent employer, Elite Ironworks, was operating under and subject to the Illinois Workers' Compensation Act on 2/14/17, pursuant to Section 3 of the Act. The fact that the Petitioner was carting heavy steel in a fashion that allowed it to fall on his foot indicates clearly to the Arbitrator that the Respondent employer's business was extra-hazardous under the Act. The Arbitrator would also note the liberal application of Section 3 of the Act pursuant to Illinois case law.

WITH RESPECT TO ISSUE (B), WAS THERE AN EMPLOYEE-EMPLOYER RELATIONSHIP, THE ARBITRATOR FINDS AS FOLLOWS:

The Petitioner testified he worked for the Respondent as an ironworker out of Local 63 on 2/14/17 and had worked for Respondent employer in this capacity for six years. The Respondent employer stipulated that the Petitioner was an employee of the company. The Respondent Second Injury Fund did not rebut this evidence. The Arbitrator finds that the Petitioner was an employee of Respondent employer Elite Ironworks on 2/14/17.

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

The Arbitrator finds that the Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent on 2/14/17. The Petitioner's unrebutted testimony is that he was performing work for Respondent Elite on that date when heavy steel fell onto his right foot. It is clear that he was injured during the course of his employment with Respondent. 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. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 541 N.E.2d 665 (1989). The risk of Petitioner being injured by the steel falling off the cart he was using to move it was specific to his employment with Respondent employer Elite Ironworks. His injury therefore arose out of the employment. Thus, pursuant to the Act, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of his employment with Respondent Elite Ironworks on 2/14/17.

WITH RESPECT TO ISSUE (D), WHAT WAS THE DATE OF THE ACCIDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner's compensable accident occurred on 2/14/17. This is consistent with both his testimony and the contemporaneous medical records submitted into evidence. There is no evidence in the record which would rebut 2/14/17 being the accident date.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner testified that the Respondent owner, Darren Enselman, and his father, Dave Enselman, were contacted to notify them of the Petitioner's injury on 2/14/17, and Petitioner was taken to Rush University Medical Center. This testimony was unrebutted. The Arbitrator finds that the Respondent was provided with timely notice of the accident within 45 days pursuant to Section 6(c) of the Act.

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

The Arbitrator finds that the Petitioner's right foot and right knee injuries are causally related to the 2/14/17 accident. The causal relationship of the right foot is obvious. The Petitioner was moving heavy steel while working for Respondent employer when a heavy portion of that steel fell onto his right foot. He had immediate pain and was diagnosed with a crush injury involving multiple toe fractures. All of the evidence in this case, including the chain of events, supports a causal connection between the right foot injury and the 2/14/17 accident.

The Arbitrator finds that the Petitioner's right knee injury was caused by the awkward and unusual use of his right leg in ambulation and therapy due to the right foot injury. After a significant period of recovery following his amputation surgery, the Petitioner's medical records support that he began to experience right knee pain as he increased his ambulation and weight-bearing post-surgery. The Petitioner testified he had no prior knee pain before the 2/14/17 accident. Dr. Hamid and Dr. Yanke both opined that the right knee condition was causally related to the accident based on the changes in Petitioner's ambulation due to the severe right foot injury and partial amputation. The significant preponderance of the evidence supports that the Petitioner's right knee condition is causally related to the 2/14/17 accident.

WITH RESPECT TO ISSUE (G), WHAT WERE THE PETITIONER'S EARNINGS, THE ARBITRATOR FINDS AS FOLLOWS:

The Petitioner and Respondent employer stipulated that the Petitioner earned $100,360.00 in the year prior to the accident, and that the Petitioner's average weekly wage was $1,930.00. This evidence was unrebutted by Respondent Second Injury Fund. The Arbitrator finds that the Petitioner earned $100,360.00 in the year prior to the accident and that his average weekly wage on 2/14/17 was $1,930.00.

WITH RESPECT TO ISSUE (H), WHAT WAS THE PETITIONER'S AGE AT THE TIME OF THE ACCIDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Petitioner and Respondent employer stipulated that the Petitioner's age on 2/14/17 was 59 years old. This is consistent with the Application for Adjustment (Arbx2), and this was not rebutted by Respondent Second Injury Fund. The Arbitrator finds that the Petitioner was 59 years old at the time of the accident, 2/14/17.

WITH RESPECT TO ISSUE (I), WHAT WAS THE PETITIONER'S MARITAL STATUS AT THE TIME OF THE ACCIDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Petitioner and Respondent employer stipulated that the Petitioner was married with no dependent children on 2/14/17, and the Petitioner testified at hearing that he had been married for 28 years. The Respondent Second Injury Fund did not rebut this stipulation with any conflicting evidence. The Arbitrator finds that the Petitioner was married with no dependent children on 2/14/17.

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

The Arbitrator finds that the Petitioner is entitled to the medical expenses contained in Petitioner's Exhibit 9. The Arbitrator notes that the Petitioner is demanding unpaid balances from several providers as follows: Gold Coast Surgery Center ($3,170.70), Athletico Physical Therapy ($4,552.00), Midwest Orthopedics ($853.00) and Midwest Anesthesia ($1,500.00). Each of the submitted invoices reflect payments by workers' compensation and various adjustments.

Therefore, while the Arbitrator awards the expenses billed by these providers related to the right foot and right knee treatment, the Respondent's liability is limited by the Fee Schedule pursuant to Section 8.2 of the Act. If the balances claimed by Petitioner result from charges which exceed the Fee Schedule limitations, the Respondent is not liable for same. Additionally, the Respondent is entitled to credit for any awarded medical expenses that may have been paid prior to hearing, so long as the Respondent holds the Petitioner harmless pursuant to Section 8(j) of the Act.

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:

While this has not been raised as an issue by the parties, the Arbitrator notes that the parties have stipulated that the Respondent employer has paid all due and owing TTD and maintenance. Therefore, while the parties have stipulated that the Respondent Elite is entitled to credit for prior payments of TTD and maintenance, the credit is applicable to periods of TTD and maintenance that were not at issue in this hearing, and Respondent is not entitled to credit for these payments against permanency.

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

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

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

edition of the American Medical Association's (AMA) "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party has submitted an AMA permanent partial impairment rating or report into evidence. Therefore, this factor does not impact the permanency determination.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as an ironworker at the time of the accident and is not able to return to work in his prior capacity as a result of said injury. This is due to the Petitioner's right foot injury. He was released to full duty with regard to his right knee condition by Dr. Yanke.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 59 years old at the time of the accident. Neither party has submitted evidence which tends to indicate the impact of the Petitioner's age on any permanent disability resulting from the 2/14/17 accident. The Arbitrator notes that the Petitioner is in his sixties and approaching a typical retirement age sooner rather than later. This factor carries minimal weight in the permanency determination.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Respondent has not accommodated the Petitioner by proving him with a job within his restrictions. His testimony indicates that his employment history has mainly involved blue-collar jobs which involve physical labor. While no specific evidence has been provided which indicates what type of loss of future earnings the Petitioner may have sustained as a result of the 2/14/17 accident, the evidence supports a strong likelihood that the Petitioner has sustained a level of loss to his future earning capacity.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the Petitioner underwent a transmetatarsal amputation of his right forefoot and as a result has lost significant function of the foot. The amputation resulted in the loss of all of his toes and a large portion of his forefoot. While he tested at the heavy physical demand level, the FCE noted difficulty with standing, walking, carrying, climbing and squatting due to the right foot. Petitioner testified he currently has difficulty transferring his weight to his right leg/foot and difficulty with balance as he cannot balance on the right leg. He has to use the right heel to walk and testified he tilts his foot to the side in order to land on his heel. He testified that his shoe insert rubs on and irritates the remaining portion of his foot. He testified that hobbles when he walks and generally uses a cane. With stairs, he indicated he can only go upstairs sideways one at a time. Petitioner also indicated that the condition of his right foot has slowed him down and has resulted in a significant amount of weight gain. With regard to the right knee, the Petitioner underwent a surgery which

mainly involved essentially a clean-out procedure, and he was released to full work duties as to the knee by Dr. Yanke. The Petitioner has no significant knee complaints beyond some soreness with overuse.

Based on the above factors, the record taken as a whole and a review of prior Commission awards with similar injuries similar outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of the loss of use of 100% of the right foot pursuant to §8(e)11 of the Act. The Arbitrator further finds that the Petitioner sustained permanent partial disability to the extent of the loss of use of 10% of the right leg pursuant to §8(e)12 of the Act with regard to his right knee.

The Arbitrator further finds that the determination that the Petitioner sustained the loss of use of 100% of the right foot did not accrue until he was released by Dr. Yanke and Dr. Hamid on 6/20/18. Therefore, statutory permanent total disability payments would not be due and owing until that date.

WITH RESPECT TO ISSUE (O), THE APPLICATION OF SECTION 18(e) OF THE ACT APPLIES TO THIS CASE AND WHETHER THE SECOND INJURY FUND IS LIABLE PURSUANT TO SAME, THE ARBITRATOR FINDS AS FOLLOWS:

Section 8(e)18 of the Act states:

> "The specific case of loss of both hands, both arms, or both feet, or both legs, or both eyes, or of any two thereof, or the permanent and complete loss of the use thereof, constitutes total and permanent disability, to be compensated according to the compensation fixed by paragraph (f) of this Section. ... loss of both hands, both arms, both feet, or both eyes, or any two thereof ... constitute total and permanent disability."

In the case at bar, the Petitioner has shown by the preponderance of the evidence that he sustained a prior injury to the right eye in 1973 which resulted in the enucleation of the eye and the placement of a prosthetic. This has resulted in a loss of all vision in the right eye. Thus, the Arbitrator concludes that the Petitioner sustained a prior 100% loss of a member, the right eye, pursuant to Section 8(e)18.

The Arbitrator has also determined, pursuant top the current hearing, that the Petitioner has sustained a loss of use of 100% of the right foot as a result of the 2/14/17 accident. The Respondent Second Injury Fund reasonably argues that the Petitioner has not lost the use of 100% of the foot, indicating he is able to walk, can drive a car and was able to ride an exercise bike in physical therapy.

There is no requirement that a claimant establish he is unable to work as a result of the loss of use of a member, but only that the member no longer performs its normal function. *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill.App.3d 225, 168 Ill.Dec. 756, 590 N.E.2d 78 (1992). The provision that an employee must be wholly and permanently incapable of work does not relate to an award based on the specific loss or loss of use of two members of the body under subdivision (e)(18) of this Section. *Scandroli Constr. Co. v. Industrial Comm'n*, 54 Ill.2d 395, 297 N.E.2d 150 (1973).

Here, the Arbitrator believes there is still ample evidence that the Petitioner has lost 100% use of the foot. It is accurate that he is able to stand and walk, albeit oftentimes with the assistive use of a cane, as well as that he tested at the heavy work level at the FCE. However, the Arbitrator finds that while the right leg is certainly usable, the function of the foot itself has been impacted in a very severe way. He has no toes and thus no ability to manipulate his forefoot in any way. He cannot push off with the forefoot. He cannot run. He testified to

difficulty climbing stairs other than by walking up sideways. The FCE noted limitations on most weightbearing tasks.

As noted above, the key question is how the normal function of the right foot has been impacted by the accident. The Arbitrator has determined that the normal function of the Petitioner's right foot has been severely impacted to the point that he has lost the use of 100% of the foot. In a similar case, *Gonzalez v. Pride Container Corp.*, the Commission determined that the claimant lost the use of 100% of a foot after amputation of the third, fourth and fifth toes and he was required to wear custom orthotics and to rely on a cane for balance. *Gonzalez v. Pride Container Corp.*, 09 IWCC 0274 (2008).

In accordance with Section 8(f), Petitioner is awarded permanent total disability benefits for the remainder of his life. In cases, such as the one at issue, where an employee had previously lost one member and then incurred the loss of a second member, the Second Injury Fund becomes liable for PTD payments.

> "If an employee who had previously incurred loss or the permanent and complete loss of use of one member, through the loss or the permanent and complete loss of the use of one hand, one arm, one foot, one leg, or one eye, incurs permanent and complete disability through the loss or the permanent and complete loss of the use of another member, he shall receive, in addition to the compensation payable by the employer and after such payments have ceased, an amount from the Second Injury Fund provided for in paragraph (f) of Section 7, which, together with the compensation payable from the employer in whose employ he was when the last accidental injury was incurred, will equal the amount payable for permanent and complete disability as provided in this paragraph of this Section." 820 ILCS 305/8(f)

Given that the Petitioner previously lost 100% of the right eye prior to 2/14/17, the Arbitrator further finds that the Petitioner has sustained the permanent and complete loss of use of two separate members, and that the Petitioner has shown that he is permanently and totally disabled by statute pursuant to Section 8(e)18 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 (accident)	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rachel Linder,

Petitioner,

vs. NO: 14 WC 00622

Valvoline/Ashland Oil, Inc.,

Respondent.

20IWCC0210

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, temporary total disability, and other, and being advised of the facts and law, reverses the Decision of the Arbitrator and denies Petitioner's claim for compensation, for the reasons set forth below.

Statement of Facts

Testimony of Petitioner:

Petitioner, a 29-year old technician, testified that she began working for Respondent in February of 2013. (T.16). She noted that her job was full time and that it entailed "[t]ire rotations, oil changes, radiator flushes, transmission flushes … things of that nature." (T.17). Petitioner testified that she worked 40 hours a week on average and earned a little over $9.00 an hour. (T.18). She indicated that at the time of her employment "Marc' was the store manager and "BJ" was the assistant store manager. (T.18). She noted Elizabeth Ross also worked there, but she did not know her title. (T.18). In addition, she stated that a person named "Megan" was a "CSA" who worked "… mostly on the computer… [and] did the sales stuff with the customers… She did the top side stuff … [which involves] fill[ing] fluids, you check your windshield washer fluid, you make sure the lights worked." (T.18-19). She noted that work in the pit involved oil changes, work on grease joints and transmission flushes. (T.20).

Petitioner testified that on 11/8/13 she was doing a particularly "... rough tire rotation. It was big over sized tires, SUV, and it was stuck on. It was very difficult. You have to pound it off to break them loose. And BJ came over and helped me get it loose. And BJ came over and helped me get it loose because he even struggled with it for a minute before we got it loose... because he had to pound on it. I was in the middle of putting the tire back on the back side. And I was down on – one knee was down on the ground, the other knee was up so I could roll the tire up and lift and put it on, and it dropped down. I didn't have it set quite in there right, and there was someone on the other side. BJ was on the other side." (T.20-21). She indicated that "[i]t dropped down on me, and I popped, like I felt a pop in my lower back." (T.21). She indicated that she had some pain in her lower back at that time. (T.22).

Petitioner testified that BJ ended up taking over and finishing the tire rotation. (T.22). She noted that she did not finish her shift that day and went home a little early, but "[n]ot very early... it was getting close to shift change." (T.22-23). She also indicated that she told BJ that "... it hurt. He sent me home. He took over the tire rotation. He said he would finish it." (T.23). She noted that she tried to go in to work the next day, 11/9/13, but that she "... ended up getting sent home" by Liz. (T.23-24).

The Commission takes judicial notice of the fact that 11/8/13 was a Friday.

Petitioner agreed that she sent text messages to Marc (admitted at PX3) where she initially requested time off work for a float trip. (T.24). When asked whether she told Marc about her injury, Petitioner noted that "[h]e asked me to call him" and that she did. (T.28-30). She claimed that she "... told him that I wasn't going – that I was off work. That the doctor had taken me off work. I told him about the accident prior." (T.30). She indicated that Marc asked more about it later, and that she told him she "... got hurt during the tire rotation..." (T.30). She stated that she then "... seen [*sic*] the doctor." (T.31).

Petitioner noted that she "... came back to work. I turned in the notice for off work and picked up the pink packet, which included a drug test... Information that I had – they told me I had eight hours and had me fill out some paperwork." (T.31). She agreed that PX5 is the off work slip that she gave them. (T.31-32). She also explained that the pink packet was "... an envelope with stuff in it, and it had a pink slip in it, and I had to go get a drug test." (T.32). She indicated that she got the drug test at the request of her employer. (T.32). She agreed that Marc informed her that he had turned in all the paperwork concerning the accident to corporate. (T.32). She also indicated that "[l]ater down the road, I was told that I wasn't allowed to return to work unless I had a full medical release." (T.33).

Petitioner testified that following the accident she visited chiropractor Dr. Chenault on 11/11/13. (T.33). She agreed she had seen Dr. Chenault in the past. (T.33). She claimed she told Dr. Chenault that she "... was hurt doing tire rotation at work." (T.34). She also noted "[h]e asked me about my job duties, what I did at work... [and] [h]e gave me physical therapy, chiropractic care, there was E stim and massage therapy." (T.34). Petitioner agreed Dr. Chenault took her off work for about four or five days and that "[l]ater he said he'd let me [return to work] for light duty." (T.35). She claimed she brought the slip to Respondent saying that she was at light duty but "... was told that I was not allowed to come back to work unless I had a full

medical release." (T.35). She indicated Dr. Chenault never released her to full duty. (T.36).

Petitioner testified that Dr. Chenault then referred her to Dr. Prasad. (T.34,36). She noted that Dr. Prasad "[m]ostly" provided pain management and told her to continue therapy at home. (T.36). She agreed she received injections from him and that he provided her with a light duty release. (T.36). She also indicated that Dr. Prasad has never given her a full medical release. (T.36). She noted that she told Respondent about Dr. Prasad's release and that she was told that she had to have a full medical release. (T.37). She testified that she "... went in later on, and people that I had worked with in the store no longer worked there, and nobody could tell me anything. I was told that it all had to go to corporate and through my attorney." (T.37). She noted that as far as she was concerned she is still employed at Valvoline. (T.37).

Petitioner testified that Dr. Prasad also sent her to Dr. Kube, a surgeon. (T.38). She noted that she has seen Dr. Kube "[m]ultiple" times and that he "... has me still on light duty and recommends surgery" on her low back. (T.38-39). She stated that she would "[a]bsolutely" have the surgery if the Commission were to award it. (T.39).

Currently, Petitioner notices that she has "... pain, numbness, tingling, sometimes sharp, shooting pains." (T.39). She also indicated that she wears a back brace prescribed by Dr. Kube, noting that "... it helps alleviate some of the pain and keeps me from moving in a manner that hurts." (T.39). She stated that she wears a brace on a regular basis, although it is not necessarily the one she was wearing on the date of her testimony at arbitration. (T.40). She noted that the tingling is in both legs, worse in the left, and that some days her symptoms are worse than others. (T.40). She also indicated that she is currently taking pain medication as prescribed by Dr. Prasad. (T.40-41). Petitioner stated that she has not worked since 11/8/13 and 11/9/13. (T.42). She noted that she has sold off personal belongings and borrowed money from her father to support herself, and that she presently lives with her father. (T.42).

Petitioner acknowledged that she had treated with Dr. Chenault in the past for her low back, and that she had a work comp accident prior to the one presently in dispute. (T.43). She agreed that this would have been in 2009, 2010. (T.43). She also noted that she had "... some small episodes..." concerning her low back for which she saw Dr. Chenault in 2011. (T.43). She agreed that from January of 2011 through about May of 2011 she received chiropractic care. (T.43-44). When asked to explain these "small episodes," Petitioner noted that she "... fell, slipped in some water, some stuff like – just more muscle and jarring." (T.44). She stated that the pain she is currently having is "[n]ot the same thing" in that "[t]he pain [now] is more intense. It's different. It starts in a different spot and continues down. It's not exact – it's not the same pain, either. It's different... It's numbness and tingling and sharp shooting pain, but it's not the same. It was not the same thing." (T.44-45). She noted that the pain now starts "[i]n my lower back" and that in the past it started "[i]n my lower back, but not – where it centers at in my lower back was not the same thing." (T.45). She agreed that the pain in her low back is in a different spot. (T.45). She also noted that in 2009 to 2011 she "... had some numbness, not so much tingling." (T.45). She testified that the numbness and tingling is "... more staticky, I guess is how to describe it. It's more like this (witness indicating), it's not just – it's in spots, and then it's constant numbness in other spots." (T.46). She claimed that the numbness in 2009-2011 went away and that it is more constant now. (T.46).

Petitioner testified that when she told Respondent's IME, Dr. Rutz, about having pains about ten years earlier she was "... talking about the work accident [in 2009] when I worked at the hospital." (T.47). She agreed that she was a "little off" when she said ten years, and that it was more like two years. (T.48).

When asked about her current activities, Petitioner noted that she "... take[s] care of [her] kids." (T.48). She also indicated that "I move slower. I don't have as full range of movement, things take longer, it's harder to do, there's pain. I have to figure out alternate ways to do certain things to get things accomplished. Shopping is a chore." (T.48).

Petitioner testified that following the accident she had "... multiple interactions with Liz. I told her about the accident... I told her that I was hurt the day after" on 11/9/13 (meaning she told her on 11/9 that she had been hurt the day before, on 11/8/13). (T.49). She noted she told Ms. Ross at that time that "... I was hurting and that I needed to stay top side because I didn't think I could handle bottom side... [b]ecause I got hurt doing a tire rotation" the day before. (T.50). Petitioner stated she "... stayed top side for most of that shift" and that Liz "... sent me down stairs to do it, and then sent me home." (T.50). She noted she didn't "quite" complete her workday on 11/9/13 and that she was sent home a little bit early by Ms. Ross. (T.50-51).

Petitioner agreed that Dr. Prasad administered some epidural injections, and that they helped, but that they have not taken away all of her pain. (T.51). She agreed that Dr. Kube has recommended surgery for her low back, and that she is presently "... in a holding pattern until we can figure out what's going on, whether or not surgery is approved or not." (T.51-52).

On cross, Petitioner agreed that she is alleging that she sustained a work accident while employed by Valvoline on 11/8/13, and that she began working for Respondent on 2/11/13. (T.53). She agreed that at the time of accident she had only been there about nine months. (T.53). She indicated that she believed she worked on 11/8 and 11/9/13, but that she was not sure whether she was scheduled to be off on 11/10/13. (T.54). She agreed that 11/11/13 was the first day she sought medical care when she visited chiropractor Dr. Chenault. (T.54).

Petitioner agreed that she had a history of treatment with Dr. Chenault for her back following an accident while she was employed at Greenville Regional Hospital in approximately 2010. (T.54-55). She noted that she would have no reason to dispute Commission records if they reflect an alleged accident in November 2010 while working for Greenville Regional Hospital. (T.55-56). She agreed that after that accident she received chiropractic care with Dr. Chenault, underwent a course of injections and had a lumbar MRI on 8/24/10. (T.56). When asked whether she told Dr. Chenault about this prior MRI, Petitioner stated that "[h]e has access to my records... [and] knew I was there for it..." (T.57). However, she stated that she did not know if she specifically told him about the MRI. (T.57). She agreed that she settled that case in March of 2014. (T.57-58). Petitioner agreed that she signed the present Application for Adjustment of Claim on 1/12/14, or three months earlier. (T.59).

When asked whether she also pursued medical care with Dr. Youkilis, a neurosurgeon, following the prior accident, Petitioner testified that she thought she was "... sent to that doctor. I don't remember the doctor's name that I got sent to... I seen [*sic*] whoever I was supposed to

see. Wherever I went, I was – I followed directions." (T.61).

With respect to the current dispute, Petitioner agreed that she underwent no medical care whatsoever from 5/19/14 through 10/14/15. (T.62-63). She likewise agreed that it was not until May of 2016, or almost three years after the alleged accident, that she was referred to Dr. Kube. (T.64). When asked if she told Dr. Kube about her 8/24/10 MRI, Petitioner replied: "He asked for medical records and releases, and I gave him whatever – I signed releases and gave medical records." (T.64).

Petitioner noted that "[i]t sounds approximately correct" that her last visit with Dr. Chenault for the previous injury was on 5/31/10 and that she rated her pain as a 5 on a scale of 10 at that time. (T.65). She also agreed she had some numbness in her left leg, and that as of that visit she had not been released from medical care by Dr. Chenault. (T.66). However, she was not sure whether she was expected to follow up with Dr. Chenault following that visit. (T.66).

Petitioner agreed her testimony was that she reported her injury after the accident, and that the assistant manager, BJ, was aware of her injury because he was present when it happened. (T.67). She likewise agreed that she gave notice the next day to Elizabeth "Liz" Ross, who she thought may have been an assistant manager. (T.67).

Petitioner was shown RX8, an accident report showing a date of accident of 11/7/13. (T.68-69). She acknowledged she signed this document on 11/16/13. (T.69). She also agreed this document reflects that she "[t]old Liz back was hurting." (T.69). She agreed that when she filled this out the accident was still fresh in her mind. (T.69). She likewise agreed that she did not go to the emergency room or present to any doctor whatsoever on 11/7/13. (T.70). Similarly, she agreed that she did not go to the emergency room or see any doctor on 11/8/13. (T.71).

She agreed she told Liz that her back was hurting and that according to this document that would have been on Friday 11/8/13. (T.71-72). She noted that she has not returned to Respondent "... in a working capacity..." since 11/9/13, although she "... did go and drop stuff – paperwork off and talk to people, figure out what I needed to do." (T.72). She agreed that this document does not show she told BJ about the accident. (T.72-73). She also agreed that she did not bring BJ in to testify, and that she did not reach out to BJ on Facebook to ask him to testify on her behalf, even though they are Facebook friends. (T.73).

Petitioner agreed that in September of 2016 she was assaulted by an intoxicated individual, although she denied that she was also intoxicated at the time. (T.73-74). When asked whether she informed Dr. Kube that she had been in pain since that incident, Petitioner responded: "I am in continual pain." (T.74). When pressed whether the pain from the attack was significant enough for her to inform Dr. Kube, Petitioner replied: "... he was my doctor. I felt that he should know." (T.74).

Petitioner indicated that she has not applied for any work since 11/9/13, her last day of work for Respondent. (T.74-75).

On re-direct, Petitioner claimed that the assault "... didn't change my symptoms. It just

intensified pain, and I walked different from the bruising on my legs." (T.78). In describing the assault, she noted that "I was on the love seat. I was sitting length-wise with my legs across it, pillows propped behind my back so I was comfortable, and he came in, and he decided that he wanted to flirt and refused to take no for an answer and came over and sat on top of my legs... [a]nd squeezed my leg and bruised by legs." (T.79). She agreed that she was having pain with her back prior to that incident, that she still has pain in her back now. (T.79). She claimed that the assault did not affect her back on a long-term basis, but that it did intensify her pain for a couple of weeks. (T.79-80).

Petitioner was asked about the report of accident and agreed that it says the date of injury was 11/7/13. (T.80-81). She indicated that this could "[p]ossibly" be the right date of injury instead of 11/8/13, and that the conversation she had with Liz that she thought was on Saturday, and where she claimed she asked to work topside instead of bottom side, could "[p]ossibly" have occurred on Friday. (T.81).

Petitioner was later recalled to testify following the testimony of former co-workers Megan Giltner and Mr. Ross. At that time she noted that she talked to Ms. Ross the day after she hurt herself. (T.148). She agreed that on the day of the incident she was changing tires with BJ, who is also an assistant manager. (T.148). She also noted that she only got the one paycheck, for the period she had worked, and that she has not received one since. (T.149). She denied picking up any other paychecks. (T.149). She also indicated that she did not receive any type of pay, whether through workers' comp or otherwise, after she picked up her last paycheck. (T.149). In addition, she did not recall telling Ms. Ross that she was going to go to dinner with her boyfriend the night of the alleged injury. (T.149). She also noted that she did not work her whole shift that day, but left "... a little early", or less than an hour. (T.150). Finally, she testified that Ms. Ross is the one who told her she could go home. (T.150).

Testimony of Megan Giltner:

Ms. Giltner was called to testify at the request of Respondent via subpoena. (T.82-83). She noted that she currently works for Worldwide Technologies, Inc., and that she was employed by Valvoline in 2013 as a senior technician. (T.83-84). She indicated that she was familiar with Petitioner and that they worked together for six months. (T.84-85).

When asked whether she had any recollection of Petitioner claiming she had a back injury prior to 11/8/13, Mr. Giltner testified that "[t]he first I heard that she claimed of the back injury is when they asked me is she told me about her back injury." (T.85). She indicated Petitioner did not tell her about her back injury on the day she claimed that she was injured. (T.85).

When asked about conversations with Petitioner prior to the accident, Ms. Giltner stated that "[w]henever we were talking, I remember her talking about back problems and talking about how surgery was expensive to fix her back." (T.86). When asked if there was more than one discussion with Petitioner regarding her back, Ms. Giltner testified: "No. It was just a comment bringing out that she – her back was hurting, and to fix it would cost a lot and that was expensive." (T.87). She agreed this occurred prior to 11/8/13 and within six months of the date

of the alleged accident. (T.87-88). However, Ms. Giltner indicated that Petitioner did not tell her how long her back had been hurting her. (T.88). She also did not recall Petitioner telling her prior to 11/8/13 that her back was getting worse. (T.88).

Ms. Giltner was shown the witness statement admitted at RX9 that she prepared and signed on 11/15/13. (T.89). She agreed that it was fair to say that she was honest when she completed this document. (T.90). She indicated she remembered writing it, but that "... I personally don't remember it because I did my best to forget everything about that place." (T.91-92). Ms. Giltner testified that she "... remember[ed] some of the things. I remembered her behavior up until the accident. So I don't remember necessarily back pain complaining, but it would be often that she would just complain of general pain, and it would change constantly. I remember that." (T.95). She noted that "I remember that [Petitioner] would complain about various pain points, and it would vary each day." (T.95-96).

When asked if Petitioner ever informed her that she had injured her back while employed by Respondent, Ms. Giltner replied: "No, not until after I was asked to write down the testimony, she talked to me about it." (T.96). When asked if she recalled another co-worker being out for a back injury, Ms. Giltner indicated that "... I'm sure it's true, but I don't remember... But I don't remember most people." (T.96-97). She also stated she could not recall Petitioner discussing the medical care that she may have had for her back prior to 11/8/13. (T.97). However, she noted that she "personally" remembered the one conversation she had with Petitioner regarding surgery because "[i]t was expensive." (T.97). She also indicated that Petitioner informed her that "[i]t would get worse" if she did not have the surgery. (T.97).

On cross, Ms. Giltner testified Respondent "... was just an awful place to work. Management didn't care about their employees. To avoid hassle, they would just pretty much say, you know, just keep your head down and work and whatnot." (T.99). She noted that it was "... very stressful" and that the working conditions were poor. (T.100). She agreed that management did not treat its employees well, noting that "... it depends on the person. Our manager, he was a great technician, but he had no management skill... So if there was any conflict between anybody, he would just say figure it out ourselves." (T.100-101). Ms. Giltner stated that "... when you first start working there, that's what they – that's what they tell you to do, because they don't want to go through all the hassle of calling in an injury and having to write it on all the reports and stuff like that..." (T.103). When asked who "they" were, Ms. Giltner replied: "So I don't remember their position at the time when I first started, but it was the senior technician and the assistant manager and a couple other co-workers." (T.103). She testified that "I remember at least two people told me personally, [i]f you get injured, just say you got it at home so that way we don't have to deal with these things." (T.104). She recalled that these two people were "BJ Parker and Josh, whatever his last name is." (T.104). She noted that at the time she started Josh was assistant manager. (T.105). She noted that "... I have had trouble where I got injured, and it was a hassle trying to get it taken care of." (T.106). She stated that "I hit my head on the metal lockers. The door was open, and when I came up, I hit my head... [I]t happened while I was at work, and I had to tell the manager that I got hurt." (T.106-107). She indicated that she "... told them I got hurt at work because I did." (T.107).

Ms. Giltner testified that she did not remember Petitioner specifically complaining about

back pain, and that she signed the statement after Ms. Linder's work accident. (T.108). She also agreed that the conversation she "vaguely" recalled about back surgery being expensive was before the accident. (T.108). However, she had "no idea" how soon before. (T.109). She indicated that this conversation took place "[i]n the basement of Valvoline by the changing lockers." (T.109). She stated she "... remember[ed] it [the conversation] being towards the end [of the six-month period they worked together] after we had known each other a bit." (T.109).

Ms. Giltner testified that she did not recall specific dates that she worked, "... but I do know I worked on the day that she [Petitioner] claimed she was injured... I remember it being a Saturday, but I could be wrong." (T.110). She noted that Liz was there that day, not BJ. (T.110). However, she reiterated that she "... didn't hear about the accident on that day... [a]nd I didn't discuss the accident with Liz." (T.110). She stated that she did not see the accident and that "[i]f there was an accident whenever we were working together, I had no knowledge of it... And I wasn't told that she was injured at work." (T.111).

Ms. Giltner testified that her employment ended with Respondent when she got fired, noting that "[t]hey said I wasn't dedicated." (T.111). She also noted that when Petitioner would talk about her pain "... the body part would just change, but that's all" and that she did not recall any specific conversations about back pain besides the one. (T.112). She stated that "I just remember it was – pain was talked about a lot. Pain was brought up a lot in a lot of our conversations." (T.112). Ms. Giltner agreed that it was a physical job, with crawling around and going top side and bottom side. (T.112-113). She agreed that "for some people" complaining about aches and pains was kind of a normal thing at work with Respondent. (T.113).

On re-direct, Ms. Giltner agreed that it was fair to say that when she drafted the witness statement on 11/15/13 she was being honest. (T.114).

Testimony of Elizabeth Ross:

Ms. Ross was called to testify at the request of Respondent. (T.115). She noted that she is on disability and not currently employed. (T.116). She indicated that she previously worked for Respondent as an assistant manager from 2012 until August of 2014. (T.116-117). She agreed that she was a working manager, and she was "[a]bsolutely" familiar with Respondent's policy and procedure as it relates to work injuries concerning employees. (T.118). She explained that "... if the patient is ambulatory or they can drive themselves, we have like a file folder on the wall down where the desk is, and there's different color packets... When they tell you that they're injured, you give them said packet, and they have to go to the occupational doctor. They have to get a drug test and be seen by that doctor, and then depending on the result of what that doctor says, will happen, like if they can return to work or if they need to be out for so long or whatever the doctor says, then you could accommodate for that, and then you would call Kathy Beers the next – like the corporate and make them aware of the situation." (T.119-120).

Ms. Ross testified that she was aware Petitioner was alleging she sustained a work accident on 11/8/13. (T.120). She noted that she was the assistant manager on that date. (T.120). She indicated Petitioner completed her scheduled shift on that date and did not voice any complaints of back pain that she recalled during the day. (T.120-121). She also stated that

Petitioner did not claim that she was unable to physically perform her job on that date. (T.121). Ms. Ross indicated that she had a conversation with Petitioner at the end of her shift on 11/8/13, noting that "... you have to change your uniform there at work before you go home, you get out of your uniform, put your regular clothes on. And after she did that, on her way out the door, she said, [o]kay, I'm going to have dinner with my boyfriend. I'll see you tomorrow. It was a matter of a few seconds conversation. It wasn't anything substantial." (T.121-122). She agreed that there was "[a]bsolutely" no mention of a back injury at that time. (T.122).

Ms. Ross testified that she also worked with Petitioner on 11/9/13, and that Ms. Linder did not report any back injury to her on that date as well. (T.122). Likewise, Petitioner did not report to her that she was physically unable to do her job. (T.122).

Ms. Ross indicated that since 11/9/13 she saw Petitioner when the latter came in to pick up her paycheck. (T.122-123). She noted that on that date Petitioner "... almost couldn't walk. She was all hunched over and took her about, I don't know, ten minutes to get from her car, inside." (T.123). She indicated that she saw Petitioner again "... every time we got paid, she came in to pick up her paycheck." (T.123). She also noted that she saw "... Rachel walking into a book store in the parking lot" and that "[s]he was completely fine." (T.123-124).

Ms. Ross agreed that she was called in by her supervisors at some point regarding Petitioner's work injury. (T.124). She noted that the meeting concerned Petitioner's reporting of an injury and "... why I did not do what I was supposed to do." (T.125). She indicated that it turned out she "... didn't need to be disciplined because I didn't do anything wrong. I wasn't ware [*sic*] of an injury. They were the ones that told me she reported it." (T.125). She agreed it was fair to say that meeting was the first time she learned Petitioner was alleging a work injury, and that Ms. Linder was alleging that she had informed Ms. Ross about it. (T.125). She agreed that these allegations surprised her. (T.125-126).

Ms. Ross testified that as of 11/8/13 she had worked with Petitioner for something like nine months. (T.126). She noted that they were both full time employees, working approximately 40 hours a week. (T.126). She agreed that some days she would be working and Petitioner would not, and that it was fair to say they talked about work related things as well as personal things once in a while. (T.126-127). Ms. Ross stated that Petitioner complained of back pain prior to 11/8/13 and that they had discussed the latter's need for surgery. (T.127).

Ms. Ross indicated that there was "[a]bsolutely" no policy with the managers wherein employees were discouraged to report work injuries, and that employees were "[a]bsolutely not" told to say that they got hurt at home, noting "[t]hat could cost you your job." (T.127-128).

On cross, Ms. Ross indicated that she is currently "[a]pplying for disability", but that she did not injure herself at Valvoline. (T.128). She noted that she was initially a senior tech and was promoted to assistant manager, but that she could not recall when that occurred, although she assumed it was during the time Petitioner was there. (T.,128-129). She also indicated that Petitioner complained about her back prior to the accident "[m]ultiple times." (T.129). When asked whether it was about her upper, middle or lower back, Ms. Ross responded: "Just her back. She didn't necessarily specify. And a lot of times it changed from time to time where she said

she needed surgery or where it hurt at." (T.129-130). She also noted that Petitioner "... said she needed surgery, and she couldn't afford it." (T.130). She stated that Petitioner "... said she had long-term back issues, in general, and that she was – when she first started, she was waiting for the insurance to kick in because you have to work there for 90 days so she could go seek treatment and see what the insurance would pay for. She hoped it would pay for enough for her to be able to get the surgery, and that it was prohibitively expensive." (T.130-131). However, Ms. Ross did not know if a surgeon had made a surgical recommendation for Petitioner's back at that time. (T.131).

Ms. Ross agreed that working for Respondent is a labor intensive job. (T.131). However, she denied that people often complained about their aches and pains as they performed that job. (T.131-132). She noted that she never complained about any aches and pains until she quit. (T.132). She explained that she has "... a preexisting condition, and it had gotten worse, and I couldn't continue to do my job duties, the physical part of my job duties, so I figured it was best to amicably stop so I did not get injured at work, because I knew that it was headed that way." (T.132). When asked if Respondent would have accommodated her problems if she couldn't do the job, Ms. Ross replied: "Well, that is part of the job is being able to physically do it, so it's part of your job duty. If you can't do it, then you're not fulfilling your obligation." (T.132-133). She indicated that for someone to return to work "[y]ou have to have a full release..." (T.133).

Ms. Ross was shown RX8, the work injury report signed by Petitioner on 11/16/13. (T.133). She indicated that she had never seen this particular form, filled out by Petitioner, and as a result would not know who asked Ms. Linder to fill it out. (T.134). When asked whether she worked on the date of accident alleged on that form, 11/7/13, Ms. Ross responded: "I don't know. That's a long time ago. I worked full time, so I would say probably, but I couldn't tell you for sure." (T.135). However, she testified that "[a]t the time of [Petitoner's] alleged accident... I was working with her because I was manager on duty but, again, I wasn't aware of an injury." (T.135). She noted that BJ was "[p]robably" working that day, and that as a working manager like herself he would have had to do tire rotations and oil changes. (T.135-136).

Ms. Ross testified that she did not talk to Petitioner when she came in to pick up her paycheck, and when she noticed Ms. Linder taking so long to ambulate to her care, "... because we're told that it was going to be a workmen's comp type of issue, and you don't want to discuss that with her." (T.136). She believed that it was "Mark", or possibly "Kathy", who told her that. (T.136). She noted that she did not have any conversation with Petitioner at that time, "... just pretty much gave her her check. I might say hi, but not anything in detail." (T.137).

Ms. Ross testified that an employee just needs to report an injury to the manager on duty at the time, and that "... if BJ and I are both working, only one of us is going to be the manager on duty. Even though we both hold the same title, on the schedule, it will say which one of us is the manager on duty, and that's who you report it to." (T.137). She did not know who was the manager on duty on 11/7/13. (T.138). However, she stated that she was the manager on duty on 11/8/13 and 11/9/13. (T.138). She indicated that she did not talk to Petitioner on her last day of work (11/9/13) about how she was in pain and could not do the bottom side work, or top side work. (T.138-139).

Ms. Ross agreed her testimony was that she saw Petitioner walking into a bookstore and that the latter appeared fine. (T.139). She noted that initially she was maybe 20 feet away or so, and that "... we wanted to verify that it was, in fact, her, so we followed her up and got closer behind her to verify that it was..." (T.139). She noted that "Serina" was with her at the time and that the episode occurred about a week after Petitioner picked up her last paycheck. (T.139-140). Ms. Ross conceded that she did not know if Petitioner was walking better because she had undergone any medical care, and also did not know if Ms. Linder had taken any medications that day that would allow her to feel and walk better given that she did not speak to her. (T.140). She noted that BJ no longer works for Respondent, and that she "... got him a job at Chatter [sic]." (T.141). When asked about the working conditions at Respondent, Ms. Ross testified: "... you're exposed to the weather, so whatever the weather is outside, like, for example, today is over 100 degrees, so you would be 100 degrees in there. I mean, it's a very physically straining job. You got to drain hot oil, you know, antifreeze, so on, so forth, but it's – you're also made aware of that when you interview, as well." (T.142).

Ms. Ross agreed that the protocol after you get hurt at work is to go take a drug test, pick up a colored packet "[a]nd see the occupational doctor..." (T.142-143).

On re-direct, Ms. Ross agreed that after the work accident she was called into a meeting with her supervisor regarding the fact that she had not fulfilled her obligations as an assistant manager. (T.144). She likewise agreed that after that meeting she saw Petitioner come in for her check, and that thereafter she saw her while she [Ms. Ross] was putting fliers on vehicles. (T.144).

When asked to explain how she was able to recall these events, Ms. Ross stated: "The reason I remember it is because I would have been fired on the spot for not fulfilling my job duties and getting her treatment. If she was injured to the point that she couldn't continue and she needed help, it is my job, as manager on duty, to get her help. And the reason I remember is because I would have been fired for not seeking treatment for her." (T.145).

On re-cross, Ms. Ross testified that she was the manager on duty every day she worked because she opened in the morning and "... whomever unlocks the door and opens the store, puts the registers in and so on and so forth, is the manager on duty." (T.146). However, once again, she conceded that she did not know if she was the manager on duty on 11/7/13 because she did not know if she worked that day. (T.146).

Selected Medical/Personnel Records:

An MRI of the lumbar spine performed on 8/24/10 (or more than three years prior to the alleged date of accident) was interpreted as revealing "degenerative disc disease most prominent at L4/5 with broad based posterior disc bulge and associated anular [*sic*] tear. No central spinal stenosis at any level." (RX2).

In a handwritten "Encounter Record" dated 1/10/11 (or almost three years prior to the alleged date of accident), Dr. Chenault appears to indicate that the Petitioner needed pain medication and that he "took x-rays – L/S – will exam next visit." (RX1).

In an "Encounter Record" dated 1/27/11, Dr. Chenault appears to record: "LBP – neck pain – has moderate pain both CC #1-2." (RX1). The diagnosis was "L/S disc." (RX1).

In an "Encounter Record" dated 1/31/11, Dr. Chenault recorded: "do feel better after therapy [illegible] really tight today – not sleeping well." (RX1). The diagnosis was "C/9 facets [illegible] – L/S disc." (RX1).

In an "Encounter Record" dated 2/3/11, Dr. Chenault recorded: "1st time since July starting to feel L foot – bottom been numb – LBP [illegible]." (RX1). The diagnosis was "L/S disc" and the patient was to "follow up Monday if needed." (RX1).

In an "Encounter Record" dated 2/7/11, Dr. Chenault recorded: "light duty at work -- back[,] somewhat better today 6/10." (RX1). The diagnosis was "L/S disc." (RX1).

In an "Encounter Record" dated 2/9/11, Dr. Chenault recorded: "busy at work – sat to [*sic*] long – slept on couch – aggravated back." (RX1).

In an "Encounter Record" dated 2/17/11, Dr. Chenault recorded: "got out of bed wrong twisted funny LBP." (RX1). The diagnosis was "L/S disc – see exam." (RX1).

In an "Encounter Record" dated 2/18/11, Dr. Chenault recorded: "still really sore – from getting out of bed wrong – LBP, meds only temp relief." (RX1). The diagnosis was "L/S disc" and the patient was instructed "no exercising at this time." (RX1).

In an "Encounter Record" dated 2/23/11, Dr. Chenault recorded: "long day – up [illegible] – back feels like crap – 8/10 about same not as swollen… rode in back seat of car which aggravated back." (RX1). The diagnosis was "L/S/ disc." (RX1). It also appears her prescription was refilled and she was given lifting instructions at that time. (RX1).

In an "Encounter Record" dated 2/24/11, Dr. Chenault recorded" "little better today – LBP – light duty at work – moderate [?] pains, neck pain med-light." (RX1). The diagnosis was "L/S disc." (RX1).

In an "Encounter Record" dated 2/25/11, Dr. Chenault recorded: "sore – feel better than yesterday – 7/10 – constant LBP." (RX1).

In an "Encounter Record" dated 2/28/11, Dr. Chenault recorded: "[illegible] better over the weekend – LBP overall – [indecipherable] over do it – doing laundry …" (RX1). The diagnosis was "L/S disc." (RX1). It also appears that Petitioner was referred back to the pain doctor at that time. (RX1).

In an "Encounter Record" dated 3/15/11, Dr. Chenault recorded: "aggravated back – been doing better last couple of weeks." (RX1). The diagnosis was "T/S & L/S disc." (RX1).

In an "Encounter Record" dated 3/22/11, Dr. Chenault recorded: "less feeling L leg – numb – LBP still on meds… mid back feels better than last [indecipherable]." (RX1). It was

also noted that "if pain/numbness persists refer back to pain MD. Patient informed me that she is still fighting with her work comp." (RX1).

In an "Encounter Record" dated 3/28/11, Dr. Chenault recorded: "LBP 5/10, not as bad, still not there yet [illegible]." (RX1). A medical evaluation was ordered "for numbness in L leg - - [illegible] pains." (RX1).

In an "Encounter Record" dated 4/1/11, Dr. Chenault recorded: "fell last night – went to stand up foot caught [?] [indecipherable]." (RX1). The diagnosis was "L/S disc." (RX1).

In an "Encounter Record" dated 4/20/11, Dr. Chenault appears to have recorded that "meds not helping much" and "sending to pain mgmt." (RX1).

In an "Encounter Record" dated 4/25/11, Dr. Chenault recorded: "LBP 5/10, R leg numb – burning pain in back [indecipherable]." (RX1). It appears the recommendation was to "follow up w/pain MD." (RX1).

In an "Encounter Record" dated 5/25/11, Dr. Chenault recorded: "LBP – 6/10, R leg numb – doing laundry at work – twisting/bending." (RX1). The diagnosis was "L/1 [?] disc." (RX1).

In an "Encounter Record" dated 5/31/11, Dr. Chenault recorded: "LBP 5/10 – unloading laundry at work." (RX1). The diagnosis was "L/S Disc." (RX1).

In a "Clinical Examination Findings" note dated 11/11/13 Dr. Chenault recorded: "[n]o [illegible] paresthesia. Change oil – tire rotation. (illegible) – 1 week "can't deal w/ it" - no way can work." (PX4). In addition, this note shows that the patient denied all traumas at that time. (PX4).

In a separate "Work/School Restrictions" note dated 11/11/13, Dr. Chenault indicated that Petitioner was excused from work starting 11/11/13 and extending through 11/15/13. (PX5).

In a "Daily Encounter Record" dated 11/12/13, Dr. Chenault noted that Petitioner was "about same – LBP into legs – can't work." (PX4). Dr. Chenault noted a diagnosis of "L/S Disc" and that Petitioner was "off work for the week." (PX4).

Dr. Chenault also appears to indicate that Petitioner is unable to work in "Daily Encounter Record[s]" dated 11/13/13 and 11/14/13. (PX4).

In a "Witness Statement" dated 11/15/13, Megan Giltner stated: "About two months ago, [Ms. Linder] specifically told me how she had had back problems for awhile and how it is getting worse[.] She needed surgery but could not afford it. Every day she complains about pain (other things along with her back), never has she said that it was from work. She said that she had problems with everything with her last job as well. When another employee went home for awhile for a back injury, she started becoming more adamant about her back. Also the time when she first told me that she need[ed] back surgery she told me how she went to multiple

doctors about this problem. She need[ed] surgery or else her back would rupture and she would not be able to walk again, she needed it bad but it would be costly. She also would randomly say one body part was injured but the next day it would switch sides. She always changed her story." (RX9).

In an "Employee's Written Statement of Injury/Illness" dated 11/16/13, Petitioner noted a date of incident of 11/7/13, stating that "I moved wrong putting a tire on during tire rotation[.] Injured lower back[.] Have pain in lower back & down both legs." (RX8). Petitioner also indicated that she "told [L]iz back was hurting on Friday." (RX8).

Thereafter, Petitioner visited Dr. Chenault with complaints of low back pain and received chiropractic treatment on 11/18/13, 11/20/13, 11/21/13, 11/25/13, 11/27/13, 12/3/13, 12/5/13, 12/9/13, 12/10/13, 12/11/13, 12/12/13, 12/16/13, 12/18/13, 12/19/13, 12/23/13, 12/24/13, 12/26/13, 12/30/13, 12/31/13, 1/13/14, 1/15/14, 1/16/14, 1/20/14, 1/23/14, 1/30/14, 2/3/14 and 2/6/14. (PX4).

In his note dated 12/10/13, Dr. Chenault recorded: "talked w/patient about MRI – and possible injection. (PX4).

In his note dated 12/12/13, Dr. Chenault recorded: "sending back to work on Monday." (PX4).

In his note dated 12/16/13, Dr. Chenault recorded: "starting getting better LTS P [?]." (PX4).

In his note dated 12/18/13, Dr. Chenault recorded: "kids laying on her aggravated LBP – I feel twisted… Sending patient back to work for light duty." (PX4).

In his note dated 12/19/13, Dr. Chenault recorded: "sending out for MRI – see on Monday for new order." (PX4).

An MRI of the lumbar spine performed on 12/20/13 was interpreted as revealing "[m]ild spondylosis, annular fissure at L4/5. Mild diffuse lumbar facet arthropathy." (PX4).

In his note dated 12/23/13, Dr. Chenault recorded: "referring out for injection will follow up w/rehab." (PX4).

In his note dated 12/24/13, Dr. Chenault recorded: "continue w/ light duty trying to contact pain MD for injection." (PX4).

In his note dated 12/26/13, Dr. Chenault recorded: "waiting to hear from pain MD." (PX4).

In his note dated 1/15/14, Dr. Chenault recorded that the patient was still waiting for an appointment with the pain management doctor. (PX4).

In his note dated 1/20/14, Dr. Chenault recorded that the patient had "... appointment w/ Dr. Bagher [?] tomorrow." (PX4).

In his note dated 1/23/14, Dr. Chenault recorded that the patient's appointment for an injection was cancelled and that she was making a new appointment. (PX4).

In his note dated 1/30/14, Dr. Chenault recorded: "cleaned puke off daughter and floor – aggravated back..." (PX4). He also noted that the injection had been scheduled for March and that Petitioner was to "treat/maintain until then." (PX4).

In his note dated 2/3/14, Dr. Chenault recorded: "got into bed – pop[p]ed – felt [indecipherable] – hurt like hell after happened." (PX4). He also noted that she was still waiting for injection in March. (PX4).

In a typewritten (and thus legible) "Daily Note" dated 2/13/14 Dr. Chenault recorded diagnoses of 1) spinal stenosis, lumbar region, 2) displacement of lumbar intervertebral disc without myelopathy, 3) deconditioning syndrome, and 4) myalgia and myositis, unspecified, lumbar. (PX4). He also noted that they were still waiting on the appointment with the pain management doctor in March. (PX4). The same was noted in "Daily Note[s]" dated 2/20/14 and 2/26/14. (PX4).

Petitioner visited Dr. Babu Prasad at Advanced Pain Management on 3/4/14. (PX6). Dr. Prasad noted that the patient was being referred by Dr. Chenault "... for low back pain radiating to both legs with numbness and tingling. Pain started 11/2013 while doing a tire rotation at work and is rated a 7. Patient has been seeing chiropractic and PT." (PX6). Dr. Prasad then proceeded to administer a translaminar lumbar epidural steroid injection at L4-5 on that date. (PX6). Dr. Prasad performed similar injections on 4/1/14, 10/14/14, 1/5/16, 3/16/16 and 7/6/16. (PX6).

In a "Daily Note" dated 3/6/14, Dr. Chenault recorded: "Ms. Linder stated: 'LBP seems little better after the injection, got some feeling back into left leg.'" (PX4).

Petitioner continued to treat with Dr. Chenault thereafter, with visits on 3/10/14, 3/13/14, 3/20/14, 3/24/14, 3/27/14, 4/3/14, 4/14/14, 4/17/14, 4/21/14, 4/24/14, 4/28/14, 5/5/14, 5/12/14 and 5/19/14. (PX4).

In an office note dated 4/20/16, physician assistant Derek Morrow, from Dr. Richard Kube's office, recorded that the patient presented with low back and leg pain and that "[s]he states she does have some history of back pain. She states that before this new injury she had somewhat of a muscle strain type injury where she just took a couple medications, and that completely resolved. She never really had any problems since then until this injury that happened somewhere around 2013 or 2014. It has been a couple of years, and she does not remember the exact date. The patient is an auto mechanic and she was, it sounds like, changing tires. She was on her knees pushing the tire back up onto a utility-type vehicle, a little bit larger [than a] SUV style vehicle, when she noticed a pop and a pull in her low back. After that she had significant low back pain. A few days later she started noticing leg symptoms going into bilateral legs, worse on the left side... She states the back pain, however, is much worse than the

leg pain. She has been doing, really exhausting, all forms of conservative treatment including epidurals, trigger point injections, physical therapy, chiropractic, narcotic medication, anti-inflammatory medication; all with very minimal relief." (PX8). Following his examination and review of the lumbar MRI, Mr. Morrow recommended x-rays and indicated that "I think she has exhausted really all forms of conservative measures. She is looking for a fix... I would like her to see Dr. Kube to talk about potential options for her. I think the facet joints may be some pain for her, but the most problematic area is probably the L4-5 disc." (PX8).

In a separate Work Status Form dated 4/20/16, Dr. Kube's office indicated that Petitioner was capable of light activity consisting of frequent lifting of 10 pounds and limited lifting up to 35 pounds, along with rare overhead and floor to waist, limited bending and twisting as well as limited prolonged sitting or standing. (PX8).

X-rays of the lumbar spine performed on 5/3/16 revealed mild facet arthropathy. (PX8).

In an office note dated 5/4/16, Dr. Kube indicated that he "... agree[s] largely with Derek's assessment. I am not really convinced about a lot of facet signals he talks about in the MRI read, but just, in general, she has the mid low back pain. It seems to be associated probably with the L4-5 disc. She also has some pain down toward the sacroiliac joints, but it is not nearly the same as what we are noticing in the mid low back. From a clinical standpoint, it appears to be a lot more lumbar rather than anything associated with the sacroiliac joints... The MRI demonstrates an annular tear with disc collapse at L5-S1." (PX8). Dr. Kube noted that Petitioner was to return after nerve conductions have been done. (PX8). He also ordered a discogram as well as a new MRI and noted that "... we will continue her activity restrictions and work restrictions ..." (PX8).

In a Greenville Rehab & Pain Clinic "Brief Exam" report dated 5/19/14, Dr. Chenault recorded that Petitioner was involved in a work-related accident on 11/8/13 at Valvoline, and "[i]mmediately following the accident, Ms. Linder experienced low back pain and pain in right sacroiliac joint, right buttock, right hamstring, and right calf." (PX4). He also noted that her lumbar pain came on immediately and "... has not changed since it started. The intensity of this complaint is severe; meaning it is so painful that it prohibits any activity. The frequency of this complaint is continuous, or occurs 80% to 100% of the time... Patient describes the feeling associated with this complaint as dull, sharp, and spasmodic. Radiates to right sacroiliac joint, right buttock, right hamstring, and right calf." (PX4). He noted the MRI performed on 12/20/13 revealed "[m]ild spondylosis, annular fissure at L4/5, mild diffuse lumbar facet arthropathy, at L4/5 mild disc bulge, mild facet osteoarthritis, mild neural foraminal stenosis and mild central canal stenosis." (PX4). Dr. Chenault also opined that "... the only way to prove the accident caused permanent injury is if you have a pre-injury MRI of the Lumbar Spine. However, there is high likelihood the injuries sustained by Mrs. Linder was caused by the accident on 11/8/13 at the Valvoline store located in Glen Carbon[,] Illinois, because the Mechanism of Injury matches the symptomology the patient is complaining of. There is also a high likelihood of future pain because of the foraminal, central canal stenosis's [*sic*], osteoarthritis and the annular fissure." (PX4). Dr. Chenault also indicated that "[b]ased on today's subjective and objective findings, as well as previous encounters, the patient hasn't reached MMI, we are referring the patient to pain management for further treatment... The patient should be considered temporarily partially

disabled for an undetermined period of time as of the date of this exam." (PX4). Finally, Dr. Chenault noted that "[a]t this point in time, it is my opinion that the prognosis for Ms. Linder is fair, with residuals." (PX4).

In a letter addressed "[t]o whom it may concern" dated 5/23/16, Dr. Prasad noted that Petitioner "... report[ed] intense pain starting after the injury [while working at Valvoline on 11/8/13]. Patient is currently being treated for disc bulging, annular tear, lumbar radiculopathy and spinal stenosis. These injuries could be caused or aggravated by the injury she sustained at work. The patient is currently being treated with prescription medications and lumbar epidural steroid injections every three months to keep pain within tolerable levels. The patient has also been referred to Dr. Richard Kube for surgical evaluation ... While the patient is being evaluated their office has restricted patient work activity to light duty including lifting up to 10 lbs., rare overhead and floor to waist work, occasional bending and twisting as well as prolonged sitting or standing. Our office agrees with these restrictions." (PX7).

Dr. Edward Trudeau performed an EMG and nerve conduction study on 6/7/16 at which time his interpretation included "[l]eft L5 radiculopathy, mild to moderate in electroneurophysiologic testing with old or chronic characterization, likely persistent/residual lesion, consistent with quite correct assessment of Dr. Kube and Mr. Morrow." (PX8).

In a Work Status Form dated 6/15/16, Dr. Kube indicated that Petitioner was capable of light activity consisting of frequent lifting of 10 pounds and limited lifting up to 35 pounds, along with rare overhead and floor to waist, limited bending and twisting as well as limited prolonged sitting or standing. (PX8).

In an office note dated 6/17/16, Dr. Kube noted that the nerve conduction study "... indicates an L5 radiculopathy. It is mild to moderate on the left side. This would be the point of the traversing roots associated with that level." (PX8). He also stated that "[t]he high-intensity zone [in the new MRI] is not as pronounced as it was on the previous MRI, butt it is still present. It is still in the same location. The disc quality, I would still say would be a Thompson grade 3. There does not appear to be any substantial advancement there since the time of her last study." (PX8). Dr. Kube indicated that "[t]he plan at this point would be to move forward with a provocative discogram and go forward from there." (PX8).

A discogram performed on 7/18/16 by Dr. Kube was found to be negative at L3-4 and positive at L4-5. (PX8).

In a report dated 7/21/16, Dr. Kube noted that "[a]t this point, based upon the results of the discogram, she would be a candidate for surgery at the L4-5 disc level." (PX8). Dr. Kube discussed disc replacement versus fusion with the patient, and "[g]iven the potential for catastrophic vascular injury [with disc replacement surgery], I would just lean toward doing the fusion." (PX8).

In a report dated 9/28/16, Dr. Kube recorded that "[b]asically, she is doing, score-wise, the same as she was before. She indicates to me that she was assaulted not long ago by another intoxicated individual. That ultimately increased her pain a bit for a while. Of note, however,

her pain scores really are unchanged with respect to her legs and her back... At this point, I do not believe the assault has any role of significance in the need for her requiring additional treatment. Her symptoms and examination and everything are largely similar. At this point, our recommendation remains the same for the decompression and fusion at L4-5." (RX6). As of that date, Dr. Kobe continued to restrict Petitioner to light activity. (RX6).

On 11/17/16, Dr. Prasad administered trigger point injections. (PX6).

Testimony of Dr. Richard A. Kube II (4/27/17):

Board certified orthopedic spine surgeon Dr. Kube testified that Petitioner visited his office for the first time on 4/20/16 at which she was seen by physician assistant Derek Morrow. (PX10, pp.4-6). He noted Petitioner presented with complaints of left lower extremity and lower back pain as well as numbness and tingling. (PX10, p.8). He noted that she had a history of previous back problems that he believed basically completely resolved with medication, and that "... she had a time period where she had no symptoms of any significance and then it looks like around the end of November [2013] an event happened." (PX10, p.8). He noted that "[s]he was at an auto mechanics location. It sounds like she was maybe changing tires. She was on her knees pushing the tire back up onto a utility-type vehicle a little bit larger than an SUV-size vehicle when she noticed a pop and pull in the low back. She had significant low back pain within a few days. She started having leg symptoms going to both legs but worse on the left side than on the right." (PX10, p.8). He noted that she had undertaken a variety of conservative treatment measures and undergone an MRI that revealed "... a little bit of L4-5 degeneration as well as an annular tear on that disk." (PX10, p.9). He noted the plan was to get some x-rays, and that her work status of light duty at that time. (PX10, pp.11-12).

Dr. Kube noted that he saw Petitioner at the time of her next visit, on 5/4/16, noting that he pretty much agreed with Mr. Morrow prior assessment. (PX10, p.12). He indicated that "[h]er exam seemed that it could be consistent with the L4-5 disk. There was some pain in the SI joints but not nearly as significant it looks like." (PX10, p.12). He noted that the reference in his report to an annular tear with disk collapse at L5-S1 "... had to be a typo", and that the tear was "... in the back part of the disk in that area at the [L]4-5 level." (PX10, pp.12-13). Dr. Kube thought it reasonable to set the patient up for a nerve conduction study with EMG as well as a provocative discogram to identify whether the L4-5 disk was the pain generator involved. (PX10, pp.14-15). He also indicated that Petitioner continued to be restricted to light duty consisting of "[l]imited lifting of 35 [pounds], rare overhead, rare floor to waist, limited bending and twisting, limited prolonged sitting or standing." (PX10, p.15).

Dr. Kube also ordered a repeat MRI which was performed on 6/2/16. (PX10, pp.15-16). He noted that this study revealed that "... we're still looking at the [L]4-5 disk. There does not appear to be any additional collapse or desiccation. The high-intensity zone is probably not quite as bright in the back of the disk, but you can still see the cleft back there where the tear had occurred." (PX10, p.16). He indicated that the brighter high-intensity in the previous MRI in December 2013 can indicate a more recent injury. (PX10, p.17). He also stated that the discogram was positive at L4-5 and that the control disk at L3-4 was negative. (PX10, p.19). In addition, Dr. Kube indicated that the NCV study indicated radiculopathy at L5. (PX10, p.22).

Dr. Kube testified that when he saw her again in follow up on 9/28/16 "... we still really did not feel a substantive change in her condition [had occurred], and our recommendation really had not changed from the decompression and fusion at L4-5 that we had recommended [at] the previous visit." (PX10, p.23). He agreed that his note at that time reflects that the patient had been assaulted by someone subsequent to her last visit. (PX10, p.23). However, he stated that it did not seem to change her pain or symptoms or the pathology in her back, noting that her visual analog scores were "not substantively different" and that the location and variety of symptoms did not seem to be different in their position. (PX10, pp.23-24). He noted that "... there wasn't anything that was markedly changed with her exam or any of those types of things. So at that point, barring that, there was not really a reason to change her surgical plan." (PX10, p.24). He indicated that he would not consider this assault an intervening event given that "... the surgery that was recommended would have been based upon the discogram that happened a couple of months before that time." (PX10, pp.24-25). He also noted that he still recommended light duty at that time. (PX10, p.26).

Dr. Kube testified that he next saw Petitioner in November [2016] at which time his recommendation remained that the patient undergo a decompression and fusion at L4-5, noting that they were basically just awaiting authorization to perform the procedure. (PX10, pp.26-27). He noted the same thing at the time of his last visit on 2/8/17, at which time he maintained her light duty restrictions, if available. (PX10, pp.27-28). He noted that he has not seen her since 2/8/17. (PX10, p.28).

Dr. Kube testified that "... at this point she has the L5 radiculopathy. She has an aggravated degenerative disk disease at L4-5 with possibly a new onset annular tear at L4-5 at the time of the injury that's causing the back pain she now experiences." (PX10, p.28). Dr. Kube also agreed that the current diagnosis might or could have been caused or aggravated by the work accident in November 2013. (PX10, p.28). When asked the basis for this opinion, Dr. Kube stated: "I mean, using her history, I take her at face value. She indicates that she did have a previous back history. To my knowledge, you know, it was an incident that resolved and that she was not requiring any ongoing treatment, no ongoing symptoms for a considerable period of time. And now, you know, during, you know, a mechanism that is pretty common by which we could injure ourselves, she had pretty contemporaneous onsets of pain. There was also a mechanical experience at the time of the pop. So mechanism, immediate onset of system [*sic*], you know, with no ongoing issues immediately prior or for some duration prior, it's much more likely than not that this caused some new problems for her." (PX10, pp.28-29).

Dr. Kube testified that he believed all of the treatment he offered Petitioner has been reasonable and necessary to cure or relieve the effects of her work injury in November 2013. (PX10, p.29). Dr. Kube also agreed that being on your knees lifting a tire to put it on an SUV-type vehicle is the type of mechanism that could cause or aggravate the pathology Petitioner has in her back. (PX10, pp.29-30). He also indicated that Petitioner is not at MMI for her alleged work accident. (PX10, p.30). With respect to the recommended surgery, Dr. Kube testified that "[m]y plan would be to decompress the nerve, create space around it to hopefully alleviate the symptoms associated with the nerve. Also then remove the disk at L4-5 as it's creating pain for her. And after achieving those things, then we would utilize the usual bone grafting and instrumentation techniques to fuse that motion segment of her spine at L4-5." (PX10, p.30).

Dr. Kube testified that "I think she has aggravated the degenerative disk at L4-5. I think she either had a cause of the annular tear, a direct cause or at minimum aggravation. Without a before and after picture, I couldn't tell you for certain that it was absolutely caused – you know, the tear anyway was caused. But, you know, there were some things that can be suspicious for that. But I think at minimum it would have been an aggravation of that. And those items are what are – what are directly relating to her radiculopathy." (PX10, p.36). He also noted that he believed the need for the surgery he is recommending is due to the work accident. (PX10, p.36).

On cross, Dr. Kube agreed that he did not actually see the patient at the time of her initial visit on 4/20/16, and that she was seen by a physician assistant at that time. (PX10, p.44). He also agreed that the MRI he reviewed from December 2013 was "more or less" normal with "nothing major going on" other than the annular tear at L4-5 and some loss of disk height. (PX10, p.49).

He noted that Petitioner "... does have reasons at L4-5 to have a radiculopathy. But it's not like there is a large extruded disk herniation taking up all kind of space in the canal where I can say, obviously, you know, if I remove that, you're going to do a lot better." (PX10, p.50). He also indicated that he would not classify it as a disk herniation or extrusion. (PX10, p.53). However, he noted that "... the herniation, whether it's present or not, really wouldn't be what would lead you to do a fusion. The fusion is mainly being performed for the consistent back pain that she's having on top of the radiculopathy. So the fusion is being done to stabilize that motion segment at L4-5 and also to remove the painful disk that she has there." (PX10, p.54). He also indicated an annular tear can demonstrate a radicular component into the lower extremities. (PX10, p.57).

Dr. Kube agreed that the history he and his physician assistant received was that Petitioner had had a previous problem with her back but that it had resolved. (PX10, pp.58-59). When asked if he reviewed any prior records, Dr. Kube stated that "I could tell you with absolute certainty that if it's not in the chart, I didn't review it. Okay. But it it's in the chart, it's quite possible that I did, in fact, review it." (PX10, p.60). He also noted that "... unless there's something [in a prior record] that tells me that her history is baloney, I would just take it at face value." (PX10, p.62).

When asked whether complaints of left lower extremity numbness, etc. and a diagnosis of lumbar disk problem in 2011 was consistent with the annular tear demonstrated in the December 2013 MRI, Dr. Kube stated: "... I guess possibly; possibly not. I guess it depends on what specific radiculopathy she had diagnosed at that time, who diagnosed her with it, is it, in fact, a radiculopathy or not and then I guess also what her studies would have looked like at that time too." (PX10, p.63). He agreed that his review of the December 2013 MRI revealed that all disk levels other than L4-5 were normal. (PX10, p.64).

When asked if it would be "significant" to see the treatment records from the chiropractor who saw Petitioner in 2011-2013, Dr. Kube responded: "I guess it just depends on whether or not information contained in there is grossly different than what the patient told me in her history." (PX10, pp.67-68). He also noted it was "possible" that a person can either herniate or aggravate a disk in the lower back by violently sneezing or having a sneezing attack. (PX10, p.68).

Dr. Kube believed that Petitioner was an honest person, noting that "... we don't have anything listed here where there was a bunch of nonorganic findings or things that red flagged her, right, or we would never offer a fusion to somebody who is like that." (PX10, p.72).

Dr. Kube indicated that he currently has Petitioner on the same light duty restrictions, which include limited lifting up to 35 pounds and 10 pounds frequently, as well as limitations on overhead work, sitting and standing. (PX10, pp.73-74). When asked if surgery is the only alternative, Dr. Kube replied: "... I don't think it's the only alternative. I mean, she could always do nothing... But, I mean, there's not going to be any kind of substantive benefit at this point to doing a bunch of additional therapy or chiropractic...I guess you could consider here and there an epidural shot. But, frankly, if it's not going to be providing long-term benefit beyond what it already has, I personally don't see a role for doing that because it's not going to provide sustained relief." (PX10, pp.74-75).

When asked if it was "conceivable" that the annular tear had healed further by this time so that the condition would not require a fusion, Dr. Kube replied: "... I guess the MRI is changed but the symptoms still remain. And she certainly still has a positive discogram that we saw with those things, you know, less than a year ago. So, no. I don't – I don't think that's likely based on the ongoing symptoms and then some of the objective issues of the discogram that we had." (PX10, pp.77-78). He noted that annular tears do improve on their own at times "... but it's rare." (PX10, p.78). He conceded, however, that if Petitioner "... showed up by some strange miracle tomorrow and said, hey, my symptoms are all gone, [there would be] no reason to operate on her." (PX10, p.80).

On re-direct, when asked again about the sneezing episode, Dr. Kube noted that "[i]t's possible that that sneeze could have zero to do with it. It's possible it might have a more significant role to do with it. What I know is she clearly sought treatment after [the work accident]... And then there is another event here that the other counselor talked about... the sneeze event... And there could be – there could be some relevance there. But, like I said, it really would boil down to what kind of documentation and increased symptoms beyond that which – for which she was already treating would help you to know how much, if any, that sneeze is involved." (PX10, p.90). However, Dr. Kube stated that "... based on what I'm hearing, it doesn't sound like there's any – it certainly sounds like it was painful, but it doesn't sound like there's – there's no documentation that her condition markedly changed in a sustained manner after that [sneezing] incident. Then it would be hard for me to put a lot of value on that additional incident since it comes after the fact." (PX10, p.92).

When asked whether the prior back condition in 2011 or the work accident on 11/8/13 was the cause of her current diagnosis, Dr. Kube testified that "... if that time duration that you're stating to me is what is the factual findings when things are said and done, that would indicate to me that there was about a two-, two-and-a-half-year window where there was not ongoing treatment for her – for her back and her – and her leg." (PX10, pp.93-94). He noted "... in my practice if somebody hits about two or three months, you know, I consider them pretty much healed at that point ... [although] you always have the ability to reinjure yourself." (PX10, p.94). He stated the prior back problems in 2011 "... had to have been resolved to a fairly good degree at that point if she wasn't requiring anything more than she was doing." (PX10, p.97).

On re-cross, Dr. Kube conceded that all he knew was that Petitioner did not seek treatment between 2011 and 2013, not whether she was symptomatic or not. (PX10, pp.98-99).

Testimony of Dr. Kevin Rutz (6/9/17):

Board-certified orthopedic surgeon Dr. Rutz testified that he specializes in the operative and non-operative treatment of the cervical, thoracic, and lumbar spine and that he was retained by the employer to conduct an independent medical examination of Petitioner on 1/28/16. (RX3, pp.5-8, 22).

Dr. Rutz reviewed the MRI from December 2013, noting that "... of all the different pathologic readings she's had, the only one that I think is significant is her annular tear... The other findings there don't tend to lead to such a high degree of dysfunction as she has been complaining about." (RX3, p.22). He also indicated that from a strictly neurological standpoint his examination of Petitioner was normal. (RX3, p.23). Based upon his examination, Dr. Rutz's diagnosis was "... low back pain and lumbar radiculopathy." (RX3, p.24). Dr. Rutz noted that his presumption was that Petitioner's radiculopathy was "... secondary to the annular tear as I didn't think her stenosis was very impressive." (RX3, p.24).

Based upon his examination and review of the MRI, Dr. Rutz stated that he could not say, within a reasonable degree of medical certainty, that Petitioner's condition was the result of the alleged work incident. (RX3, p.25). Reading from his report, he explained that "[t]he problem with this case, as far as causation, is concerning – is the lack of documentation of an injury during the early part of the patient's treatment... The first documentation of an injury comes from Dr. Prasad on 3/4/14, in which he stated that her pain started while doing a tire rotation, which is four months after the alleged date of injury." (RX3, p.26). Dr. Rutz indicated that "[i]t is true that pulling a tire – pulling off a tire could cause an injury to the back, but there was no documentation of this available for me to review until four months after the date of injury. Therefore with the information given to me at this time, I cannot say one way or the other within a reasonable degree of medical certainty if there was truly an alleged work accident." (RX3, p.27). Dr. Rutz indicated that he believed Petitioner's current complaints were related to the annular tear. (RX3, p.28). However, he did not believe that the annular tear was related to the alleged work activity. (RX3, p.28).

When asked if Petitioner was at MMI as of 1/28/16 (the date of his IME), Dr. Rutz responded: "[s]o putting causation to the side, I thought she needed a new MRI of her lumbar spine. So, and then further decision making could be made on what to do for her based on that new data, assuming she has as much pain as she said she did in the office." (RX3, pp.28-29). Dr. Rutz testified that he had since reviewed the MRI performed on 6/2/16 which he noted "... demonstrated mild disc desiccation at L4-5 with a central annular tear. So from a big picture perspective, all three MRIs [from 8/24/10, 12/20/13 and 6/2/16] basically looked the same." (RX3, p.30). He noted that "... the annular tear was there in 2010 for sure. And it continued to be there on the two subsequent studies. So my opinion on causation didn't change having this [record]. It basically just reinforced my opinion... that her problem was not work related." (RX3, pp.33-34). He noted that even if you just rely on the 2013 and 2016 MRIs "[t]hen we're back to my opinion on causation generated in my reports ... in which I didn't feel that her

problem was work related." (RX3, p.34). He agreed that the MRI studies basically reinforce his position that this is not causally related. (RX3, p.34).

Dr. Rutz agreed that when he saw Petitioner she gave a history of problems approximately ten years prior, and that she had not had any problems since. (RX3, p.35). He indicated that she did not tell him about treatment she had received throughout 2011 from Dr. Chenault, including visits in January, March, April and May of 2011 at which time she was diagnosed with lumbar disc disease. (RX3, pp.35-36). When asked if knowing this would impact his position, Dr. Rutz noted that "[w]hen someone withholds information ... the truthfulness of the patient becomes an issue. And so it becomes harder to take them at their word for things when they're not being truthful about their history." (RX3, pp.36-37).

Dr. Rutz noted that he didn't think there was "... a lot of controversy about what her actual problem is, it's just the timeline of her symptomatology." (RX3, p.39). He indicated that this brings him back to the problem with documentation of the injury that he noted in his report, which he noted he finds "frustrating" and which makes it "complicated trying to be the detective in a situation like this." (RX3, p.40).

With respect to the question of surgery, Dr. Rutz stated that "I believe if she had appropriate diagnostic findings on discography, she would be a candidate for a lumbar fusion." (RX3, p.41). However, he indicated that he believed the need for that fusion was unrelated to the work activity. (RX3, p.41). He further noted that the fusion he is suggesting would be a single-level procedure. (RX3, p.41).

On cross, Dr. Rutz reiterated that, by way of prior history, Petitioner "... told me that she had a lumbar strain [ten years earlier] and that it had gotten better." (RX3, p.45). He noted "I ask an open-ended question, you know, 'What other problems have you had with your lower back in the past?' And, and then they have the opportunity to tell me about those things. And all she told me about was a lumbar strain ten years ago that had gotten better." (RX3, p.46). He stated she did not tell him about any radiculopathy that she may have had in the past. (RX3, p.46).

Dr. Rutz agreed that Petitioner has an L4-5 annular tear in her low back and that surgery would be appropriate "[a]ssuming she's still symptomatic." (RX3, p.46). When asked whether being symptomatic would be an indicator for surgery, Dr. Rutz stated: "Degree of symptoms. People with mild symptoms do not choose to have surgery. People with severe, unrelenting symptoms are usually the ones that choose surgery." (RX3, pp.46-47). He also agreed that pulling off a tire could cause an injury to the back such as the annular tear Petitioner suffered at L4-5, noting that "[a]ssuming it's a big enough tire with enough force, I, I think that's a reasonable way to hurt your back." (RX3, p.47). He also agreed this is the history Petitioner gave Dr. Prasad in March of 2014 as well as Dr. Kube when she started seeing him. (RX3, p.47). He noted Petitioner gave a history of "[c]hanging oil and tire rotations" to chiropractor Dr. Chenault when she saw him in November 2013. (RX3, pp.47-48). He likewise agreed she complained of low-back pain with radiation bilaterally into her legs at that time. (RX3, p.48).

When asked what more information he needed to conclude that she injured herself at work, or aggravated her annular tear as a result of these activities, Dr. Rutz responded: "... the

earliest records don't demonstrate – well, for example, that first note we just looked at [by Dr. Chenault], it said she was doing oil changes and tire rotations. That's not an injury, that's a description of the work she does. And as opposed to later, it's a different testimony to say, 'I hurt my back pulling a tire off.' Those are two different things. So that's an inconsistent testimony which is – makes causation very difficult." (RX4, pp.48-49).

Dr. Rutz testified that "[i]f I had a patient that had some problems with her back in the past, might have some good days and bad days, but they're generally okay and able to do their work and activities of life, and then they're at work and do something that places an abnormal physiologic load on their spine and their same problem becomes worse and is sustained worse and they don't go back to their baseline, I'll say it's an aggravation secondary to work. And I don't know that I can say that's the case in this case." (RX3, p.49). He also conceded that if the evidence showed Petitioner reported the incident to her employer within a week or two that would change his testimony or at least call into question his previous opinions on causation. (RX3, p.50).

Conclusions of Law

To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that she has suffered a disabling injury which arose out of and in the course of her employment. *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 203, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003).

In the present case, the Commission finds that the Petitioner failed to sustain her burden of proof along these lines. More to the point, the Commission finds Petitioner less than credible as to her prior history of lower back problems as well as the circumstances surrounding her alleged accident -- which she claimed occurred on 11/8/13 and which the Arbitrator found occurred on 11/7/13. Along these lines, the record clearly shows that Petitioner had a prior history of lower back problems, necessitating treatment from at least 2009 through May of 2011 and in regard to which she filed a previous workers' compensation claim alleging a date of accident in November of 2010, which she settled a mere three months after filing the current claim in dispute. This prior treatment included ongoing chiropractic care with Dr. Chenault through 5/31/11 during which time Petitioner continued to complain of lower back pain and numbness down her leg. These records also reference multiple exacerbating incidents caused by such things as sleeping on a couch, getting out of bed the wrong way, riding in a car, and doing laundry. (PX4). More importantly, the record shows that Petitioner underwent a lumbar MRI on 8/24/10, or more than three years before the alleged accident in dispute, evidencing an annular tear and which Dr. Rutz testified looked basically the same as the two subsequent MRIs performed on 12/20/12 and 6/2/16.

Furthermore, Petitioner was less than clear as to the date of the accident, given that the injury report she signed on 11/16/13 referenced a date of accident of 11/7/13, while she testified to a date of accident on 11/8/13. Her manager, Ms. Ross, also flatly denied that Petitioner informed her about any injury Ms. Linder may have sustained to her back at the time it allegedly happened. In addition, Ms. Ross and co-worker Ms. Giltner both credibly testified that prior to the alleged accident Petitioner complained to them that she needed back surgery but could not

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afford same, an allegation that seriously calls into question Petitioner's entire claim that she was injured as a result of an incident at work on the claimed date. Indeed, the one person she claims witnessed the accident and finished the tire rotation for her, a manager named "BJ", apparently never gave a statement and was not called to testify at arbitration – a fact that while not warranting an adverse finding contrary to Petitioner's position, as Respondent requested, still raises doubts as to the legitimacy of Petitioner's claim.

In addition, the Commission finds the opinions of Respondent's §12 examining physician, Dr. Rutz, to be considerably more persuasive than those offered by treater Dr. Kube, who was under the misimpression, based on the history provided to him by the patient, that her lower back complaints had completely resolved prior to the alleged date of accident – a claim that is most certainly at odds with the record.

Therefore, the Commission reverses the Arbitrator and finds that Petitioner failed to prove by a preponderance of the credible evidence that she sustained accidental injuries arising out of and in the course of her employment on either 11/7/13 or 11/8/13 and failed to prove that her current condition of ill-being relative to her lumbar spine was causally related to said alleged accident.

Thus, the Arbitrator's award is vacated and Petitioner's claim for compensation is denied.

Finally, the Commission notes that on its Petition for Review form, under "Other", Respondent had noted "Motion for Finding" as an issue on review. This was apparently in response to the Arbitrator's denial of Respondent's Motion for Adverse Finding relative to Petitioner's alleged refusal and/or failure to execute a release in order to obtain the records of Dr. Youkilis. However, Respondent failed to address the matter in its brief, and as such has waived the issue. Regardless, as already indicated, the Commission finds no reason to make any such adverse ruling based on the facts of this case and affirms the Arbitrator's ruling in this regard.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 3/5/18 is reversed and Petitioner's claim for compensation is hereby denied.

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

DATED: MAR 3 0 2020
o:2/4/20
MP/pmo
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Maria Elena Portela

Maria E. Portela

Kathryn A. Doerries

Kathryn A. Doerries

DISSENT

I believe the record fully supports the Arbitrator's well-reasoned and thoughtful decision finding that Petitioner proved by a preponderance of the credible evidence that she sustained accidental injuries arising out of and in the course of her employment with the Respondent on or about 11/7/13, and that Petitioner's current condition of ill-being is causally related to said accident. This was a decidedly difficult case to decide, one that the Arbitrator no doubt struggled to fairly adjudicate. But the Arbitrator heard the live testimony, evaluated the relative credibility of the various witnesses and reviewed the medical record and found that the greater weight of that evidence supports Petitioner's claim that she sustained a work-related accident and that at the very least said accident aggravated her lower back condition. And I see no reason to disagree with the Arbitrator's assessment in this regard.

Therefore, I respectfully dissent from the majority decision to deny compensation in what I consider a clearly compensable case.

Marc Parker

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

LINDER, RACHEL
Employee/Petitioner

Case# **14WC000622**

VALVOLINE/ASHLAND OIL INC
Employer/Respondent

20IWCC0210

On 3/5/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.83% 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:

5545 STEVEN A TREFTS
6978 CHIPPEWA ST
SUITE 1
ST LOUIS, MO 63109

1872 SPIEGEL & CAHILL PC
CHRISTINA H BAWCUM
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

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
CORRECTED ARBITRATION DECISION
19(b)/8(a)

RACHEL LINDER
Employee/Petitioner

v.

VALVOLINE / ASHLAND OIL, INC.
Employer/Respondent

Case # **14** WC **00622**

Consolidated cases: _____

20IWCC0210

An *Application for Adjustment 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 **July 20, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On the date of accident, **November 7, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**11,338.83 (36 weeks)**; the average weekly wage was $**304.39**.

On the date of accident, Petitioner was **29** years of age, ***single*** with **2** dependent children.

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

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

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

ORDER

The Arbitrator finds that the Petitioner sustained accidental injuries arising out of and in the course of her employment with the Respondent on November 7, 2013. The Arbitrator further finds that the Petitioner's lumbar condition of ill-being is causally related to the November 7, 2013 accident.

Respondent shall pay Petitioner temporary total disability benefits of **$286.00 per week**, the minimum applicable statutory TTD rate, for **192-5/7 weeks**, commencing **November 10, 2013 through July 20, 2017**, as provided in Section 8(b) of the Act.

Respondent shall pay the reasonable and necessary causally related medical expenses contained in Petitioner's Exhibit 9 as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize the L4/5 fusion surgery recommended by Dr. Kube.

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

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

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

Signature of Arbitrator

March 5, 2018
Date

MAR 5 - 2018

STATEMENT OF FACTS

The Petitioner, 34 years old as of the 7/20/17 hearing date, testified she started working for the Respondent at its Glen Carbon facility full time in February 2013 as a technician, which involved performing tire rotations, transmission and radiator flushes, joint greasing and oil changes. She testified that she earned a little over $9 per hour. Mark Vioc was the store manager, "BJ" was the assistant manager, Elizabeth (Liz) Ross was a co-worker, and Megan Giltner was a co-worker who did mainly computer and "topside" work, i.e. above ground work like adding fluids, changing wipers and checking lights. Petitioner worked "below ground."

On 11/8/13, the Petitioner testified she was rotating large oversized tires and had to pound on one that was stuck to break it loose. BJ helped her and was struggling himself. In the process of putting the tire back on, she was down on one knee. The tire dropped down off the vehicle because she didn't have it on quite right, and she felt a pop and pain in her lower back. She told BJ at the time that she hurt, and he said he would finish the tire rotation and sent her home early. When she tried to return to work the next day, she testified she was sent home by Liz Ross.

Px3 contains the documentation of text messages the Petitioner had with Mark Vioc after the alleged accident date. The initial series of texts are from 11/11/13. The Petitioner informed Mr. Vioc she would not be able to make it to work, and Vioc asked what was wrong and "why not." The next text is dated 11/14/13 from Petitioner indicating she is off work until at least the 21st, and Vioc responded: "Can you give me a call. I need to ask you some questions about your injury." About an hour later Petitioner texted that she needed to pick up a "pink packet" the next day, and Vioc responded asking when she would be coming in, again requesting a call and indicating "we are trying to get all of the information together now." The final text from Vioc that day about an hour and a half later stated: "Rachel, we spoke to Ashland and we need you to please bring in all of your paperwork from your doctor's visit. Ashland needs it for their records." (Px3). Petitioner testified that "Ashland" is the Respondent's corporate facility.

The Petitioner said when she called Mr. Vioc in response to the 11/11/13 text, she reported that she had been injured doing a tire rotation and was medically taken off work. She testified that Vioc asked her for more detail about the incident at a later time. When she came in to turn in her off work slip (Px5) to Mr. Vioc, she picked up the pink packet at work, which included accident report documents, and she was sent for as drug test. The note in Px5 is from Dr. Chenault taking Petitioner off work from 11/11/13 to 11/15/13.

An accident report completed for Respondent is dated 11/16/13, and in it the Petitioner indicated the date of accident was 11/7/13, that she "moved wrong putting a tire on during tire rotation injured lower back have pain in lower back

and down both legs." Petitioner also noted "Told Liz back was hurting" on Friday. (Rx8). The Arbitrator takes judicial notice that 11/7/13 was a Thursday, and 11/8/13 was a Friday.

The Petitioner testified that she had multiple interactions with Liz Ross after the 11/8/13 work incident. On 11/9/13, Petitioner testified she went into work and told Liz what had happened the day before, and that she was hurting and needed to work top-side because she didn't think she could handle bottom-side. She stayed topside for most of that shift, and Liz sent her home a little early that day.

A witness statement of Megan Giltner, dated 11/15/13, was submitted into evidence as Rx9. The document states that Petitioner told Giltner two months prior that she had a back problem for a while that was worsening, and that she needed surgery and couldn't afford it. Giltner also indicated Petitioner complained of pain every day, "other things along with her back", and never indicated it was due to work. Giltner added that Petitioner said she had problems with everything with her last job as well. She further stated: "When another employee went home for a while for a back injury, she started becoming more adiment [sic] about her back. Also the time when she first told me that she needed back surgery she told me how she went to multiple doctors about this problem. She need surgery or else her back would rupture and she would not be able to walk again, she needed it bad but it would be costly. She also would randomly say one body part was injured but the next day it would switch sides. She always changed her story." (Rx9).

Respondent called Ms. Giltner to testify pursuant to subpoena. She testified she worked with the Petitioner at the Glen Carbon facility for about 6 months prior to the alleged date of accident in 2013. She testified she was previously terminated by Respondent. While Ms. Giltner verified that she completed her witness statement honestly on 11/15/13 (Rx9), she did not have a current independent recollection of the information contained in the document ("I was accurate when I wrote this, so I still think that this is true, but I personally don't remember it because I did my best to forget everything about that place."). Prior to 11/8/13, Ms. Giltner recalled having a conversation with Petitioner where Petitioner discussed her back problems, how expensive surgery was and that if she didn't have surgery she would get worse. She testified that this was the only conversation she recalled having with Petitioner about her back, and that Petitioner would complain of various general pains that would change constantly - "I remember that." She did not recall the Petitioner saying how long she'd had back pain, did not recall Petitioner discussing any other medical treatment with her, and did not recall another person being off work for their back at the Respondent. On cross exam, Ms. Giltner testified: "It was just an awful place
to work. Management didn't care about their employees. To avoid hassle, they would just pretty much say, you know, just keep your head down and work and whatnot." She testified that when you started working there, people in management, including a senior technician and assistant manager, would say that if you got hurt at work it was better to say you were hurt at home because they didn't want to go through the hassle of what was involved in reporting an injury. This included BJ Parker and "Josh." She testified she tried to turn in a claim when she hit her head on a locker and "it was a hassle trying to get it taken care of." She testified that the job with Respondent was physical.

Elizabeth Ross, also known as Liz, also testified on behalf of Respondent. She testified she worked for Respondent from 2012 to August 2014 as a working assistant manager. She testified she was familiar with Respondent's policy and procedures as it relates to work injuries of the employees. Following such a report, the employee would be given a colored packet of documents, and they are sent to occupational health for a drug test and any needed treatment. Ross then would have called Kathy Beers at corporate to report it.

Ms. Ross testified that she is aware Petitioner is claiming an 11/8/13 work injury, but testified that the Petitioner worked her shifts on that date and 11/9/13 and never made any mention of a work injury. She worked with Petitioner on 11/9/13 and she did not report any difficulty performing her work. She next saw Petitioner when she came in to pick up

her check, testifying that at that time she came in hunched over and walking with difficulty. She also testified that at some point after this, she and another assistant manager were putting fliers on cars and she saw the Petitioner walking from a parking lot into a bookstore with no evidence of difficulty. She didn't know the date, but said it was within a week of the Petitioner coming in to pick up her check. As of November 2013, Ms. Ross testified she had worked with the Petitioner for approximately nine months, and that prior to 11/8/13, the Petitioner did make complaints of back pain to her, telling her that she needed back surgery but couldn't afford it. At some point, Ms. Ross was called into a meeting by her supervisors regarding why she didn't follow injury protocol for Petitioner's work accident, and she testified that this was the first time she became aware that Petitioner was alleging that she sustained a work accident. She did not testify as to the date of this meeting. Ms. Ross testified that she didn't ask the Petitioner about her condition when she came in hunched over to pick up her check because she was told by either Mr. Vioc or Ms. Beers at the meeting not to do so since it was a workers' compensation matter. Ms. Ross completely denied that managers at the Respondent would discourage employees from reporting work accidents, noting she could be fired on the spot for failing to refer an injured worker for treatment. She testified that she got BJ a job at her old employer while he had been employed by Respondent.

On cross examination, Ms. Ross testified that Petitioner complained of back pain multiple times prior to 11/8/13, but conceded that she didn't indicate whether it was upper or lower back, and that "And a lot of times it changed from time to time where she said she needed surgery or where it hurt at", including the upper, mid and lower back. She testified that Petitioner told her she had long term back issues, and that when she first stated working for Respondent she was waiting for the insurance to kick in after 90 days so she could see what portion of surgery the insurance would pay for. Ross testified that the job with Respondent is physical, and agreed that light duty was not available. She testified that she had not seen Ms. Giltner's witness statement before, and that she did not provide it to Giltner and did not know who did. Ms. Ross could not recall whether she or BJ worked on 11/7/13, but as assistant manager believed she likely did. She denied ever having a conversation with the Petitioner after 11/8/13 regarding the Petitioner having back pain and being able to only do top side work. She agreed that an employee need only report an injury to one manager, the "manager on duty" for that day, not all of them. She couldn't say if she or BJ was the manager on duty on 11/7/13, but that she was the manager on duty the next two days, 11/8 and 11/9/13.

Petitioner testified she initially sought treatment post-accident with chiropractor Dr. Chenault on 11/11/13, noting she had seen him in the past. She testified that she reported injuring her low back doing a tire rotation, and that he asked her about her job duties.

The 11/11/13 report of Dr. Chenault indicates a report of low back pain. The report is handwritten, but appears to indicate a one week history or an approximate one week history of symptoms. Something is indicated about "change oil – tire rotation", and numbness is indicated, but the Arbitrator cannot read the rest. The report next states: "1 week 'can't deal w/it' – no way can work." (Px4). A second report from the same date appears to note low back pain into the legs. It appears to say "new # job – changing oil – rotations." The diagnosis was lumbosacral disc. (Px4).

Treatment continued with Dr. Chenault from 11/12/13 to 5/19/14. In general, these records reflect transient minimal improvement. On 11/12/13, Petitioner was taken off work for a week. Petitioner reported difficulty walking on 11/13/13. She reported pins and needles on 11/21/13. On 12/9/13 she reported a pain increase due to going up and down stairs at a mall. On 12/10/13, Dr. Chenault discussed injections and an MRI with Petitioner. On 12/12/13 he noted "sending back to work on Monday." On 12/18/13, Petitioner reported an aggravation of pain from her kids laying on her, and Dr. Chenault noted Petitioner was being released to light duty. On 12/23/13 he referred Petitioner for injections, and the records show that this took some time to accomplish. (Px4).

The Respondent submitted some pre-accident records applicable to Petitioner. A prior 8/24/10 lumbar MRI showed degenerative disc disease most prominent at L4/5 with a broad-based posterior disc bulge and associated annular tear. It was requested by a Dr. Holbrook. (Rx2). The prior records of Dr. Chenault run from 1/13/11 through 5/31/11. The initial report appears to indicate the Petitioner fell at work, and reflects cervical and shoulder focus. On 1/27/11 she noted both neck and low back problems into the legs, and L4/5 is specifically identified. Left leg/foot numbness was noted on 2/3/11. The next note of 2/17/11 notes Petitioner was sleeping and pulled something and "popped" her back, with low back focus. On 3/22/11, it is noted that Petitioner was battling with workers' compensation for coverage, and that she was being referred to a pain doctor. On 4/1/11 she noted she fell. The last two notes of 5/27 and 5/31/11 indicate Petitioner reported low back symptoms with unloading laundry at work. She was generally taken off work for a day here and there when she treated, and then was put on light duty for about a month prior to the last month or so of treatment. (Rx1).

A 12/20/13 lumbar MRI indicated mild spondylosis, an L4/5 annular fissure and mild diffuse facet arthropathy. Mild foraminal and central canal stenosis were noted at L4/5 and L5/S1 with a mild disc bulge at L4/5. (Px4).

Petitioner initially saw Dr. Prasad on 3/4/14, who noted she was referred for low back pain radiating into both legs with numbness and tingling which began while doing a tire rotation at work in November. An epidural was performed at L4/5, and Norco and Flexeril were prescribed. (Px6). On 3/6/14, the Petitioner noted to Dr. Chenault that her low back pain was improved with injection, and some of the feeling came back in her left leg. While his subsequent reports note Petitioner reporting a little improvement, there does not appear to be significant change. (Px4). Petitioner underwent another epidural on 4/1/14 at L4/5, with Dr. Prasad noting the first injection provided relief for several weeks. (Px6). While Petitioner reported some improvement again with this injection to Dr. Chenault, his records continue to note complaints of 6 to 7 out of 10 pain. His last report of 5/19/14 is a narrative which indicates Petitioner has not had much overall improvement. Dr. Chenault stated that the only way to prove that the work accident caused a permanent injury would be via a pre-accident MRI, but opined that there is a high likelihood her injury was due to the accident because the mechanism of injury, which is not stated, matches her symptoms, and that there is a high likelihood of future pain because of the foraminal and central canal stenosis as well as osteoarthritis and the annular fissure. She was referred to pain management. (Px4). The Petitioner testified that Dr. Chenault provided therapy, chiropractic care, e-stim and massage. After initially taking her off work for 4-5 days, she testified he released her to light duty, but was told by the Respondent's corporate office that she couldn't come back without full release. Dr. Chenault never gave her a full release prior to referring her to pain management specialist, Dr. Prasad.

Petitioner underwent a third L4/5 epidural injection on 10/14/14. The report notes: "Injections helped for several months but pain is now returning. Is very active right now related to car ride from Springfield. Pt still not working at her oil change job related to increased pain." At each of these visits the Petitioner reported 7 out of 10 pain. A prior history of an epidural in 2011 was noted. (Px6).

The Petitioner did not return to Dr. Prasad again until 10/14/15. The report notes the Petitioner had improvement with the last epidural for several months but her pain again increased and was radiating into the left leg with numbness and tingling, again indicating the drive from Springfield increased her pain. She reported 7 out of 10 pain, and an epidural was performed at left L4/5. On 1/5/16 the Petitioner noted the left-sided injection helped more than the prior injections had, so this was repeated at that time and again on 3/15/16, at which time Dr. Prasad referred Petitioner to Dr. Kube with diagnoses of lumbar spondylosis and radiculopathy. (Px6; Px8).

Petitioner was examined by orthopedic surgeon Dr. Rutz at the request of the Respondent on 1/28/16. Petitioner reported the current work injury, and that she'd had a lumbar strain about 10 years prior which got better. Petitioner

stated she reported her work injury the same day it happened as well as the next day, but didn't complete paperwork, and felt like "she was getting the run around from her employers." Dr. Rutz pointed out that the initial November 2013 records of Dr. Chenault don't identify a specific accident, but rather just note that the Petitioner did oil changes and tire rotations at work. He indicated that the first medical note that specifically references she had pain while doing a tire rotation was the 3/4/14 report of Dr. Prasad. Petitioner reported low back pain, left greater than right, radiating into the left leg and posterior right thigh. While he reviewed lumbar x-rays, Dr. Rutz did not have any MRI reports or films. Physical exam was essentially normal. Dr. Rutz diagnosed low back pain and lumbar radiculitis, noting he could not be more specific without reviewing lumbar MRI. Dr. Rutz indicated that he could not say that the Petitioner's lumbar condition of ill-being was related to a work injury given the lack of initial documentation of a mechanism of a work injury in the records of Dr. Chenault, and the Petitioner's report to Chenault on 11/11/13 of a one week history of onset when the alleged accident occurred only three days prior. He did opine that if the MRI showed mild degenerative changes at L4/5, this may or may not be related to a work accident, as well as that the pulling of a tire could be a competent cause a back injury. The report states: "The issue of causation on this has less to do with being a spine specialist and more of one on documentation." He did not know if the Petitioner verbally reported the alleged accident. Based on the lack of known documentation from his perspective, Dr. Rutz stated that "I cannot say one way or the other within a reasonable degree of medical certainty if there was truly an alleged work accident", but that he could not say that her current problem is related based on the information he had. Based on the lumbar condition regardless of causation, Dr. Rutz opined that she likely could minimally work with a 20-pound restriction and the ability to change positions as needed, and potentially could do more. He opined that she was not at maximum medical improvement (MMI) and that an updated MRI was indicated. If the Petitioner has significant pain and difficulties with activities of daily living, he opined that he would consider surgery reasonable if clear cut pathology could be identified. (Rx4).

Petitioner initially saw orthopedic surgeon Dr. Kube's assistant, Derek Morrow, on 4/20/16. She reported low back pain into the left leg to the foot with numbness and tingling. She noted "some history of back pain" before the current injury that was more of a muscle strain that completely resolved with medication, also noting no further problems until the current injury of 2013 or 2014. She was on her knees putting a tire onto a large SUV and felt a pop and pull in her back with significant pain, with pain going into the legs a few days later, left greater than right. The back pain was much worse than the leg pain. She indicated minimal relief with multiple conservative measures to date. Morrow noted pain with range of motion and a sensory deficit consistent with L5, but no motor weakness and negative straight leg raising. He noted MRI appeared to show some L4/5 degenerative disc disease with a significant annular tear and central disc bulge, with some fluid in the bilateral L4 to S1 facet joints. Updated x-rays and a follow up with Dr. Kube were recommended, noting she had exhausted conservative treatment and it appeared that her main problem was the L4/5 disc, with some facet joint pain. The Petitioner was limited to light duty (frequent lifting up to 10 pounds and limited lifting up to 35 pounds, rare overhead and floor to waist lifting, limited bending and twisting and limited prolonged sitting or standing). (Px8).

5/3/16 lumbar x-rays reflected mild facet arthropathy. At 5/4/16 follow-up, Dr. Kube indicated he largely agreed with Morrow's assessment, though he wasn't convinced that the facet joints were a big factor, noting the back pain seemed to be associated with the L4/5 disc. He also noted an annular tear with disc collapse at L4/5 (Dr. Kube testified that the L5/S1 disc indicated in his report was a typo). He recommended a repeat MRI and EMG/NCV testing followed by discogram to try to verify the source of the symptoms. Petitioner was continued on light duty. Dr. Kube's office noted on 5/17/16 that the Respondent indicated no further treatment would be covered based on the opinion of Dr. Rutz. (Px8).

Dr. Prasad issued a "To whom it may concern" narrative on 5/23/16. He states that Petitioner reported intense pain following an 11/8/13 injury while at work for Respondent. He noted she was being treated for disc bulging, annular tear,

lumbar radiculopathy and spinal stenosis, opining that these injuries could have been caused or aggravated by her work injury. While the Petitioner was undergoing surgical evaluation, she was being seen every three months for epidurals and medication to reduce pain. He concurred with the work restrictions imposed by Dr. Kube. (Px6).

Petitioner underwent EMG/NCV testing with Dr. Trudeau on 6/7/16. He noted the testing reflected evidence of chronic mild to moderate left L5 radiculopathy, with no evidence of any other radiculopathy, plexopathy or peripheral neuropathy. (Px8).

At 6/15/16 follow up with Dr. Kube, he noted the EMG/NCV findings, as well as that an updated MRI showed no significant interval change, other than the high intensity zone (annular tear) being less pronounced. Light duty was again continued. (Px6).

Petitioner returned to Dr. Prasad for an injection on 7/6/16. She reported 7 out of 10 pain into both legs, left greater than right with numbness and tingling, and that her pain increased with activity and improved with rest. Dr. Prasad noted the EMG/NCV reflected chronic left L5/S1 radiculopathy, and that Petitioner was awaiting discogram and surgery with Dr. Kube. Epidural was performed at left L4/5 and right L5/S1. (Px6).

Discogram was performed by Dr. Kube on 7/18/16 at L3/4 and L4/5, with negative findings at L3/4 and concordant pain at L4/5. The Arbitrator notes that in a follow up call to Petitioner the next day, she complained that greater care should be taken with a patient with PTSD and anxiety issues. On 7/20/16, Dr. Kube noted the positive discogram at L4/5 and indicated Petitioner was a candidate for L4/5 surgery, recommending a fusion versus a disc replacement given the Petitioner's body mass and the location of her great vessels at L4/5. No specific work note was issued on this date. (Px8).

On 10/6/16 Petitioner reported 6 weeks of improvement with the prior injection, and Dr. Prasad performed trigger point injections on 11/17/16. (Px6). On 9/28/16, the Petitioner returned to Dr. Kube with the same pain score report as previous, but noted that she had been assaulted "not long ago" by an intoxicated person, and that this "increased her pain a bit for a while." Dr. Kube did not believe that the assault had any role of significance in the need for any additional treatment, as her symptoms and exam were essentially the same. Light duty was continued. On 11/30/16, Dr. Kube noted ongoing substantial pain and continued to recommend fusion surgery. (Rx6).

Dr. Rutz issued an addendum report on 4/6/17 after reviewing the 6/2/16 MRI, noting it showed mild L4/5 disc desiccation with a central annular tear, and that his diagnosis was low back pain most likely secondary to discogenic L4/5 back pain. The films did not change his causation opinion, as Dr. Rutz noted the current MRI showed the same pathology as the reports from her prior MRIs. As he had not seen Petitioner in over a year, he had no opinion on her ability to work, but that any such limitations would be based on her subjective symptoms. He opined that any need for surgery would be considered only after a discogram from L3 to S1 and positive findings at L4/5. (Rx4).

Petitioner testified that Dr. Prasad had advised her to perform home therapy and continued her light duty restrictions, again indicating the Respondent would not allow her to return unless at full duty. At some point, Petitioner testified she didn't recognize anyone else working at the Glen Carbon facility and was told she had to communicate directly with corporate. Petitioner testified that she believed she remains an employee of the Respondent. While she wasn't sure when she last saw Dr. Kube prior to hearing, she testified that he still has her on light duty pending surgical authorization.

The deposition of Dr. Kube was obtained by the parties on 4/27/17. Dr. Kube testified that the Petitioner has some disc collapse at L4/5 with desiccation as well as an annular tear, which can be painful. He had both MRI films to review, and

testified that the high intensity zone was brighter on the initial post-accident MRI than the one in 2016, which could indicate a more acute problem at the time of the 2013 films. He testified that the L4/5 disc was consistent with the Petitioner's subjective complaints and his exam findings, and is the most likely source of her pain. He acknowledged that there was not a specific major neurocompressive lesion, "but a lot of times there can be a chemical irritation associated with the annular tear." He obtained EMG/NCV testing as well as the discogram to identify the pain generator. (Px10).

With regard to the Petitioner's 9/28/16 report about being assaulted, Dr. Kube testified that the incident did not seem to impact her symptoms, and there was nothing markedly changed on exam. Therefore, there was no reason to change the surgical plan and he did not consider the assault to be an intervening injury. He testified that at that visit as well as her November visit, the Petitioner remained a surgical candidate. He testified that they are waiting for surgical authorization, and the Petitioner has remained on light duty through her last visit of 2/8/17 pending same. (Px10).

Dr. Kube diagnosed an aggravation of degenerative disc disease at L4/5 with possibly a new onset annular tear at the time of the injury that's causing back pain, as well as L5 radiculopathy. Dr. Kube opined that, based on the Petitioner's stated history, the diagnoses were caused or aggravated by the November 2013 work accident. He noted she had no ongoing treatment or symptoms for a considerable period of time prior to the accident, the mechanism of injury was a competent cause of a low back injury, and she had a contemporaneous onset of pain as well as a mechanical experience at the time of the pop in her back. Based on this, he opined it is much more likely than not that the accident caused some new problems for her. Dr. Kube noted statistics which indicate 85 to 90% of people have back pain in their lifetimes, yet only 5% have surgery. In terms of causation where a prior back problem is involved, Dr. Kube testified he would look at how significant the previously work-up had been, as well as whether there were recent symptoms and treatment leading up to the current injury. To his knowledge, any prior problems the Petitioner had resolved with some conservative measures, and she had been working full time prior to the work accident. There was no indication she would have needed any further back treatment but for the accident. He believes that the work accident caused the need for the recommended surgery. (Px10).

On cross examination, Dr. Kube testified that he did not see anything significant in the Petitioner's lumbar MRI films other than the annular tear and loss of disc height at L4/5, which he identified as the most likely pain generator, noting the discogram and EMG/NCV testing was performed to try to pinpoint such level. Petitioner has more of a radiculitis, meaning inflammation of the nerve, then a true radiculopathy with an impinging herniated disc. He did not see evidence of any actual disc extrusion, but the annular tear was visible in both MRI films. Dr. Kube testified that the purpose of the fusion would be to stabilize the motion segment at L4/5 and to also remove the painful disc at that level. There's no way to absolutely know why the L4/5 disc is painful, but he opined to a reasonable degree of certainty that this disc is a pain generator for Petitioner, and there is inflammation in that area impacting the nerve. The Petitioner's exam demonstrated a left L5 dermatomal paresthesia, which can be consistent with the annular tear. He could not say for certain whether he reviewed any of the Petitioner's prior medical records other than the prior MRI. He agreed that his causation opinion was based on Petitioner's stated history of prior and post-accident pain, and if her history is inaccurate per the medical records, his opinion could change. Prior complaints of low back pain into the left leg could indicate that the annular tear was preexisting, but noted these symptoms could have been coming from any lumbar level. Dr. Kube conceded there is no way to say for sure how old the annular tear is. (Px10).

Dr. Kube agreed that any flexion type maneuver, including sneezing, could cause a lumbar disk to be painful, or could aggravate an already injured disc further. He did not dispute that the Petitioner reported on 11/20/13 that she had low back pain which brought her to tears after she sneezed. The Petitioner remains on light duty restrictions. The recommended L4/5 fusion is not emergent, its elective, so the Petitioner has a choice of living with her condition and continuing conservative measures for pain relief, or to have surgery. He testified, however, that doing the same

conservative treatment she had been doing would not be likely to provide substantive long-term benefit. Dr. Kube did not know how many times the Petitioner has suggested she injured her low back prior to 2013, and had no knowledge as to whether the Petitioner in 2011 was referred to pain management due to burning low back pain and leg numbness. Whether the annular tear may have healed to some degree since the last MRI, which would be rare, isn't as relevant to his surgical recommendation as the Petitioner's symptoms, as a surgeon operates based on symptoms, not simply diagnostic test findings. If Petitioner's symptoms somehow resolved, she may no longer be a surgical candidate. When she was last seen in February 2017, she was still complaining of 9/10 pain. (Px10).

On redirect, Dr. Kube testified that even if the sneezing event caused something, the Petitioner already had symptoms and sought treatment just days after the work accident, so "I would say there is the potential that both could have some bearing." He testified that the impact of the sneezing was unclear, while the impact of the work accident was clear. There did not appear to be any marked change in symptoms after the sneezing other than some increased back pain, but her pain scores were basically the same as prior to that sneezing incident. If it is accurate that the Petitioner had chiropractic treatment from January to May 2011 for back pain shooting into the legs, then returned to full duty work for the Respondent and was relatively asymptomatic until the 11/8/13 accident, he testified he would consider the prior condition to have been healed by then, as it was over two years later. If it involved the same disc, it could have left that disc more susceptible to future injury. Barring the new accident, she could have gone any number of years without a significant problem. On re-cross examination, Dr. Kube agreed he had no specific knowledge if the Petitioner had symptoms or not between May 2011 and November 2013, just that she didn't seek treatment. (Px10).

Section 12 examiner Dr. Rutz' testimony was obtained via deposition on 6/9/17. He testified that his practice is generally restricted to the spine. He testified consistently with his 1/28/16 report. A 10-page intake form is completed by the patient when they come in, which includes questions about prior back pain that the Petitioner left blank. The Petitioner did not report in the form or in her verbal history the treatment she received from Dr. Chenault in 2011. This includes her 1/13/11 indication to Chenault that she fell at work and had back pain into her legs, or her 5/31/11 indication of 5 out of 10 low back pain after unloading laundry. She didn't indicate Dr. Chenault had diagnosed her with lumbar joint, disc and facet problems. The records he reviewed of Dr. Chenault do not reference him seeing the Petitioner prior to the alleged accident date. While Dr. Chenault issued a 5/19/14 causation report, Dr. Rutz noted that nowhere in his records or in that report does he describe the actual mechanism of injury he is relating the condition to. Dr. Rutz testified that spondylosis/arthropathy and annular tears can cause pain without trauma. When canal and/or foraminal stenosis is mild, he testified it wouldn't be considered to be a cause of symptoms into the legs: ". . . if someone is having, you know, symptoms of their nerves being pinched but their stenosis is mild, there's probably something more going on than just mild stenosis causing it." The Petitioner's most significant MRI finding is the L4/5 annular tear, and, he testified: "Her symptoms, her complaints make sense with this." An annular tear can be asymptomatic or it can be severely symptomatic. Rutz opined that the rest of the MRI findings were mild and would not lead to the Petitioner's significant subjective complaints. (Rx3).

Dr. Rutz testified Petitioner's physical and neurologic examinations were normal, other than subjective pain complaints. He diagnosed low back pain and radiculopathy. As she didn't have impressive stenosis, Dr. Rutz presumes that the nerve aggravation causing radicular symptoms is due to the annular tear. He referenced the reasons he provided in his 1/28/16 report for opining that he could not say that the Petitioner's lumbar condition is related to the alleged work accident. Putting causation aside, he felt Petitioner should have an updated MRI. He testified that he then reviewed that new 6/2/16 MRI alongside the other two MRIs from 8/24/10 and 12/20/13, and opined that the 2010 MRI showed the annular tear, meaning it preexisted the alleged accident date, and that all three films, including the tear, looked exactly the same, indicating no interval change. He testified that this further reinforced his causation opinion. (Rx3).

Dr. Rutz indicated that trying to analyze causation is difficult in a case like this because there is no objective proof of a change, just a change in subjective symptoms. In doing so, he looks at the mechanism of injury, how different the current symptoms are from prior symptoms, and whether the patient returned to a baseline level or had a sustained change. Ultimately, he testified he isn't certain if the lumbar condition is or isn't causally related, but based on the information he has, he cannot say that it is. Outside of causation, if the Petitioner has the appropriate diagnostic findings on discogram, he agreed she would be a lumbar fusion candidate. (Rx3).

On cross examination, Dr. Rutz testified that the Petitioner did report to him a lumbar strain 10 years prior that had gotten better. He agreed that she has an L4/5 annular tear, and given she has exhausted conservative treatment, if she has a positive discogram and ongoing symptoms, fusion would be appropriate treatment at that level. He agreed that the mechanism of injury of pulling a tire off could cause a back injury, assuming the tire is big enough and involves enough force. He also agreed that the Petitioner did provide a history of the accident to both Dr. Prasad and Dr. Kube, and that she did give a history of doing tire rotations to Dr. Chenault – though he noted the latter just described a work duty, not a mechanism of injury. However, if he assumes that the Petitioner did give a history of the injury to Chenault, Dr. Rutz testified: "If I had a patient that had some problems with her back in the past, might have some good and bad days, but they're generally okay and able to do their work and activities of life, and then they're at work and do something that places an abnormal physiologic load on their spine and their same problem becomes worse and is sustained worse and they don't go back to their baseline, I'll say it's aggravation secondary to work." He testified that he didn't know that he would say that is the case in this matter, but agreed that it would be reasonable to say that the preexisting annular tear was at least aggravated by the accident if she reported it to the Respondent within a week or two of the incident, and that is she did, this could change his opinion. (Rx2).

Currently, the Petitioner reports low back pain, with numbness and tingling into both legs, left greater than right. The pains are sometimes sharp and shooting. The Petitioner testified that she moves slower with less range of motion due to pain, and has learned to do things in alternative ways. She uses a back brace prescribed by Dr. Kube, which relieves her pain and keeps her from moving in ways that cause pain. She also uses other braces, some of which go up to the shoulders. Some days are worse than others. She takes medications prescribed by Dr. Prasad. The Petitioner testified that she desires to undergo surgery.

The Petitioner testified she has incurred medical expenses totaling $10,279.65 (Px9) to date, from Drs. Chenault, Prasad and Kube. She hasn't worked at all since 11/8/13, and testified that she moved in with her father to avoid having to pay rent.

As to her prior low back problems, the Petitioner testified she had a prior workers compensation claim for the low back in 2009 or 2010, and treated with Dr. Chenault at that time. She agreed that when she reported a back injury 10 years prior to Dr. Rutz in 2016, she meant the work injury of 2009/2010. She also testified to having "small episodes" in 2011, including slipping and falling, and treatment with Dr. Chenault from 1/11 to 5/31/11. She testified the pain she had before 11/8/13 was different than her current pain. She agreed she had prior low back pain and numbness, but that the symptoms now start in a different area of the low back and includes tingling and being more "static-y", intense and constant.

On cross examination, the Petitioner agreed that she started working for the Respondent on 2/11/13, about 9 months before the accident. She worked on 11/8 and 11/9, but didn't recall if she was scheduled off on 11/10/13 or not.

Petitioner also agreed she previously injured her lumbar spine in November 2010 while working for Greenville Regional Hospital. She treated with Dr. Chenault at that time, including lumbar injections and MRI. She acknowledged the MRI

was performed on 8/24/10, which would be prior to a November 2010 accident, and testified that she didn't recall if she specifically told Dr. Chenault about the MRI. She agreed that she signed the current Application for Adjustment in December 2013, and subsequently settled this prior workers compensation claim in 2014. She agreed she had been seen by neurosurgeon Dr. Youkilis prior to the current claim, but believed this was at the request of the employer.

Subsequent to the currently claimed accident, the Petitioner agreed the only medical care she had between the accident date and her 10/14/15 injection with Dr. Prasad was her care with Dr. Chenault through 5/19/14. She was not referred to Dr. Kube until May 2016. She agreed she didn't tell Dr. Kube about her August 2010 MRI, but signed releases for him. Petitioner agreed that her last visit with Dr. Chenault after the prior accident was on 5/31/11, and that she complained of 5 out of 10 low back pain and left leg numbness at that time. She testified she wasn't sure if she had been expected to continue to follow up after that or not.

On further cross examination, Petitioner agreed that BJ was aware of the accident because he was present when it happened, and that she notified Liz Ross the next day. She wasn't certain what Ross' title was, but she may have been the assistant manager. She agreed that she signed the accident report contained in Rx8, and that this was dated 11/16/13 and referenced an 11/7/13 date of accident. She agreed that it's possible that the accident was on 11/7/13, not 11/8/13, which means the date she reported the injury to Ross may have been a Friday, not a Saturday. The document states she told Liz Ross that her back was hurting on 11/8/13. The Petitioner agreed she didn't seek any treatment on 11/7/13 or 11/8/13. Petitioner didn't recall what her schedule was at that time or if she was scheduled off work on 11/10/13. Other than going in to address her injury, Petitioner never returned to work after the alleged accident date. Petitioner did not recall what time it was when the accident occurred, and agreed that the accident report doesn't say anything about her reporting the injury to BJ. The Petitioner testified she was aware this claim is being disputed by the Respondent, and that while she is friends with JB on Facebook, but did not ask him to testify.

The Petitioner agreed that she was assaulted by an intoxicated person in September 2016, and testified that she did inform Dr. Kube about this. She testified that this assault did not change her symptoms, but it intensified the pain for a couple of weeks. She testified she was lying down at the time, a man she had a relationship with came in and sat on top of her legs, and squeezed them until they were bruised. It did intensify her back pain for a couple weeks and she walked differently due to bruising.

The Petitioner agreed she did not apply for employment anywhere between November 2013 and October 2015.

The Arbitrator notes that the Respondent submitted a Motion for Adverse Finding (Rx7) in this matter. The Motion sought an entry of an order by the Arbitrator finding that the records of Dr. Youkilis would not be favorable to the Petitioner's position in this case. This was based on Dr. Youkilis refusing to provide records based on an out-of-state subpoena, and the Petitioner's failure to execute a release to obtain same. The Arbitrator denied this Motion at hearing. In reviewing the Motion, the Arbitrator notes in support of this finding that the Respondent states that "upon information and belief', the Petitioner treated with Dr. Youkilis prior to the alleged 11/8/13 accident. The Arbitrator is hard-pressed to understand how an adverse finding could be based on "information and belief' that such records exist without proof. The Petitioner did testify on cross examination that she believed she did see Dr. Youkilis, but that it was at the request of her employer at that time. The Arbitrator notes that the Respondent was given the opportunity to obtain these records and to continue the hearing, as well as that other avenues were available to the Respondent to try to obtain such records, including by order of Circuit Court, and there is no indication that this was done.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the preponderance of the evidence supports the determination that the Petitioner sustained accidental injury arising out of and in the course of her employment with the Respondent.

The Petitioner testified that she injured her low back on 11/8/13 when she was rotating large tires on an SUV. She testified that while doing so on one knee, she felt a pop in her low back with low back pain. She testified that an assistant manager, JB, was assisting her at the time, and she made him aware that she was injured. There is no evidence which specifically rebuts this testimony. The Respondent's defense is mainly based on a failure to promptly report this accident, and the Respondent clearly has a point in defending this case based on the uncertainty of the accident date and this alleged delay. However, the Arbitrator finds that the evidence presented in support of this defense is lacking.

The Petitioner testified she obtained a pink injury report packet and was sent for a drug test. The only real rebuttal evidence presented was the testimony of Liz Ross, who indicated the Petitioner did not report an injury to her, and that she was the assistant manager on duty on 11/8/13. However, she did not believe she worked on 11/7/13, which the most contemporaneous evidence, the accident report (Rx8), indicates to be the correct accident date. It is entirely possible that BJ was the assistant manager on duty on the date of accident. Ms. Ross also acknowledged that the procedure for a work injury would be to obtain a colored packet, which she did believe was blue but wasn't certain, and then to be sent to the occupational clinic for a drug test. This is consistent with Petitioner's testimony.

The text messages with Mr. Vioc (Px3) and the accident report (Rx8) support that an accident was reported by the Petitioner in a timely fashion. There are clearly discrepancies related to the testimony of Liz Ross and Megan Giltner versus Petitioner. However, these discrepancies, in the Arbitrator's view, do not take away from the fact that the Petitioner reported an accident occurred while she was rotating tires, and that this resulted in an injury. There is too much evidence around the time of 11/7 to 11/20/13, from the text messages to the accident report, that reflects that an accident was reported by the Petitioner. The Respondent may be arguing that the Petitioner didn't actually sustain a work accident to her back and is not credible in arguing that she did, but there is no weighty rebuttal evidence which would support this. The Respondent's defense, particularly without the presence of BJ or Vioc at trial, seems weak. The Petitioner's testimony is sufficient to support a finding of accident, given the additional evidence noted of her reporting such injury.

While the records of Dr. Chenault are difficult to decipher given the minimal information indicated and the difficulty with reading his handwriting, his May 2013 narrative report does indicate that he had knowledge of a work accident. And, again, the Petitioner did complete an accident report for the Respondent early on in this treatment, so the idea that she never reported it to anyone until she saw Dr. Prasad seems unlikely. It would have been nice if the records of Chenault had been more legible, but the Arbitrator must address the evidence as presented.

Unfortunately, Mr. Vioc and BJ were not called to testify. While the Respondent questioned the Petitioner's failure to produce BJ for testimony, it would appear to the Arbitrator that both parties had the opportunity to attempt to call either or both of these people as witnesses but chose not to do so. There is nothing the Arbitrator sees that would infer that BJ's testimony would be positive or negative for the Petitioner. While the evidence presented made this determination

difficult as there was evidence on both sides of the issue, the Arbitrator believes the greater weight of the evidence indicates that an accident occurred which arose out of and in the course of the employment.

The other issue related to this is the accident date. Much of the testimony, as well as the medical records, appear to indicate an 11/8/13 date of accident. However, following the Respondent's questioning of the Petitioner about the Respondent's accident report (Rx8), and the submission of same into evidence, the most contemporaneous document indicates an accident date of 11/7/13. The Petitioner orally motioned to amend the date of accident, the Respondent did not object to this based on the presentation of proofs, and the Arbitrator granted the motion instanter. Based on this, the Arbitrator finds that the Petitioner sustained accidental injury to the lumbar spine arising out of and in the course of her employment on 11/7/13.

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

The Arbitrator finds that the Petitioner's lumbar condition is causally related to the 11/7/13 accident. The Respondent's defense is that the Petitioner has a long-standing history of low back pain.

The Arbitrator absolutely agrees that, based on the pre-accident records of Dr. Chenault, the Petitioner had prior low back problems which were basically the same as her post-accident complaints, and that she had an annular tear at L4/5. However, the Arbitrator also believes that the evidence shows that something about her condition changed as of the accident date in a way that appears to have permanently altered her symptoms.

Both Ms. Ross and Ms. Giltner testified that prior to 11/7/13, the Petitioner told them that she had a bad back, needed surgery and didn't have it because she couldn't afford it. The Arbitrator does not feel that this testimony ultimately was very strong, however. The Arbitrator believes that the Petitioner likely did indicate this to these witnesses. However, Ms. Giltner's testimony is that the Petitioner said this to her only one time, not regularly, and that she also had pains that were always changing in terms of the parts of the body. While Ms. Ross testified that the Petitioner wanted to wait to have her insurance kick in before seeking surgery, and that this took 90 days, that 90-day period had passed well before the accident date, so the Petitioner could have sought a surgery then. There is no evidence that she did. There also is no medical evidence in the record indicating that lumbar surgery had been previously recommended. The statement of Giltner that the Petitioner reported that if she didn't have surgery she would not be able to walk does not make sense given the actual condition and the testimony of Dr. Kube that this is elective surgery, not emergent. It gives the sense that even if the Petitioner said this, there is a lack of accuracy to such a statement. The medical evidence that pre-dated the accident and which involved the low back is dated over two years prior to the date of accident. It appears that the Petitioner had continued to work in a significantly physical job for at least 9 months prior to the accident date. Both Ms. Ross and Ms. Giltner testified to the physical nature of the job duties with Respondent.

The Arbitrator also notes with interest the testimony of Ms. Giltner, in that she made it quite clear that, from her perspective, the Respondent facility was not supportive of work accident claims. While this does not automatically mean this opinion is accurate, it certainly provides a perspective from a Respondent witness that matches the Petitioner's testimony regarding the lack of best practices in the handling of injury claims by Respondent management.

Ms. Ross testified that the Petitioner had been hunched over and walking with great difficulty when she picked up her check, but then within a week after that was seen walking normally into a bookstore. This seems to imply to the Arbitrator that she questioned the Petitioner's credibility in terms of her pain level. However, the Arbitrator notes, as indicated below, that there are multiple sources of medical evidence which clearly support the Petitioner had an

abnormal condition at L4/5 with EMG/NCV evidence of radiculopathy. Thus, the evidence supports that the Petitioner has an injury. This weakens the argument of the defense based on Ms. Ross' testimony.

In terms of the medical opinions, both treating surgeon Dr. Kube and examining surgeon Dr. Rutz agree on the Petitioner's diagnosis and the reasonableness of surgery. Both also testified that the mechanism of injury described by Petitioner is a competent cause of a low back injury. The only real difference of opinion is regarding causation. However, it is important to note that Dr. Rutz' opinion is solely based on there being no evidence of an accident on or about 11/7 or 11/8/13. Respondent did not provide Dr. Rutz with Linder's written statement of injury dated 11/16/13. The Arbitrator has determined that the greater weight of the evidence supports a compensable accident, and this leads to the conclusion that Dr. Rutz agrees with the causation opinion of Dr. Kube. His testimony indicated that if the Petitioner had two plus years without treatment or ongoing low back pain while continuing to work, then had an accident as she described with an onset of pain that hasn't since relented, this would support a determination that the Petitioner's preexisting L4/5 condition was aggravated by the accident.

With regard to the L4/5 annular tear, the evidence clearly supports its existence in 2010 per the MRI at that time, and thus that it preexisted the accident. However, again, the preponderance of the evidence indicates that something changed in the Petitioner's symptoms in a significant way, and thus the aggravation of this condition is more significant than a temporary type of aggravation.

The Arbitrator notes that, in submitting the 2010 lumbar MRI into evidence, Respondent's counsel indicated, in response to objection from the Petitioner's counsel, that over 400 pages of certified records were obtained from Greenville Hospital, and, in agreement with the Arbitrator, there was no desire to put the entirety of these records into evidence. The Arbitrator would then presume that the remainder of this large volume of records did not indicate anything about a low back condition prior to November 2013.

The Arbitrator notes that the determination of this issue was very difficult and that this is a close case. However, while the Arbitrator has some questions with regard to the Petitioner's veracity about everything in this case, there are also significant questions with regard to the veracity of the Respondent and the Respondent witnesses. The Arbitrator believes the preponderance of the evidence, on balance, favors the Petitioner.

The Arbitrator further notes his agreement that the Petitioner's surgery would address a problem at L4/5 that preexisted the accident. However, pursuant to *Sisbro, Inc. v. Industrial Comm'n*, 797 N.E.2d 665, 207 Ill.2d 193, 278 Ill.Dec. 70 (2003) and its progeny, the issue is whether the accident involved in this case is a causal factor in the current lumbar condition and need for surgery, and the Arbitrator believes the preponderance of the evidence supports the accident as being at least a factor. As such, the Arbitrator finds that the Petitioner's lumbar condition is causally related to the 11/7/13 accident.

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

The Arbitrator finds that the Petitioner's treatment with Dr. Chenault, Dr. Prasad and Dr. Kube has been reasonable and causally related to the 11/7/13 accident. As a result, the Arbitrator finds that the Petitioner is entitled to the medical expenses contained in Px9, and that the Respondent is liable for same. This award is made pursuant to Sections 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:

The Arbitrator finds that the L4/5 fusion surgery contemplated by Dr. Kube is reasonably required to cure or relieve Petitioner from the effects of the accidental injury of 11/7/13. The Petitioner's subjective complaints correlate with the findings at L4/5. There is objective evidence on MRI and EMG/NCV that supports the L4/5 level as pathologic, and the discogram performed by Dr. Kube further supports this finding. Both Dr. Kube and Section 12 examining surgeon Dr. Rutz agree that this surgery is medically reasonable. As such, the Arbitrator finds that the Respondent shall authorize this surgery and any related required pre-surgical care. As post-surgical treatment is not yet known, a specific award cannot be issued for same at this time.

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:

According to Arbitrator's Exhibit 1, the Petitioner claims entitlement to TTD from 11/10/13 through the 7/20/17 date of hearing. The Arbitrator notes that both the Petitioner and Ms. Ross testified that the Respondent does not have light duty available. No evidence was presented which indicates that the Petitioner was ever terminated from her position with the Respondent. Dr. Kube testified that he has continued the Petitioner on light duty status. The Arbitrator finds that the Petitioner is entitled to TTD from 11/10/13 through the 7/20/17 hearing date.