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

Brandon Timpe,

Petitioner,

vs. NO: 18 WC 003019

19IWCC0213

Crown Linen,

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 causal connection, medical expenses, prospective medical care, 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 Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Petitioner sustained an accident on January 16, 2018 when he hit his head on a steel support beam. The parties stipulated that this accident arose out of and in the course of Petitioner's employment. Subsequently, Petitioner underwent treatment for concussion and severe headaches.

On January 30, 2018 Petitioner was transported by Monroe County EMS to Barnes-Jewish Hospital for reports of delirium and confusion. Petitioner exhibited "bizarre" behavior prior to his arrival in the emergency department and during his evaluation. He was admitted involuntarily to the psychiatric unit.

A comprehensive inpatient psychiatric evaluation was conducted and Petitioner was diagnosed with "Unspecified schizophrenia spectrum and other psychotic disorder." Petitioner was discharged from the psychiatric unit on February 3, 2018.

A 19 (b) hearing was conducted on July 21, 2018. Petitioner was present at the hearing but did not testify. Petitioner's wife testified concerning Petitioner's present medical condition and her observations of Petitioner including a psychotic episode she witnessed in late January 2018. The Arbitrator commented in her Decision on Petitioner's failure to testify on his own behalf to rebut the findings of Respondent's Section 12 neuropsychologist Nancy Landre, PhD.

In the Arbitrator's opinion at page 26 she states as follows:

> Petitioner bears the burden of proving by a preponderance of evidence all the elements of his claim, including causation. Petitioner has not met his burden. *Petitioner did not testify to rebut Dr. Landre's findings of symptom magnification or malingering or provide testimony related to his current condition, even though he was present at the hearing. 'Where a party has the means in his power of rebutting and explaining evidence adduced against him the omission to do so furnishes a strong presumption or inference that he cannot do so'.* Shumak v.Shumak, (1975), 30 Ill. App.3d 188, 332 N.E. 2d 177. *As noted above, the medical records cause the Arbitrator to question Petitioner's credibility regarding the histories and complaints given to doctors. (Emphasis added).*

The Arbitrator erred in applying the principal set forth in the *Shumak* decision to the case at bar. The *Shumak* decision was a divorce case involving a party's failure to testify to rebut allegations of mental cruelty. The opinion states in significant part, that the party must possess positive and complete knowledge concerning the existence of facts he is called upon to negate.

Petitioner was diagnosed with a mental disorder which impacted his cognition. During the period of his involuntary commitment he was hallucinating and unable to respond appropriately to questions asked by his medical providers. There is a serious question concerning his ability to give competent testimony under oath at hearing, and we will not hold this against him.

The 19(b) hearing was held on July 21, 2018 only a period of seven months after Petitioner was diagnosed with mental illness i.e. schizophrenia and psychosis, that clearly explains Petitioner's failure/inability to give sworn testimony.

The Commission finds that the error in applying this presumption to this case does not affect the findings of the Arbitrator as there is sufficient evidence otherwise to support the

conclusions and award. The Commission hereby strikes the above referenced language from the Arbitrator's 19(b) Decision and otherwise affirms and adopts the Decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 16, 2018, is hereby modified as stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner total temporary disability benefits of $465.87/week, commencing January 17, 2018 through March 4, 2018, a period of 6 5/7 weeks, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $4,991.45 for total temporary disability benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner all reasonable and necessary medical expenses incurred through March 4, 2018, pursuant to the medical fee schedule as provided in Section 8(a) and 8.2 of the Act. Respondent shall be given a credit for any medical benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that prospective medical treatment is denied as Petitioner's current conditions of ill-being are not causally connected to his work accident.

IT IS FURTHER ORDERED BY THE COMMISSION that penalties and fees pursuant to Section 16, Section 19(k), and Section 19(l) are denied

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

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

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

19IWCC0213

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: MAY 1 - 2019
MP/msb
o-4/4/2019
68

Marc Parker

Deborah Simpson

Barbara Flores

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

TIMPE, BRANDON M
Employee/Petitioner

Case# **18WC003019**

19IWCC0213

CROWN LINEN SERVICES INC
Employer/Respondent

On 9/20/2018, 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 2.29% 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:

4077 CROWDER & SCOGGINS LTD
CLAY B ST CLAIR
121 W LEGION AVE
COLUMBIA, IL 62236

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

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)

Brandon M.Timpe
Employee Petitioner

v.

Crown Linen Service, Inc.
Employer Respondent

Case # **18 WC 03019**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **July 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. ☒ Is Petitioner entitled to any prospective medical care?

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other ______

FINDINGS

On the date of accident, **1/16/2018**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**23,608.25**; the average weekly wage was $**698.81**.

On the date of accident, Petitioner was **36** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**4,991.45** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**$4,991.45**.

Respondent is entitled to a credit of $**0** for any medical bills paid by a group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Prospective medical treatment is denied as Petitioner's current conditions of ill-being are not causally related to his work accident.

Respondent shall pay Petitioner temporary total disability benefits of **$465.87/week**, commencing **January 17, 2018 through March 4, 2018**, a period of **6 5/7 weeks**, as provided in Section 8(b) of the Act. Respondent shall be given a **credit of $4,991.45** for TTD paid.

Penalties and fees pursuant to Section 16, Section 19(k) and Section 19(l) are denied.

Respondent shall pay reasonable and necessary medical services incurred through March 4, 2018, pursuant to the fee schedule as provided in Section 8(a) and 8.2 of the Act. Respondent shall be given a credit for any medical 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.

Nancy Lindsay
Signature of Arbitrator

September 16, 2018
Date

SEP 2 0 2018

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

The parties stipulated that on January 16. 2018 an employee-employer relationship existed between Petitioner and Respondent. The parties also stipulated that on that day Petitioner sustained an accident arising out of and in the course of his employment.

Medical records regarding treatment Petitioner had undergone pre-accident were admitted into evidence.

On July 7. 2002 Paramedics were called to Petitioner's home where Petitioner was found lying on the ground after consuming an unknown amount of alcohol. Petitioner smelled strongly of alcohol and was only responsive to painful stimuli. He was given Narcan with no response and taken to the hospital. (Ex. G to PX A: RX 1)

On September 4. 2008. Petitioner presented to Red Bud Hospital after shooting himself in the foot while cleaning a gun. His complaints were limited to pain. A history of depression was noted for which Petitioner was treating with Lexapro. An MRI of the brain was recommended, but it appears that it was never performed. (RX10; Ex. G to PX A)

Petitioner was seen at Red Bud Hospital on December 30. 2010 for symptoms which would be diagnosed as the flu. Petitioner's medications included Xanax. (RX 1))

On May 17, 2011 Petitioner was seen at Gateway Regional Medical Center regarding his right shoulder. (RX 5)

On November 18, 2011, Monroe County EMS responded to a call that Petitioner was having a seizure. Petitioner was noted to be experiencing a grandmal seizure and transported to Red Bud Hospital. (RX 6) At Red Bud Hospital Petitioner reported going out to the BBQ grill and that was all he remembered. Friends told him he had a seizure lasting five minutes. He was alert upon EMS arrival. He was seen at the Hospital and discharged with a diagnosis of recurrent seizures. A CT of the head was essentially normal. If symptoms recurred or persisted, an MRI was recommended. Per the Consultation Note of the same date it was felt Petitioner's seizure was, most likely, a combination of Tramadol and Tricyclic. He was told to stop using the Tramadol. (RX 10)

Petitioner was seen at Gateway Regional Medical Center on December 19. 2011 for right shoulder symptoms. A history of right shoulder surgery being performed in August of 2011 was noted. (RX 5)

On May 24, 2012 Petitioner underwent a right front scalp lesion and superior midline back lesion removal. The doctor's noted that Petitioner's medications included Xanax and a daily antidepressant. (RX 10)

On August 8, 2012, Petitioner sought treatment with psychiatrist Dr. Chalfant at PSSI. Petitioner was diagnosed with major depressive disorder and continued on medications including Alprozolam and Despiramine Hyrocholoride. This does not appear to be the first time Petitioner was seen by Dr. Chalfant. (RX 7)

On October 8, 2012, Petitioner was seen by Dr. Chalfant and was noted to be on edge because of his wife's back surgery. Petitioner was diagnosed with major depressive disorder and instructed to continue with his medications. (RX 7)

In November of 2012, Petitioner sustained an injury at work to his shoulder and ankle. Petitioner was treated at Gateway Regional Medical Center. (RX 5)

On December 14, 2012, Petitioner returned to Dr. Chalfant with complaints of severe depression after injuring himself at work. Petitioner diagnosis as of December 14, 2012 was updated to include panic disorder without agoraphobia and his Desipramine (a/k/a Norprimin) was increased. (RX 7)

On December 19, 2012 Petitioner presented to Gateway Regional Medical Center after climbing down off an engine and experiencing shooting pain to his right shoulder. His past medical history included anxiety and depression. He was diagnosed with a shoulder sprain. His medications included Xanax, Ibuprofen (800 mg.) and Norprimin. (RX 5)

On January 15, 2013, Petitioner was seen by Dr. Chalfant and reported worsening mood and thoughts of wanting to die, as well as difficulty sleeping. Petitioner reported having thoughts of driving his car off of the road. In reviewing Petitioner's past psychiatric history, Dr. Chalfant noted Petitioner had one prior psychiatric hospitalization and two suicide attempts. Based on Petitioner's reports, Dr. Chalfant modified Petitioner's medications to include Doxepin and Vistaril. (RX 7)

On February 4, 2013, Petitioner was seen by Dr. Chalfant and reported improvement in his mood and that he was no longer having suicidal thoughts but was experiencing ongoing problems sleeping. Petitioner reported he was only getting one hour of sleep. Based on Petitioner's ongoing complaints of difficulty sleeping, his Vistaril was discontinued and he was prescribed Ambien. (RX 7)

On February 25, 2013, Petitioner was seen by Dr. Chalfant and noted to be doing well with Ambien. Petitioner was noted to be sleeping better and having clearer thoughts. (RX 7)

On March 7, 2013, Petitioner was seen at Red Bud Hospital for an MRI of the head. Upon discharge he was advised to stop driving until he followed up with Dr. Mahtani. Then, subsequently, on March 13, 2013 he was seen for an MRI of the brain. Petitioner's diagnosis at the time of his admission included syncope and collapse. Petitioner's MRI of the brain showed a sub-centimeter focus of flair hyper-intensity in the right

periventricular white matter. It was noted age, vasculitis, non-acute demyelination or drug-related pathologies such as cocaine use could cause a similar appearance. He also underwent imaging studies to his eye due to a history of metal in it. (RX10)

On April 26, 2013, Petitioner was seen by Dr. Chalfant. Petitioner reported he was better in regard to his depression, anxiety, and sleeping, but noted problems doing things he could not remember. Petitioner was instructed to discontinue the Ambien. (RX 7)

On June 28, 2013, Petitioner was seen by Dr. Chalfant and reported difficulty related to the anniversary of the death of his grandfather. Petitioner reported he was more irritable and had gotten into a fight. Petitioner reported he had a long history of fighting and had only lost a couple of times. Petitioner was prescribed a mood stabilizer, Risperidone, and advised to continue with his other medications. (RX 7)

On August 7, 2013, Petitioner was seen by Dr. Chalfant and was noted to be doing better with Risperidone. He denied getting as angry and felt that things were going well. He had had a good vacation and was not having any problems. He did fell it was easier for him to not get upset. Thinks had been going okay at home and at work so far. Petitioner was instructed to continue with his medications. (RX 7)

Petitioner was seen at Red Bud Regional Hospital ER on May 15, 2013 for a possible allergic reaction. Petitioner reported using a new brake cleaner today and he went home and laid down because he wasn't feeling well. Petitioner stated there was no air in the garage where he was working. He woke up later in the evening and noticed a rash. His past history included anxiety, depression, and a seizure. His medications included Xanax and Desipramine. (RX 10)

On September 18, 2013 Petitioner underwent a left elbow MRI due to a history of lateral epicondylitis and elbow pain. He also underwent imaging for a possible foreign body in his right eye. Both were ordered by Dr. Ryan Pitts. (RX 10)

On November 20, 2013, Petitioner was seen by Dr. Chalfant and reported he was a little anxious because his wife was in the hospital. Petitioner also reported that he was off work because he had torn a muscle and was scheduled for surgery on December 9, 2013. He denied any increased anxiety. Petitioner was instructed to continue with his medications. (RX 7)

Petitioner was seen at Red Bud Regional Hospital's emergency room on January 5, 2014 for gastrointestinal/abdominal pain issues. He was given Norco, among other medications and discharged. (RX 10)

On February 18, 2014, Petitioner was seen by Dr. Chalfant and reported things had been going "alright." He had been diagnosed with ulcerative colitis and had lost a significant amount of weight. As a result, he had to change his diet. He wasn't reporting any problems with his mediation but was a little stressed about the diagnosis. (RX 7)

On April 18, 2014 Petitioner again presented to Dr. Chalfant noting that he was doing "all right" even with surgeries. He had undergone surgery on his left elbow with a tendon being taken from his lower leg and he'd had some problems with swelling. He did feel that his medications were helping. Things had been going well as far as his mood although he'd been a little stressful over the past couple of months. (RX 7)

Petitioner underwent right clavicle x-rays on June 11, 2014 at Red Bud Regional Hospital after having been kicked on June 6th. (RX 10)

On July 11, 2014 Petitioner presented to Gateway Regional Medical Center after being at work and "ending up in a dark cloud of smoke/waste and he breathed it in twice. He has been feeling dizzy and nausea since then and it happened about an hour ago. He vomited twice." Petitioner also complained of headaches. He was assessed with carbon monoxide exposure. (Ex. G to PX A; RX 5)

Petitioner returned to see Dr. Chalfant on July 21, 2014 reporting that he had been doing poorly as his friend had been murdered in the past week. He hadn't been able to eat and had stopped taking his medication three weeks earlier. He had lost forty pounds due to his colitis. He was advised to continue with his medications. (RX 7)

On August 19, 2014, Petitioner returned to see Dr. Chalfant and reported that he was doing better since he had gone back on his medications. Petitioner was back at work and doing okay there. He was instructed to continue with his medications. (RX 7)

On September 7, 2014, Petitioner was transported by Monroe County EMS to St. Anthony's Hospital after being involved in a motorcycle accident. It was noted Petitioner was not a wearing a helmet at the time of his accident and smelled of alcohol. Petitioner admitted drinking six beers prior to his accident. His blood alcohol level equaled 245. Petitioner was noted to have a laceration to his forehead and reported headaches. A CT scan of the head and cervical spine were normal. Petitioner was diagnosed with a head injury, forehead laceration and abrasion to the left knee. (RX 6; RX 9, RX 1 and Ex. G to PX A)

On October 10, 2014, Petitioner was seen by Dr. Chalfant and reported he was doing well but still grieving. He was not reporting any depression and felt he was doing well at work and was now getting used to a new shift. Petitioner was instructed to continue with his medications. (RX 7)

On December 10, 2014, Petitioner was seen by Dr. Chalfant and reported he was very stressed lately with worsening anxiety over the past month. Petitioner reported biting his nails and looking for a new job. Petitioner was instructed to increase his Xanax and continue his other medications. (RX 7)

On January 5, 2015, Petitioner was transported by Monroe County EMS to Red Bud Hospital ER for reports of convulsion seizure after coming home from a bar and taking a Xanax. Petitioner characterized the event as follows: "I went into the bedroom and my chest throat became tight. I fall to the floor and start shaking and

my tongue is out of my mouth. I couldn't breathe. I had a seizure." (Ex. G to PX A) Petitioner was diagnosed with an allergic reaction. His past medical history included anxiety and depression. His home medications included Risperdal and Xanax. He was allergic to Ultram which caused seizures and Haldol "damn near killed [him.]" (RX 6; RX 10)

On January 5, 2015, Petitioner was also seen by Chalfant and reported thing were going poorly. Petitioner reported he ended up in the hospital the night before after having an allergic reaction and that he had lost his job. Petitioner reported he was struggling and trying to find a job. Petitioner was instructed to continue with his medications. (RX 7)

On March 30, 2015, Petitioner was seen by Dr. Chalfant and reported he was under a lot of stress and anxiety. Petitioner had a suspended driver's license due to speeding tickets and he was having a difficult time finding a job he liked. Petitioner was instructed to continue with his medications. (RX 7)

On June 11, 2015, Petitioner was seen by Dr. Chalfant and reported his license had been suspended as he had six speeding tickets and he was still looking for a job. Petitioner was instructed to continue with his medications. (RX 7)

On July 16, 2015, Petitioner was transported by Monroe County EMS to St. Anthony's Medical Center and treated for an allergic reaction after eating pizza. (RX 6; RX 9)

On September 9, 2015, Petitioner was seen by Dr. Chalfant. Petitioner reported he was taking his Xanax but was out of his other medications. Petitioner reported getting angry and having episodes of rage. Petitioner reported he made a post on Facebook to a family member of his wife and started getting death threats. Petitioner also reported thoughts of hurting others, but said he did not have any intention of acting on his thoughts because he would not see his wife anymore. Petitioner's wife was advised to get any guns out of the house. Petitioner's medications were refilled. (RX 7)

On September 19, 2015, Petitioner was transported by Monroe County EMS to St. Anthony's Medical Center after responding to a report that Petitioner had shot a shotgun into the ceiling of his house and was suicidal. Petitioner reported fighting with his wife after ruining his step-daughter's wedding. Petitioner admitted to drinking alcohol that night with his wife and it was the first time he had been drinking in three months. He had lost his driver's license after getting a DUI. Petitioner was noted to be intoxicated. Petitioner also reported having been sexually molested by his father at age 5. Petitioner was admitted to Hyland Behavioral Health Center and discharged on September 22, 2015. (RX 6; RX 9)

On October 13, 2015, Petitioner was seen by Dr. Chalfant. His wife was with him. Petitioner reported he had not been doing bad since his hospitalization. Petitioner was instructed to continue with his medications. (RX 7)

On October 29, 2015, Petitioner was seen by Dr. Chalfant and reported he was upset because he got a summons related to charges he was facing for reckless discharge of a firearm. Petitioner reported feeling like his life was out of control, and he was having blackouts, manic symptoms, and suicidal thoughts. He also reported homicidal thoughts against the person charging him with reckless discharge of a firearm. Petitioner was advised not to have any guns. Petitioner was instructed to continue with his medications and advised to see a counselor as he appeared to be a danger to himself and others. (RX 7)

On November 18, 2015, Petitioner was seen by Dr. Chalfant and reported he was no longer having suicidal or homicidal thoughts. He had been in the hospital and was taken off the Xanax. He had since started it again but only 1 mg., and as needed. Petitioner was instructed to continue with his medications and his Risperidone was changed to Geodon. It was again noted that, in the future, he needed a counselor. (RX 7)

On December 9, 2015, Petitioner was seen by Dr. Chalfant and reported Geodon was not helping and that he was having anxiety about his court date. Petitioner also reported he had thrown a baseball through his television as he was angry about his court dates. Petitioner was instructed to discontinue the Geodon. (RX 7)

On January 8, 2016, Petitioner was seen by Dr. Chalfant and reported he was doing alright. Petitioner was instructed to continue with his medications. He was taking his Xanax when filling out job applications as the process made him anxious. (RX 7)

On February 2, 2016, Petitioner was seen by Dr. Chalfant and reported he was doing well and he was starting a new job. Petitioner was instructed to continue with his medications. Petitioner's wife concurred that things were going well and that there had been an improvement with his use of Latuda. (RX 7)

On April 12, 2016, Petitioner was seen by Dr. Chalfant and reported he had to go to a task group to get the charges cleared. He was continuing to look for a job. Petitioner was given a new prescription for Trazodone. (RX 7)

On June 16, 2016, Petitioner was seen by Dr. Chalfant and reported he was now on two years of probation. He was still looking for a job, and things were reportedly fine except for sleep. Petitioner was instructed to continue with his medications. (RX 7)

Petitioner was seen at Red Bud Regional Hospital's emergency room on September 23, 2016 for an abscess. He had been there earlier but was now experiencing more redness. His mediations included Trazadone, Desipramine, Busprinone, Norco, Bactrim, and Latuda. His past medical history included shoulder surgeries and anxiety and depression. He was treated with an IV and later discharged. (RX 10)

Petitioner underwent a right shoulder x-ray on October 17, 2016 due to right shoulder pain. He denied any injury. (RX 5)

On October 25, 2016 Petitioner underwent a right shoulder MRI after hyperextending his right shoulder while boating. (RX 5)

On December 6, 2016, Petitioner was seen by Dr. Hayat at Millstadt Medical Center to establish care. Petitioner reported he had been seeing a psychiatrist for his anxiety and depression but that he had stopped due to his insurance. Petitioner reported a past medical history including, gout, skin cancer, and two right shoulder surgeries. Petitioner reported no alcohol or drug use. Petitioner reported he worked as a mechanic, but was waiting for a job. (RX 11)

On January 5, 2017, Petitioner was seen by Dr. Hayat and they reviewed the results of his lab work. Petitioner also reported right shoulder pain for three months. (RX11)

On January 10, 2017, Petitioner underwent an ultrasound of his thyroid. (RX 5)

On February 6, 2017, Petitioner was seen by Dr. Hayat and they reviewed the results of his thyroid ultrasound. Petitioner was noted to be scheduled to see an orthopedist for his shoulder. (RX 11)

On February 17, 2017, Petitioner was seen at Red Bud Hospital for neck pain. He underwent x-rays of his thoracic spine after presenting with complaints of pain following a back injury as a result of jumping from a window. His home medications included Busprinone HCL for anxiety. Petitioner was diagnosed with cervical radiculopathy and prescribed Norco, Robaxin and Medrol. (RX10; Ex G to PX A)

On February 21, 2017, Petitioner was seen by Dr. Hayat for complaints of cervical radiculopathy. Petitioner was referred for x-ray and physical therapy. X-rays of Petitioner's cervical spine were unremarkable. (RX 11)

On March 13, 2017, Petitioner was seen at Red Bud Hospital for an area of redness to his right arm. Petitioner also reported he had been involved in a motor vehicle accident. Petitioner reported neck pain and an abscess to his right arm was debrided and irrigated. (RX10)

On March 14, 2017, Petitioner was seen at Barnes-Jewish Hospital Petitioner reporting severe nausea and a headache after being involved in a motor vehicle accident the day before. Petitioner reported he was driving approximately 60 mph when he swerved to avoid hitting a deer and hitting a guard rail. He had been seen at Redbud Hospital the day before where he received an incision and drainage for a right arm abscess. He reported telling the Redbud personnel of his recent accident but did not receive any further work-up. Petitioner reported hitting his head on the steering wheel, but was unsure if he lost consciousness. He was amnesic to the event. Petitioner presented with profuse nausea and vomiting, complaining of head, cervical spine, thoracic, arm and ankle pain. A CT scan of Petitioner's abdomen, brain and cervical spine was negative. Petitioner was diagnosed with a concussion and sent to occupational therapy for a concussion evaluation. (RX 8; PX B to PX A)

On March 15, 2017 Petitioner underwent an occupational therapy evaluation during which he obtained 19 out of 30 on the Montreal Cognitive Assessment, suggesting an impairment of cognitive functioning. He also performed in the impaired range on the Trail Making Test, Part B. He reported blurred vision during that evaluation. Recommendations included referrals for cognitive and driving evaluations. (Ex. G to PX A)

On May 10, 2017, Petitioner was seen at Gateway Regional Medical Center for reports that he could not think straight. Petitioner reported it had taken him 20 minutes to get dressed. Petitioner also reported nausea and diarrhea. Petitioner reported that he had suffered a head injury at work the day before when he struck his head on a steel beam at work. Petitioner denied a loss of consciousness. Petitioner reported two prior concussions, one in 2014 and another in 2017. Petitioner was diagnosed with a concussion and referred to St. Anthony's Medical Center for further evaluation. (RX 5)

When he arrived at St. Anthony's Medical Center, Petitioner reported a head injury the day before when he was bent over repairing an air conditioner and when he stood up quickly he hit his head on a tree branch. Petitioner reported it had taken him 20 minutes to get dressed and that he was experiencing nausea and could not think clearly. Petitioner was diagnosed with a head injury. (RX 9)

On May 11, 2017, Petitioner was seen by Dr. Hayat for follow up after his ER visit on May 10, 2017. Dr. Hayat noted she did not yet have the records from the ER, but Petitioner reported that an accident occurred at home and was not work-related. Petitioner complained of headaches and was diagnosed with a concussion and polyneuropathy. Petitioner was prescribed Topomax and Gabapentin. (RX 11)

On October 3, 2017, Petitioner was seen by Dr. Hayat with complaints of ongoing headaches. Petitioner reported dizziness and photophobia, along with nausea. He stated the headache had been ongoing for three days. Petitioner described his headache at the worse of his life and much more severe than his usual ones as they usually didn't last that long. Petitioner was instructed to continue with Topomax and was prescribed Topiramate and Ketrolac. A CT scan of his head was taken and noted to be negative for signs of acute intercranial process. According to the history found in the CT report, Petitioner was complaining of right frontoparietal headaches of three days' duration along with nausea, vomiting, dizziness, and light sensitivity. There was no known injury. (RX 5; RX 11)

On October 5, 2017, Petitioner was seen at St. Anthony's Medical Center's ER with ongoing complaints of headaches. Petitioner reported his headaches were associated with nausea and vomiting, photophobia, left upper extremity numbness and tingling, and generalized weakness. Petitioner reported no improvement in his symptoms without fluids and a migraine cocktail. Decadron was then given and Petitioner reported some improvement in his nausea, but not his headache. A drug screen was positive. After being administered Fioricet, Petitioner reported his symptoms had nearly resolved. (RX 9)

On October 10, 2017, Petitioner was seen by Dr. Hayat for follow up of his headache post ER visit. Upon reviewing Petitioner's records from St. Anthony's Medical Center, Dr. Hayat noted a urine sample taken from Petitioner revealed benzodiazepines, cocaine, and oxycodone. Petitioner demanded Fioricet from Dr. Hayat, but she refused based on the results of Petitioner's drug test. Petitioner was diagnosed with polysubstance abuse and chronic headache disorder and was referred to Dr. Lardizabal. Dr. Hayat noted Petitioner was not to have any controlled medications and placed him on a sixty-day medical leave. Petitioner never returned to see Dr. Hayat. (RX11)

On October 16, 2017, Petitioner was seen by Dr. Lardizabal for headaches. In the Division of General Neurology Patient Questionnaire, Petitioner described the reason for his visit as "severe migraines." Dr. Hayat had referred him. Petitioner reported headaches since 2016 at a frequency of 3 to 4 per week with 1 to 2 being severe, but worsening symptoms since March of 2017. He also reported a traumatic brain injury (TBI) in 2014 while driving a motorcycle. He lost consciousness and recalled having a few concussions. He recalled three episodes where he nearly passed. They were located bilaterally, front, and peri-orbital. Petitioner also reported blurred vision, and problems with right hand weakness and tingling sensations. Petitioner described the headaches as more intense since May of 2017. He had been on medical leave since October 5, 2017 due to the headaches. Petitioner was counseled on diet, lifestyle changes, sleep hygiene and medication overuse headaches. He was placed on medications of Amitriptyline and Baclofen and alaternative medications of Depakote, Lamotrigine, Zonisamide, Inderal and Botox were noted. Petitioner was advised he could return to work on November 1, 2017 and was asked to follow up in six weeks. (RX 8; Ex B to PX A))

On December 28, 2017, Petitioner was seen at Red Bud Hospital for calf pain. Petitioner reported that the leg pain had begun that afternoon but was bearable; however, that night it woke him up while sleeping. He complained of leg pain rated 10/10 which interfered with sleep and his ability to walk. Petitioner was given a dose of Lovenox and discharged to return the next day for a Doppler. After the ultrasound he was to follow up with Dr. Hidalgo. The ultrasound was performed and was negative. (RX10)

Petitioner's accident which is the subject of this claim occurred on January 16, 2018.

An accident report completed by Petitioner on January 16, 2018 was submitted into evidence. In the report Petitioner wrote "I was walking in blinding steam from the boiler brining in an air hose and blow gun to Ellis #2. I ducked to go under a beam and came up to soon and hit my head." Petitioner also confirmed in the report that there were no witnesses to his accident and that he did not lose consciousness. (RX 3) Photographs of the accident scene depict the beam Petitioner struck his head on. (RX 4)

Immediately following his accident Petitioner presented to Gateway Regional Medical Center. Petitioner reported striking his head on a beam at work while walking through steam. Petitioner reported striking the frontal

region of his head, but denied loss of consciousness. His supervisor instructed him to drive to Urgent Care. His gait was unsteady. When asked for his date of birth, he provided his address. Petitioner complained of pain in the top of his head and forehead. It was described as an aching, throbbing pain which began suddenly. His speech was slurred and his gait unsteady. He denied any similar symptoms in the past. After being examined and displaying symptoms of confusion. Petitioner was transported via ambulance to Barnes-Jewish Hospital for further evaluation. (RX 5; PX B)

The City of Columbia Ambulance Service was dispatched to Gateway Urgent Care. Petitioner was found sitting in an exam room. The doctor advised that Petitioner had been brought in after striking his head on a steel beam at work and he reported a brief loss of consciousness but no bleeding. Staff had reported that Petitioner had an altered mental status upon arrival and was unable to give them basic information upon arrival. He was assessed with no neck pain noted but a visible hematoma on his forehead where he struck the beam could be seen. Petitioner gave a history of approximately sixteen concussions, a traumatic head injury in 2014 from a motorcycle accident, and anxiety. His current medications included Xanax. Petitioner was placed in the ambulance and transferred to Barnes-Jewish Hospital for further work-up and care. (RX 13; PX C; RX 5)

Upon arriving at Barnes-Jewish Hospital Petitioner reported confusion, nausea and dizziness after striking his head at work, but again denied losing consciousness. Petitioner also reported some cervical spine tenderness, along with a history of 18 prior concussions. It was also noted that Petitioner was seeking ongoing treatment with a neurologist for his concussions. After CT scans of the head and cervical spine came back negative, Petitioner was diagnosed with a concussion and instructed to follow up with his neurologist, Dr. Lardizabal, as scheduled on January 23, 2018. Petitioner was not prescribed any medications. (RX 8; PX D)

Petitioner returned to see Dr. Lardizabal on January 23, 2018. Dr. Lardizabal noted that since his earlier visit in October of 2017 Petitioner had reported no change in the frequency or severity of his headaches but light sensitivity was markedly improved. Petitioner denied any side effects from the Amitriptyline and Baclofen. Dr. Lardizabal noted that Petitioner's alcohol use included 15 drinks per week (vodka with tonic water). Petitioner further reported that on January 16th he had accidentally hit a metal beam on his forehead due to poor visibility. He lost consciousness for less than 15 minutes and was confused and taken to BJH ED. Petitioner reported that since the accident his headaches had worsened and his light sensitivity had returned. Petitioner was diagnosed with a concussion with loss of consciousness and chronic intractable migraines. His Amitriptyline was increased. If he continued to have severe migraines the doctor was going to increase the Amitriptyline. If he had no response to it, he would try a different medication. He was also given a handout about Botox treatment as it was another option. Petitioner remained off work until February 7, 2018 as he had told the doctor he didn't believe he could work with his current condition. (RX 8; Ex D to PX A)

On January 23, 2018 Dr. Lardizabal issued a note stating that Petitioner had suffered a recent concussion and was having more severe migraines. He was engaged in medication adjustments to help manage the headaches. Petitioner had been advised to undergo two weeks of rest as part of his recovery and he could return to work on February 7, 2018. (Ex. C to PX A)

On January 24, 2018 Petitioner signed his Application for Adjustment of Claim herein alleging head, neck and "body as a whole" injuries after an accident on January 16, 2018 in which he hit his head on a support attached to a pole which caused him to fall. (AX 2)

On January 30, 2018, Petitioner was transported by Monroe County EMS to Barnes-Jewish Hospital for reports of confusion and delirium. According to the EMS report, EMS had received a call for a 33 y/o male who was having a seizure. Petitioner was found lying on his bed room floor in no distress. Petitioner stated that he was sitting on the couch and they had just come home from the bar where Petitioner had had a few beers and wings. He went home, took a Xanax and sat down and his chest/throat became tight. He then went into the bedroom to lay down and he fell to the floor and start shaking, and sticking his tongue out of his mouth. Petitioner advised that he couldn't breathe and he had a seizure. Petitioner's wife reported that he had experienced one seizure about four years earlier due to a medicine mix up by the doctors. Petitioner was able to get himself up off the floor but just "didn't feel right." Petitioner had a rapid strong radial pulse and redness covering his neck and red spots on his upper chest. He was transported to the hospital. (RX 6)

At the hospital Petitioner was noted to have answered all questions without problems, but repeated "Weird, Very Weird." Petitioner's wife reported that over the prior week Petitioner had been exhibiting odd behaviors including barely sleeping, crying, barely responding to questions, and speaking random words repetitively, such as "that's weird" and "Trump". Petitioner admitted to vague suicidal ideations of wanting to jump head first off a building and when questioned answered, "Trump." (RX 6; RX 8)

Petitioner was also observed exposing himself in the ER waiting room and engaging in activities which would later be described as evidence of hypersexuality (and is). Petitioner also attempted to urinate in a corner when asked to provide a urine sample. Petitioner was noted to vacillate between periods of lucidity and confusion. (RX 6; RX 8)

Petitioner was admitted under a psychiatric hold and underwent a comprehensive work-up. According to the Barnes-Jewish Physician Discharge Summary, Petitioner had been admitted involuntarily under "Suicide/Elopement/Assault" precautions due to one week's worth of minimal sleep, staring spells, flat affect, bizarre behavior, and nonsensical perseverative responses to questions. When asked why he had engaged in some of the behavior he had while in the exam room, he replied "Groundhog Day" and when asked to explain what he meant by that he replied, "It's the same thing over and over." No additional explanation was provided.

While hospitalized Petitioner was examined by Dr. Rahman. Dr. Rahman's Discharge Summary listed a primary diagnosis of unspecified schizophrenia spectrum and other psychotic disorder. Petitioner was not deemed reliable for history and information at the time of his admission. Dr. Rahman noted that this was the second psychiatric admission for Petitioner who had had a history of depression, past suicide attempts and chronic intractable migraines in the setting of 4 TBIs presenting with one week of bizarre behavior. Petitioner's history included depressive symptoms episodically in the past with unclear characterization and three prior suicide attempts. One had occurred ten years earlier when Petitioner had overdosed on Flexeril and required psychiatric admission. Most recently, in 2010, Petitioner, "in the setting of cocaine and alcohol" fired a loaded gun into a room and voiced that he was trying to kill himself (it was unclear if he was intoxicated when he made those statements). He had been seen by a psychiatrist in the past for depression and had been on an antidepressant but he had reportedly been off the medication and had not seen a psychiatrist in several years and doing well. Medications included Latuda, Norpramin, Gabapentin, Oxycodone, Buspirone and Xanax. There was no history of manic symptoms. He had used cannabis rarely in the past. Petitioner's history was also noted to be significant for roughly 4 or 5 TBIs secondary to motor vehicle accidents. He had been admitted to BJH in March of 2017 after a high speed motor vehicle accident. At that time his UPS was positive for opiates and benzodiazepines. Petitioner had no known bizarre behavior as a result of those head injuries. More recently, on January 16, 2018, Petitioner had hit his head against a pole due to poor visibility while at work. He lost consciousness for five to ten minutes. He reportedly returned to baseline. When seen one week later in a neurology clinic, the frequency and severity of his migraines had not changed although he reported improved light sensitivity. At that appointment, Petitioner's Amitriptyline was increased and his wife reported his frequency of headaches had decreased. She had not noticed any abnormal movements, rhythmic jerking, gaze deviations or staring spells. (Ex. B to PX A)

According to the Discharge Summary, Petitioner's home Amitriptyline was discontinued on admission due to concerns for anticholinergic delirium and/or lowered seizure threshold as explanation for his bizarre behavior. However, on further discussions with his wife it appeared he had only taken one dose of the Amitriptyline two days before the admission. He had an extensive work-up with a normal brain MRI and head CT, normal EEG, normal LP, and negative urine drug screen (UDS). Considerations at the time of discharge included a substance-induced delirium not detected by UDS, post-concussion syndrome (although the time course was unusual), or front seizures 2/2 TBI that were not detected on EEG. Petitioner improved spontaneously over the course of the next few days and said he felt back to baseline by February 2nd, which was confirmed by his wife. His MoCA on that date was 24. He had no further outbursts of hypersexuality or agitation and required no

PRNs. For his migraine prophylaxis, Divalproex was begun daily in place of Amitriptyline. He was felt to be at low risk for harm to himself and no longer needed psychiatric hospitalization. (Ex. B to PX A; RX 6; RX 8)

On February 6, 2018, the day before he was to return to work per Dr. Lardizabal, Petitioner returned to see the doctor, accompanied by his wife. The doctor noted that the week before, Petitioner's wife had left a message that Petitioner was acting strange in that he was crying or laughing and repeating the same words. The doctor had instructed her to take Petitioner to the ER for evaluation. That was done. A Urine Drug Screen was negative. CSF studies were negative for a CNS infection. A brain MRI and EEG were normal. Dr. Lardizabal stated, "He had psychosis" and details of the psychosis were reviewed in the discharge summary. Petitioner had been discharged from Barnes on February 3, 2018 and upon discharge he stopped taking the Depakote (it made him feel like a zombie) and he resumed taking the Amitriptyline. Dr. Lardizabal reviewed the records from Petitioner's ER visit and noted that some traumatic brain injury, as well as depression, could present with psychosis. His headaches were better with the Amitriptyline and Petitioner had not experienced any psychotic episodes since discharge but he did have some occasional agitation. Petitioner was restarted on Amitriptyline, continued off work until March 1, 2018, and instructed to return for follow up on April 24, 2018. (RX 11; Ex. B to PX A)

Dr. Lardizabal issued a note on the 6th stating that Petitioner had suffered a recent concussion on January 16th and was having more severe migraines. He was still adjusting medication to help manage the headaches and Petitioner had also been hospitalized from January 30, 2018 through February 3, 2018. Dr. Lardizabal wrote, "He has post-concussion syndrome with recent altered mental status. I recommend that he stay home and resume back to work on March 1, 2018." (Ex. C to PX A)

On February 15, 2018, Petitioner was seen by Dr. Wall at Red Bud Clinic to establish care as a new patient. Petitioner reported his work accident on January 16, 2018 and memory problems. Petitioner was diagnosed with a drug abuse screen, work comp accident and head injury and instructed to follow up in two weeks. (RX 12; Ex. E to Ex. A)

On February 17, 2018, Petitioner was seen at Red Bud Hospital for back pain after jumping out of a window located eight feet above ground, landing on landscaping block and on his back. He also complained of left outer foot pain. Petitioner reported experiencing seizures since his work accident. Petitioner's wife reported he had a seizure and then jumped out of a window running to a neighbor's house with no shoes. Petitioner was diagnosed with a thoracic strain. (RX 10; Ex. D to EX. A)

On February 19, 2018, Petitioner was seen by Dr. Wall. He reported having gone to the ER on February 17, 2018 for a work-related injury. Petitioner reported that he experienced a seizure at home and was confused after coming to. He then jumped from a window of the house thinking he was being attacked. Petitioner reported

chest pains from his ribs during the fall. Petitioner advised the doctor he had followed up with his neurologist who said the incident was related to his head injury. Petitioner was diagnosed with low back pain and unspecified seizure convulsions and was instructed to follow up with Dr. Lardizabal. Dr. Wall also advised Petitioner not to drive for at least six months due to the seizures he had been experiencing. (RX 12: Ex E to PX A)

On February 28, 2018, Dr. Lardizabal issued a note extending Petitioner's off-work excuse until April 2, 2018. In his report he stated that he had "receive[d] an update that [Petitioner was] still having severe headaches and unable to function well." Therefore, he extended his off-work status until April 2, 2018. (Ex. C to PX A: RX 8) Dr. Lardizabal did not examine Petitioner that day as there is no office note pertaining to a visit. (Ex B to PX A)

Petitioner returned to see Dr. Wall on March 1, 2018 in follow-up for workers' compensation. He was ambulating normally and appeared to have normal recent and remote memory. His mental status was good. He mentioned headaches. Petitioner's back appeared fine. Petitioner was told to return to the office as needed. (Ex. E to PX A)

On March 5, 2018, Petitioner was seen by Dr. Wall for a DCFS Daycare Physical. He reported no problems, including no loss of consciousness, no weakness, no numbness, no seizures, no dizziness, no headaches, no depression, no sleep disturbances, no alcohol abuse, no hallucinations, and no suicidal thoughts or fatigue. Petitioner felt safe in a relationship. Petitioner reported "occasional alcohol intake." During Petitioner's examination Dr. Wall noted a history of seizure, post-concussion syndrome, opioid abuse (clean for 60 days), bipolar disorder, cocaine abuse (clean for 60 days), gout, insomnia, depressive disorder, migraine and anxiety. He noted the onset date for Petitioner's anxiety and depression was 12/6/16 and the onset date for Petitioner's migraines was October of 2017. He further listed Petitioner's seizures, post-concussion syndrome, opioid abuse, bipolar disorder and cocaine abuse as having begun 2/15/18. On exam Petitioner's gait was described as normal, his Dr. Wall found no abnormal findings upon examination. (RX12: Ex. E to PX A)

That same day, March 5, 2018, Petitioner was again seen by Dr. Lardizabal and reported ongoing severe daily headaches. Petitioner reported no response with Amitriptyline at bedtime. The doctor noted, "His stuttering has improved." He also reported that since Petitioner's concussion, his mood was labile and he had been upset and irritable and having difficulty sleeping. Petitioner was instructed to discontinue use of the Amitriptyline and start Zyprexa and Melatonin. Dr. Lardizabal also noted that Petitioner reported experiencing an episode of altered awareness and muscle twitching on February 16, 2018. He had been on Lamotrigine. The doctor's diagnoses included post-concussion syndrome, chronic intractable migraines, anxiety, mood disorder, insomnia, and convulsions. The doctor counseled Petitioner about his diagnosis and treatment. He felt his sleep and mood problems were part of the recovery from the concussion. The doctor noted that Petitioner had not been able to

resume working. He had sent a letter out on February 28th indicating Petitioner could not resume work. Dr. Lardizabal also continued Petitioner's off work status until April 24, 2018. (RX 8; Ex. B and Ex. C to PX A)

On March 7, 2018 Petitioner was seen at Red Bud Regional Hospital due to eye pain and nausea. Petitioner was accompanied by his wife who was there to be seen so he wished to be also. Petitioner reported hitting his head on a piece of steel at work on January 16th with an eight-minute loss of consciousness. He also reported having had a grand-mal seizure in the past week followed by blurry vision since then. He was given Zofran for nausea and told to follow up with his neurologist, as needed. He was stable upon discharge. (Ex. D to PX A)

On March 8, 2018, Petitioner was seen by Dr. Wall. Petitioner reported headaches causing nausea and vomiting. Petitioner reported to Dr. Wall that he was not happy with Dr. Lardizabal because he would not prescribe him any pain medication. Dr. Wall confirmed plans to consult with Dr. Lardizabal. (RX 8)

Between March 8, 2018 and March 21, 2018 counsel for both parties communicated regarding TTD benefits allegedly due and owing. As of March 21, 2018, Counsel for Respondent advised Petitioner's attorney that her client would be issuing payment of TTD to Petitioner from February 7, 2018 through April 2, 2018. She further advised that an IME was being scheduled with a doctor in Chicago and she needed confirmation that Petitioner could travel that distance. (PX G 1 – 4)

Dr. Lardizabal issued a note on April 2, 2018, noting his ongoing adjustment of medications post-concussion and Petitioner's earlier hospitalization. He recommended that Petitioner stay home for his recovery and limit his physical activity as he had received an update that Petitioner was still having severe headaches and insomnia. The doctor wrote, "I am extending his request for work excuse for another month. He may return to work on May 1, 2018." (Ex. C to PX A)

By letter dated April 4, 2018 Respondent's attorney advised Petitioner's attorney that an IME had been scheduled for May 3, 2018 with Dr. Nancy Landre. (PX G5)

On April 10, 2018 Petitioner's attorney emailed and mailed an off-work slip to Respondent's attorney indicating Petitioner was off work until May 1, 2018. (PX G6)

Between April 20, and 2, 2018 counsel for both parties emailed back and forth regarding TTD checks and details of the upcoming IME. (PX G7 – 9)

On April 24, 2018, Petitioner returned to see Dr. Lardizabal, reporting that while he was still experiencing headaches daily; however, the severe episodes were now only one per week. The doctor noted that at the time of the last visit he was reporting daily severe headaches. Dr. Lardizabal also noted that before the concussion, Petitioner's severe migraines were two per week. The Indomethacin was reducing his headaches partially and the Zofran worked well but he didn't like the taste. He also noted improvement in his light sensitivity and he was now able to tolerate room light. His vomiting episodes were also less. Petitioner said his headaches were on the

top of his head; however, his head wasn't tender. Petitioner reported that since his last visit he had experienced one episode where he texted his wife from the bedroom (she was in the living room) and he felt like he was having a seizure. He fell off the bed and was drenched with saliva on his shirt. He had been having some twitching of his extremities. His mood was still the same and he continued to get upset easily. He was also having trouble with restless sleeping and vivid dreams as well as episodes of dizziness. Sometimes he slept during the day rather than at night. Petitioner's diagnoses no longer included anxiety or mood disorder. Dizziness was added. Dr. Lardizabal recommended Petitioner move forward with Botox injections. (RX 8)

In a note dated April 24, 2018 Dr. Lardizabal noted Petitioner's concussion injury of January 16, 2018. He also noted that Petitioner had intractable chronic migraines and convulsion. The doctor had reviewed a job description and based upon Petitioner's current clinical condition he did not believe Petitioner could perform most of those job requirements as he shouldn't operate heavy machinery or equipment since his ability to focus or pay attention to tasks will likely be impaired. Dr. Lardizabal was referring Petitioner to physical and occupational therapy as well as a functional capacity evaluation. (Ex. C and Ex. F to PX A)

By email dated April 25, 2018 Respondent's attorney advised Petitioner's attorney that Respondent was not going to pay additional TTD pending the IME in light of "legitimate questions" given Petitioner's prior condition and whether his current condition was related to his work accident. She also wrote regarding IME travel details and a need for a release from Petitioner in order to get Dr. Lardizabal's records. (PX G10) Petitioner's attorney responded by email dated April 30, 2018. (PX G 11)

Counsel for Petitioner advised Respondent's attorney of another off-work slip going beyond May 1, 2018. Additional matters were also discussed. (PX G12)

On May 2, 2018 Dr. Lardizabal's office faxed office notes to Nicole Christoffel, the adjuster, to see if she would approve Botox. On May 7, 2018 office staff noted that Ms. Christoffel was not authorizing "any appointments or anything" at this time as Petitioner was being sent for an IME. (Ex. B to Exhibit A, p. 35/53)

* Respondent presented for a Section 12 examination with Dr. Nancy Landre, a neuropsychologist, on May 3, and May 18, 2018. Dr. Landre is a licensed clinical psychologist and is also board certified in clinical neuropsychology.

According to her report, Dr. Landre conducted an interview with Petitioner and reviewed his pre- and post-accident medical records. Petitioner told Dr. Landre that he was working as a mechanic on January 16, 2018 when he struck his head on a metal support beam. He was running back to the maintenance shop to get some supplies and struck his head on a beam obscured by steam. Petitioner fell to the ground and struck his head. He reported losing consciousness for twenty minutes, then woke up, shivering and drove himself to an Urgent Care Clinic from which he was taken by ambulance to Barnes Jewish Hospital. Petitioner did not remember driving to

the Urgent Care Clinic or telling any of his co-workers that he felt fine to drive. He was released from the hospital the same day after which he experienced worsening symptoms, including three seizures, the first of which occurred on February 16, 2018 followed by a second one on April 17, 2018. Performance and symptom validity testing and comprehensive cognitive and psychological assessment was also undertaken. (RX 1; Ex. G to PX A)

Dr. Landre noted that Petitioner presented as stable, but moderately dysphoric and highly symptomatic, with a wide variety of alleged injury-related complaints, including memory loss, daily headaches, insomnia, vision issues in his left eye, mood changes, dizziness, vomiting, sleep disturbance, and social withdrawal. (Id.)

After completing her interviews and testing, Dr. Landre opined that Petitioner had sustained, at worst, an "uncomplicated concussion" in connection with his work accident, for which he reached recovery one month post-accident and that his current complaints were not related to his work injury, but, rather, non-work-related factors. (Id.)

On performance and symptom validity testing, Dr. Landre noted Petitioner's scores were highly abnormal. Dr. Landre noted that Petitioner demonstrated consistent problems with effort and failed nearly all of his performance validity tests during the cognitive portion of the evaluation. Furthermore, his performance on symptom validity testing suggested extreme over-reporting of injury-related symptomology. (Id.)

Also of note, on the Battery for Health Improvement test (Second Edition (BHI-2)), which is a comprehensive measure of physical and emotional functioning that is developed for use with medical patients, Petitioner was noted to have presented himself in an unusually negative manner. Petitioner was recorded as reporting a level of psychological and life problems that was higher than that seen in 96% of complex medical patients and even higher than that reported by 84% of patients who were specifically asked to "fake bad". (Id.)

Dr. Landre noted that, according to test developers, this reported level of problems was so high that it cast doubt on the accuracy of Mr. Timpe's self-reporting and suggested secondary gain and was suggestive that Petitioner purposely biased the information he provided in a negative manner in order to strengthen his case. Petitioner was also recorded as over reporting on the MMPI-2-RF. (Id.)

On/about June 13, 2018 Petitioner filed his Petition for Immediate Hearing. (AX 1) Respondent filed its Response on/about July 2, 2018. (AX 1)

On July 2, 2018 counsel for Petitioner contacted Respondent's attorney about whether she had yet received the IME report. She had not. (PX G13,14)

By letter dated July 9, 2018 Petitioner's attorney was sent a copy of the IME report and advised that Respondent was disputing liability for Petitioner's condition beyond that of a simple concussion and, therefore, it disputed liability for treatment after February 16, 2018. (PX G15)

Dr. Lardizabal was deposed on July 18, 2018. (PX A) Dr. Lardizabal testified that he is certified by the American Board of Neurology and Psychiatry, maintains a clinical practice specializing in seizures and major headache disorders at Barnes Jewish Hospital, and is an associate professor of neurology at the Washington University School of Medicine in St. Louis, Missouri.

Dr. Lardizabal testified as to his treatment of Petitioner from October 17, 2017 through April 24, 2018. He distinguished the differences in Petitioner's symptoms and diagnoses prior and subsequent to the January 16, 2018 work injury. While Petitioner was experiencing headaches for prior to January 16, 2018, Dr. Lardizabal noted that, as of October 17, 2017, Petitioner was having no problems with sleep, no episodes of confusion, no blackouts, and no convulsions. His gait was normal. Dr. Lardizabal noted no other pertinent neurological collateral symptoms other than the severe headaches. He described Petitioner's neurological examination as normal prior to January 16, 2018 and Petitioner's only diagnosed condition was that of chronic migraines. While he acknowledged that Petitioner had been off work for headaches for a period of time in 2017, (pre-accident) Dr. Lardizabal explained that he was able to manage Petitioner's symptoms through medication such that Petitioner was able to return to work on November 1, 2017.

Dr. Lardizabal further testified that several new symptoms which arose as a result of Petitioner's January 16, 2018 injury including, but not limited to:

(a) increased headaches;

(b) increased sensitivity to light;

(c) unsteady gait;

(d) walking slowly;

(e) loss of balance;

(f) acute psychosis;

(g) agitation;

(h) flat affect;

(i) occasional eye contact;

(j) mood swings;

(k) stuttering;

(l) disturbed and irregular sleeping patterns;

(m) seizures; and

(n) loss of awareness.

Dr. Lardizabal testified that when he last saw Petitioner on April 24, 2018, Petitioner's post-concussion headaches and dizziness were improving, he was walking better, and his neurological examination was normal. However, he further testified that Petitioner was not at maximum medical improvement, that his symptoms could continue to flare up, and that he continued to need additional medical care as a result of his work injury. More specifically, Dr. Lardizabal recommended Botox injections as a more aggressive approach to addressing Petitioner's intractable chronic migraines, a functional capacity evaluation to determine Petitioner's current level of function, and physical and occupational therapy to improve Petitioner's level of function, balance, and cognition. He also recommended a return to his care for further evaluation subsequent to these recommended treatments.

As to his medical opinions relevant to his treatment of Petitioner, Dr. Lardizabal opined that Petitioner's diagnosed conditions of concussion, post-concussion syndrome, worsening migraines/posttraumatic migraines, mood disorder, insomnia, convulsions, dizziness, and posttraumatic epilepsy were all causally related to Petitioner's January 16, 2018 work accident. Furthermore, he testified that all of the treatment he rendered, the hospital and psychiatric admission at Barnes Jewish Hospital from January 30 - February 3, 2018, the February 17, 2018 admission at Red Bud Regional Hospital following the episode where Petitioner had a seizure and injured his back and foot after jumping out of a widow, the March 7, 2018 admission at Red Bud Regional Hospital following Petitioner's grand mal seizure, and the treatment rendered by Southern Illinois Healthcare Foundation/Dr. Walls on February 15, February 19, and March 1, 2018, were all causally related to Petitioner's work injury and that the treatment rendered by those providers on those dates was both reasonable and necessary to treat Petitioner's condition of ill-being. Additionally, Dr. Lardizabal testified that it was both reasonable and necessary for Petitioner to remain off work at all times from January 16, 2018 to the present, both for the treatment of Petitioner's condition and for the safety of Petitioner and those around him. As to future treatment, Dr. Lardizabal opined that the prospective course of care he prescribed on April 24, 2018 (namely, the Botox injections, the functional capacity evaluation, the physical and occupational therapy, and the return to his care for re-evaluation thereafter) were all reasonable, necessary, and would be causally related to Petitioner's work injury. Dr. Lardizabal expressed concern over the fact that Petitioner was not receiving the treatment prescribed given Petitioner's objective improvement to this point and because the time within which proper treatment is administered is important to clinical outcomes in these types of cases.

During the deposition Dr. Lardizabal was given copies of medical records to review and address through testimony (Exhibits B – I). The doctor was asked questions about some of the entries, notes, and records pre-dating Petitioner's accident and he opined that those incidents and conditions did not cause Petitioner's

symptoms subsequent to the January 16, 2018 work injury but, rather, may have made him more susceptible to injury on that date or, at a minimum, presented risk factors for worsened symptoms relevant thereto.

Dr. Lardizabal also addressed the findings and opinions rendered by Dr. Landre, Respondent's examining neuropsychologist. He first noted that neuropsychologists, unlike neurologists, are not medical doctors. They do not treat neurological disorders. While they can provide counseling, they cannot prescribe medication, order diagnostics studies, or perform medical procedures such as spinal taps. Having had an opportunity to review Dr. Landre's testimony by and through her Section 12 examination report, Dr. Lardizabal testified that no part of her testimony affected or otherwise altered his post-accident diagnoses or the opinions to which he had testified.

Dr. Lardizabal also offered opinions contrary to those rendered by Dr. Landre. First, he disagreed with Dr. Landre's diagnosis of "Probable Malingering." Specifically, Dr. Lardizabal testified that he has never suspected malingering of any sort on the part of Petitioner throughout his course of treatment. Further, Dr. Lardizabal explained that psychological symptoms, like conversion disorders and somatization disorders which often result in the symptom magnification, are often a byproduct of the underlying neurological condition. He further testified that any perceived somatic response noted by Dr. Landre was likely the result of Petitioner's neurological condition that was caused by the work injury. Going further, Dr. Lardizabal noted that somatic responses of the type referenced by Dr. Landre were frequently elicited when examinees were stressed or anxious. In the instant case, on the day of testing Petitioner was driven by courier from his home in Waterloo, Illinois all the way to Dr. Landre's office in Park Ridge, Illinois. Petitioner was late to the Section 12 examination as the courier was delayed by inclement weather. Petitioner was thereafter exposed to a battery of tests he was unable to complete in the time allotted; thus, he was required to submit to additional testing via telephone more than two weeks later. According to Dr. Lardizabal, all of the foregoing, combined with the stress of submitting to neuropsychological testing generally, would have further increased the likelihood of Petitioner giving responses which, in Dr. Landre's estimation, were exaggerated or inconsistent.

Dr. Lardizabal further disagreed with Dr. Landre's opinions that Petitioner's current condition was unrelated to his work injury and that he would have reached maximum medical improvement one month post-injury. Dr. Lardizabal testified that treatment of traumatic brain injuries is an ongoing process which cannot be completed in one month; rather, it is a condition that is oftentimes treated over a course of 6 - 12 months and, in Petitioner's case, will continue to require additional treatment and cognitive rehabilitation at some point in the future. Similarly, Dr. Lardizabal disagreed with Dr. Landre's characterization of Petitioner's injury as "an uncomplicated concussion." In so doing, he referenced Petitioner's post-concussion symptoms of psychosis.

convulsions, altered awareness, unsteadiness in walking, and balance issues as evidence of the fact that Petitioner's concussion was far from "uncomplicated."

Dr. Lardizabal further testified that Petitioner has returned to his pre-accident base line related to his headaches, but that he continues to suffer from post-concussive symptoms related to his January 16, 2018 work accident. Dr. Lardizabal related both Petitioner's ongoing headaches, as well as his concussion, to his work accident. (PX A)

The Arbitration Hearing

Petitioner's case proceeded to arbitration on July 20, 2018 pursuant to a Petition for Immediate Hearing. The disputed issues included causal connection, medical bills, temporary total disability, prospective medical care and penalties and attorney's fees. Petitioner was present during the proceeding but did not testify.

Petitioner's wife, Donna Timpe, testified that she has been married to Petitioner for ten years. She and her husband have two foster children. She testified that since January 16, 2018 she has noticed that her husband is a lot moodier and agitated and she "walks on egg shells a lot." As an example, she explained that the kids have to "tip toe" around and he's just real short fused. She further testified that he sleeps a lot and doesn't have any "oomph" to even go outside like they used to to "garden and stuff like that." She also testified that he has a lot of headaches and sits and watches T.V. most of the time or sleeps. He also has trouble with insomnia. Mrs. Timpe was asked if her husband had any memory issues and she replied, "Always. Can't remember yesterday." As an example, she testified that she will ask him if he would vacuum or something and then ten minutes later, he'll ask her what she asked him to do. She also testified that most of the stuff he does right now is not reliable. She has to go back and redo everything. As an example she referred to a time when she asked him to make a bottle for the little on and he said he had done it or she'll have to make sure that it's done. If she asks him to take something out of the freezer, she'll have to double check and make sure it was done.

Petitioner's attorney asked Mrs. Timpe if her husband had suffered any seizures and she replied, he had had a few. She witnessed the ones on February 17th and March 7th. She also testified that he had just had a seizure in the past week. When he came home he was really lethargic and pale. He went right to bed and slept until the next day.

Mrs. Timpe testified that she accompanied Petitioner to the Section 12 exam with Dr. Landre in Chicago. While it was true they were late, they were taken there by a courier and they traveled through a thunder storm. She was present when Dr. Landre met with her husband. The meeting with her was about twenty minutes long and then another co-person handled the rest of the interview. She further testified that he had to complete some additional testifying over the telephone and she listened in but Dr. Landre did not participate in the call.

Mrs. Timpe testified that since April 24, 2018, when her husband was examined by Dr. Landre, his headaches have become a little less frequent but he is still forgetful, moody and easily agitated. She further testified that when her husband is going to have a seizure she'll notice that he starts to stutter and Dr. Lardizaval said that can sometimes be a symptom.

Mrs. Timpe also testified that her husband had a psychotic episode in late January or early February of this year when he was "just not her husband." She noticed that he was just staring into space, saying one word at a time like "weird" and "that's weird." He stared at the TV and had conversations on his own and his gait was really unstable. She called Dr. Lardizaval and he instructed her to take him to the ER.

Mrs. Timpe was not cross-examined.

The Arbitrator concludes:

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

Petitioner did not testify during the arbitration hearing. As such, he did not testify to rebut Dr. Landre's findings of symptom magnification or malingering or provide testimony related to his current condition. "(W)here a party has the means in his power of rebutting and explaining evidence adduced against him the omission to do so furnishes a strong presumption or inference that he cannot do so." *Shumak v. Shumak*, (1975), 30 Ill.App.3d 188, 332 N.E.2d 177. Furthermore, the Arbitrator has found numerous inconsistencies in the medical records admitted into evidence which, by themselves, are contradictory but, additionally, since Petitioner did not testify, he did not attempt to explain or correct them. For example, on February 19, 2018 Petitioner was seen by Dr. Wall. He told the doctor he had been seen at the emergency room on February 17th for a "work-related injury." He further stated that he had seen his neurologist (Dr. Lardizabal) in follow up and the doctor had told him the incident for which he went to the ER was related to his head injury. Petitioner did not see Dr. Lardizabal between February 17th and February 19th. Therefore, he neither saw his neurologist in follow-up nor is there corroboration for his claim that the doctor told him the visit on the 17th was related to his head injury. Medical records also contain inconsistencies regarding Petitioner's use of drugs (ex. Dr. Hayat's records). The Arbitrator also has concerns about drug-seeking behavior as when Petitioner told Dr. Wall on March 8, 2018 that he was unhappy with Dr. Lardizabal because he would not prescribe him pain medication. The Arbitrator has serious misgivings regarding Petitioner's ongoing motivation in this case as it appears quite self-serving. Petitioner tells doctors only what he wants them to hear. He reportedly told all providers (except the initial ER and responders) that he lost consciousness when he hit his head on the beam. While Dr. Lardizabal felt the loss of consciousness

didn't matter with regard to his care and treatment, it does to the Arbitrator as it affects Petitioner's credibility. He misrepresented the history of the accident to his providers and provided no testimony to clarify these inconsistencies. Additionally, Dr. Lardizabal's office notes and off work letters repeatedly state that he is keeping Petitioner off work became Petitioner, himself, feels he cannot return to work. For a significant period of time Dr. Lardizabal did so with no apparent knowledge of Petitioner's job duties (as none is discussed in the records until April of 2018).

Perhaps the most troubling inconsistency in this record is the history and exam findings from Dr. Wall's examination of Petitioner on March 5, 2018 and any subsequent medical visits with Dr. Lardizabal, as well as the inconsistency of that visit with Petitioner's wife's testimony at arbitration. Mrs. Timpe testified that she and Petitioner have two foster children. Petitioner was seen by Dr. Wall on March 5, 2018 for a DCFS Daycare Physical, which the Arbitrator reasonably infers had something to do with Petitioner and his wife becoming/remaining foster care parents. Petitioner denied absolutely any problems during that visit and the doctor expressly noted no evidence of headaches, seizures, anxiety, depression, etc. He specifically stated, "no abnormal findings upon examination." The significance of this examination cannot easily be overlooked. Petitioner has suggested to the doctor signing off on a DCFS Physical that his patient has not problems whatsoever and, yet, Petitioner then followed up with his neurologist that very same day and painted an extremely different picture. Mrs. Timpe suggested in her testimony that her husband has ongoing issues and is difficult to be around (they must "walk on eggshells") and has never been the same since this work accident. However, none of these issues were raised to Dr. Wall on March 5, 2018 and Petitioner never had any problems mentioning his headaches to Dr. Wall before that visit. Petitioner provided no explanation for any of this and the Arbitrator, relying upon the admitted records and their inconsistencies, finds Petitioner's motivation and credibility regarding his condition and its link to his accident highly questionable.

The Arbitrator also takes note of the inconsistencies in Petitioner's reporting of his level of consciousness following his accident. Upon first seeking treatment Petitioner denied loss of consciousness, but later reported losing consciousness for 10 to 15 minutes. Again, Petitioner did not provide any testimony to clarify this inconsistency.

Having stated the foregoing, the Arbitrator notes that there was an accident and she believes that Petitioner suffered a concussion (albeit with no loss of consciousness). She feels it is reasonable that such an injury could exacerbate a pre-existing history of migraines and even anxiety depression, and moodiness. However, she does not find Petitioner's ongoing condition after March 4, 2018 (the day before the visits with Dr. Wall and Dr. Lardizabal) to be causally related to his accident.

Petitioner bears the burden of proving by a preponderance of evidence all the elements of his claim, including causation. Petitioner has not met that burden. Petitioner did not testify to rebut Dr. Landre's findings of symptom magnification or malingering or provide testimony related to his current condition, even though he was present at the hearing. "(W)here a party has the means in his power of rebutting and explaining evidence adduced against him the omission to do so furnishes a strong presumption or inference that he cannot do so." *Shumak v. Shumak*, (1975), 30 Ill.App.3d 188, 332 N.E.2d 177. As noted above, the medical records cause the Arbitrator to question Petitioner's credibility regarding the histories and complaints given to doctors.

While Dr. Lardizabal provided testimony that he saw no malingering or symptom magnification on the part of Petitioner during his examinations of him, the Arbitrator does not believe that Dr. Lardizabal was fully aware of the extent of Petitioner's pre-existing conditions, including his history of drug use and psychiatric treatment; which the Arbitrator finds relevant given the facts of this case. Unlike Dr. Landre, Dr. Lardizabal did not administer any objective tests to Petitioner.

Dr. Lardizabal was unfamiliar with any of Petitioner's prior medical treatment until the day of his deposition. Based upon the doctor's office notes, Petitioner never gave Dr. Lardizabal a thorough and complete history of his medical problems, accidents, and lifestyle. It was only at the time of his deposition that Petitioner's attorney tendered records to the doctor to review at that time. The deposition was approximately three hours long with no indication of how much time was spent by the doctor during the deposition actually reviewing the records which are approximately 2 ½" thick (see PX A exhibits). Based upon the questioning, the doctor did not actually read all of the exhibits; rather, bits and pieces were pointed out to him and he was simply asked to assume they were true. While Petitioner's counsel indicated that he provided the doctor with a comprehensive set of records like the ones provided to Dr. Landre for review, he acknowledged that he did not review "that whole stack." He then added that he "reviewed this one" meaning the "backup documents to what was summarized here". (PX A, pp. 62 – 63) It is not entirely clear from this exchange just which records were reviewed by the doctor. Additionally, the doctor made several concessions on cross-examination regarding his limited knowledge of Petitioner's medical condition and problems prior to October of 2017. (ex. PX A, pp. 97-99) Dr. Lardizabal further testified that sometimes he states that he reviewed a record but he really didn't. (PX A, p. 99) Dr. Lardizabal was not made aware of all the entries and histories found in the exhibits provided to him at that time. Furthermore, the doctor was never asked about the contradictory histories and exam findings of his visit with Petitioner on March 5, 2018 and Dr. Wall on March 5, 2018.

Dr. Lardizabal is recommending Botox injections as a more aggressive approach to addressing Petitioner's intractable chronic migraines, a functional capacity evaluation to determine Petitioner's current level of function, and physical and occupational therapy to improve Petitioner's level of function, balance, and cognition. In so

recommending, the doctor has had to rely upon Petitioner's ongoing complaints of migraine headaches and their severity and limitations. Additionally, when one reads the doctor's letters regarding Petitioner's remaining off work, it is interesting that he bases most of them on being informed by Petitioner that he, himself, does not feel he is ready to return to work until he referenced reviewing a job description (which wasn't a part of the record). The doctor, objectively, had no basis to keep Petitioner completely off work. He was relying solely on Petitioner's subjective representations. Furthermore, since Petitioner didn't testify, the Arbitrator has no knowledge of his exact job duties. Additionally, the doctor is seemingly unaware that, when Petitioner was seen by Dr. Wall on March 5, 2018, he exhibited no gait problems whatsoever and denied same. Dr. Lardizabal testified that Petitioner had gait problems/unsteadiness. In sum, Dr. Lardizabal is making treatment recommendations in whole, if not in substantial part, based upon Petitioner's subjective reporting, which the Arbitrator finds suspect. Dr. Lardizabal is a neurosurgeon and, as such, his opinions regarding Petitioner's concussion carried some weight. However, he was unaware of Petitioner's history of anxiety and depression, and other psycho-social issues which would be an area of expertise by Dr. Landre. As such, her opinions regarding symptom magnification carry weight.

Again, the Arbitrator also takes note of the inconsistencies in Petitioner's reporting of his level of consciousness following his accident. Upon first seeking treatment Petitioner denied loss of consciousness, but later reported losing consciousness for 10 to 15 minutes. Again, Petitioner did not provide any testimony to clarify this inconsistency. This also suggests, as Dr. Landre found, that Petitioner was engaging in symptom magnification.

The Arbitrator finds that Petitioner did sustain a concussion and temporary aggravation of his pre-existing headaches as a result of the January 16, 2018 accident. However, she further finds that, based upon Petitioner's presentment and representations to Dr. Wall on March 5, 2018 (which were not addressed or considered by Dr. Lardizabal or Petitioner) Petitioner reached maximum medical improvement for his concussion and work-related headaches as of March 4, 2018, the day before that visit. Petitioner has failed to prove that his condition of ill-being thereafter is causally related to his work accident. In so finding, the Arbitrator relies upon her credibility and motivational concerns, including symptom magnification as opined by Dr. Landre regarding Petitioner, Dr. Wall's office note of March 5, 2018, and Dr. Landre's opinions. The Arbitrator found persuasive Dr. Lardizabal's opinions and testimony regarding a causal relationship between Petitioner's accident and his hospitalizations in January and February of 2018; however, based upon the doctor's lack of adequate familiarity and consideration of Petitioner's extensive medical history and records coupled with his lack of testimony (or possibly even knowledge of) Petitioner's visit with Dr. Wall on March 5, 2018, and Petitioner's credibility issues which would affect everything he told Dr. Lardizabal, any opinions as to ongoing causation simply were not persuasive.

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 on the finding that Petitioner's condition of ill-being after March 4, 2018 is not causally related to the injury, Petitioner is ordered to pay all reasonable and necessary medical services required by Petitioner through March 4, 2018, pursuant to the medical fee schedule. Respondent is to be given a credit for any bills already paid.

Issue (K). Is Petitioner entitled to any prospective medical care?

Based on the finding that Petitioner's current condition of ill-being after March 4, 2018 is not causally related to the accident, Petitioner's request for prospective medical treatment is denied.

Issue (L). What temporary total disability benefits are due?

Based on the finding that Petitioner's condition of ill-being after March 4, 2018 is not causally related to the accident, Respondent shall pay to Petitioner TTD for the period of January 17, 2018 through March 4, 2018. Respondent shall be given a credit for TTD paid in the amount of $4,991.45.

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

Petitioner argues that he is entitled to penalties and attorney's fees pursuant to Section 19(k), 19(l) and 16 due to Respondent's failure to pay TTD or maintenance benefits after April 2, 2018. Given Petitioner's significant pre-accident medical history, and in light of the Arbitrator's causation determination, Petitioner's petition for penalties and attorney's fees is denied.

****

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF SANGAMON	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Randall Speck,

Petitioner,

vs. NO: 15 WC 31232

City of Springfield,

19IWCC0214

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 27, 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.

19IWCC0214

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: MAY 1 - 2019
MP/sj
04/04/2019
68

Marc Parker

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

SPECK, RANDY
Employee/Petitioner

Case# **15WC031232**

CITY OF SPRINGFIELD
Employer/Respondent

19IWCC0214

On 8/27/2018, 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 2.18% 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:

2217 SHAY & ASSOCIATES
TIMOTHY M SHAY
1030 DURKIN DT
SPRINGFIELD, IL 62704

0332 LIVINGSTONE MUELLER O'BRIEN
L ROBERT MUELLER
620 E EDWARDS PO BOX 335
SPRINGFIELD, IL 62704

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

RANDY SPECK,
Employee/Petitioner

v.

CITY OF SPRINGFIELD,
Employer/Respondent

Case # **15** WC **31232**

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 **7/25/18**. 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. [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 ______

19IWCC0214

FINDINGS

On 8/27/15, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $88,208.70; the average weekly wage was $1,696.32.

On the date of accident, Petitioner was 58 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 $755.22/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 reasonable and necessary medical services related to petitioner's left shoulder from 8/27/15 through 10/26/16, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

Signature of Arbitrator

8/14/18
Date

ICArbDec p. 2

AUG 27 2018

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 58 year old carpenter foreman, sustained an accidental injury to his left shoulder that arose out of and in the course of his employment with respondent on 8/27/15. Petitioner started full duty work with respondent in 1988. Before that he worked part time for respondent for about 4 months. Petitioner worked a total of 30 years with respondent. During his 30 years with respondent petitioner worked in carpentry. His last job with respondent was as a carpenter foreman from about 2010 through 2015. As a carpenter foreman petitioner was in charge of the crews. Petitioner answered to his boss at the beginning and end of the day. Petitioner was a working carpenter foreman.

Prior to 8/27/15 petitioner had injured his right biceps and was getting treatment from Dr. Wottowa that included physical therapy, injections, and surgery on his right biceps. After surgery petitioner worked in an office setting with no use of the right arm and no driving. While on restriction, petitioner overcompensated with his left arm and had some soreness in his left arm.

On 8/27/15 petitioner returned to field work for the first time since his surgery on his right arm. On that day, petitioner coordinated with the crews and got the carpenters out on the job. Petitioner was trying to gather materials for the carpenters. There were materials throughout the facility that he wanted someone to load on the truck. The other foreman said he could not help because he had to gather stuff for his project. Petitioner got the material for the carpenters' project outside in a single pile by himself. When he asked for help again, the laborers were still busy, so he picked up a 21 foot pole that had been taken down from fence. He grabbed the pole with his left arm and pulled it past one garage. As he tried to pull it around another garage he could not, so he raised it with his left arm in order to get it just barely around the garage and pull it into place with the other materials. Petitioner testified that when he lifted the pole above his head with his left arm he felt a dull pain in his left shoulder.

After placing the pole with the other materials, he proceeded to the beach house where he was working with a welder to make it ADA compliant. Petitioner's job was to do the layout and help hold the bar so that the welder could weld it. After working on this project, later in the afternoon petitioner told the welder he was tired. By the time he was done working his left shoulder became more and more painful. He had trouble sleeping that night due to the pain in his left shoulder. Petitioner testified that this pain was different than the pain he had in his left shoulder prior to 8/27/15. He testified that the pain was sharp and it kept him awake.

On 8/28/15 petitioner completed an accident report.

On 9/2/15 petitioner presented to Dr. Wottowa's Physician Assistant Purves. He reported a new problem with his left shoulder. Petitioner reported that over the last week his right arm was better, however, he had increased pain involving his left shoulder. He reported that it had been bothering him for a couple of months, but that he noticed increased discomfort initially over the anterior aspect while moving a 21 foot pole. He stated that while he was moving the 21 foot pole it got stuck and he had to maneuver it around with his left arm over his head. Petitioner reported that he still has pain over the anterior aspect, but more pain laterally over the shoulder. He noted that most of his pain occurs with activity away from his body, overhead, and at night. He had restriction of his motion secondary to pain. He denied any numbness or tingling. He noted that the home exercise program he had previously been given had only resulted in minimal improvement. Following an examination, Dr. Purves assessed a left shoulder rotator cuff injury and performed an injection into petitioner's left shoulder.

Purves was of the opinion that petitioner had some irritation in his left shoulder for a while, and it was obviously made worse with the injury last week at work. He recommended a formal therapy program and injected the left shoulder. Purves released petitioner to light duty work with no lifting greater than 10 pounds on the right or left upper extremity, and desk work only.

On 9/11/15 petitioner retired. Two weeks after he retired he did 2 weeks of carpentry clean up and prep work for Ricardi Floor Company. He ran a machine that helped grind down the surface and laid 12 x 12 tiles and carpet tiles. He performed no overhead work. Petitioner worked a very short time, just enough to get the few hours he needed in order to better his retirement amount with the union.

On 9/23/15 petitioner's Application for Adjustment of Claim was filed. He alleged an injury to his left shoulder while pulling out rails from behind the garage. Petitioner signed the Application on 9/16/15.

On 10/7/15 petitioner presented to Dr. Wottowa. He reported 6 days of relief following the injection on 9/2/15. Dr. Wottowa wanted him to do more supraspinatus strengthening for his left arm. He released petitioner to full duty work on 10/12/15, and on an as needed basis, with respect to the right arm. He placed petitioner at maximum medical improvement with respect to his right arm.

On 11/18/15 petitioner returned to Dr. Wottowa. Petitioner noted that his left shoulder continued to bother him. He reported that the past month was a little bit more uncomfortable for him in terms of sleeping at night. He also reported discomfort in the day, but stated that night time was worse. He reported a little improvement in the last 3-4 days with Aleve in the AM and PM. An examination revealed full range of motion,

but positive impingement signs. Dr. Wottowa performed a 2nd injection to the subacromial space of the left shoulder. Petitioner stated that he was doing his exercises faithfully.

In January of 2016 petitioner went to Florida and did some kayaking with his wife.

On 2/17/16 petitioner followed-up with Dr. Wottowa. Petitioner reported pain relief for three weeks following the 2nd injection on 11/18/15. Petitioner reported that his current pain was as bad as it had always been. He noted that the pain was localized to the anterolateral aspect of the left shoulder with certain lifting activities. He denied any decrease in strength, and no numbness or tingling. X-rays showed impingement syndrome and mild narrowing of the glenohumeral joint, suggestive of early glenohumeral arthritis. Dr. Wottowa assessed impingement syndrome and rotator cuff tendinitis. A potential arthroscopic surgery to perform a distal clavicle excision and subacomial decompression was discussed, and an MRI of the left shoulder was ordered.

On 2/18/16 petitioner testified at arbitration with respect to his right shoulder injury (case 15 WC 19677). Petitioner testified that he did some flat water paddling in Florida with his wife in January. He stated that the first time out he had difficulty because there was a lot of twisting of the arms, and with the length of the paddle his arms got tired and sore and he cut the ride short. Petitioner tried it again because he knew he needed to build up his strength.

On 3/1/16 petitioner underwent an MRI of the left shoulder. The impression was a small full-thickness supraspinatus tendon tear; large partial-thickness with only mild tendon retraction; moderate supraspinatus muscle atrophy; mild lateral downslopping of the acromion; mild osteoarthritis and joint hypertrophy at the acromioclavicular joint; thickening of the coracoacromial ligament; and subchondral cysts in the humeral head with surrounding bone marrow edema.

On 3/2/16 petitioner returned to Dr. Wottowa complaining of ongoing pain over the lateral aspect of his arm. Petitioner still had full range of motion, with a positive impingement. Dr. Wottowa reviewed the MRI and noted a lot of edema in the superior aspect of the humeral head, especially the rotator cuff insertion area. Dr. Wottowa only saw a high grade partial thickness tear, and not a full thickness tear of the supraspinatus. Dr. Wottowa did not see any moderate atrophy of the supraspinatus. He noted that there was a lot of fluid in the subacromial space and edema in the proximal humerus, and at the rotator cuff insertion. He believed petitioner's glenohumeral joint looked pretty reasonable. Dr. Wottowa recommended an arthroscopic evaluation of the left shoulder to assess the rotator cuff, biceps, and fix what was needed, and do a subacromial

decompression and take the bony spur off the acromion. Petitioner indicated that he wanted to undergo the recommended surgery.

On 5/23/16 petitioner underwent a Section 12 examination with Dr. Gregory Paletta, at The Orthopedic Center of St. Louis, at the request of the respondent. Dr. Paletta noted that he did not have all of Dr. Wottowa's medical records regarding the treatment of petitioner's left shoulder. He did not have any records prior to 11/18/15. Petitioner complained of left shoulder pain dating back to 8/25/15. Petitioner reported that when he injured his left shoulder he was working under restrictions for his right elbow. He gave a history of trying to get some material out for a job, which normally someone else does. Petitioner reported that he was moving 21 feet fence poles, and while pulling one around a corner he had to extend his left arm overhead. He noted no obvious injury when he was pulling the pole, but his left shoulder was sore at the end of the day. Dr. Paletta had none of the medical records from the date of injury to 11/18/15 to review. Dr. Paletta did see a loss control medical slip dated 10/7/15 filled out by Dr. Wottowa, without any office note attached. He noted that it had a diagnosis of left shoulder strain, with an excellent prognosis. He noted that petitioner was given a self directed home exercise program. He also noted that the slip indicated that petitioner was returned to work without restrictions on 10/12/15.

Petitioner reported ongoing issues related to his left shoulder. He noted minimum to mild rest pain with more pain with use of the arm in the overhead position or when doing overhead activities. He also reported pain at night. Petitioner reported that he was retired and does outdoor activities such as hiking, biking, camping, kayaking and canoeing. He stated that he could not currently swim. He reported that when he tried to get off Naproxen he had increased soreness in his left shoulder. He stated that his two to three weeks flooring job had increased his problem, but not bad.

Following an examination and record review, which did not include any records prior to 11/18/15, or the MRI scan of the left shoulder, but did include the MRI report, Dr. Paletta's impression was chronic impingement syndrome with small underlying rotator cuff tear. He was of the opinion that this appeared consistent with a symptomatic small focal full thickness rotator cuff tear in the setting of a chronic impingement. He also noted an associated more extended partial thickness rotator cuff tear. He opined that the rotator cuff tear is not related to the 8/27/15 claim. He was of the opinion that the rotator cuff tear is attritional in nature based on the degree of supraspinatus muscle atrophy that was noted at the time of the MRI scan. He was of the opinion that the degree of muscle atrophy certainly suggested a more longstanding rotator cuff problem. Based on petitioner's history, Dr. Paletta was of the opinion that it is certainly possible that his work activities resulted in an aggravating factor, but his opinion is that it did not cause the rotator cuff tear. He saw no evidence of a distinct

injury. Despite his causal connection opinion, Dr. Paletta was of the opinion that if petitioner's symptoms continued an arthroscopy with subacromial decompression and probable rotator cuff tear repair would be reasonable and necessary. Dr. Paletta was of the opinion that kayaking, canoeing and swimming can cause increased symptoms related to the shoulder, and in an underlying condition of a rotator cuff tear and impingement. Dr. Paletta was of the opinion that petitioner had not yet reached maximum medical improvement.

On 7/20/16 petitioner underwent a pre-operative examination with Dr. Harney. Petitioner reported that he believed he injured his left shoulder in August of 2015 while working.

On 7/28/16 petitioner underwent a left shoulder arthroscopy with arthroscopic subacromial decompression and arthroscopic rotator cuff repair performed by Dr. Wottowa. The post-operative diagnosis was left shoulder pain with rotator cuff tear and subacromial impingement syndrome. Petitioner followed-up post-operatively with Dr. Wottowa on 8/10/16, 9/14/16, and 10/26/16. He also underwent a course of physical therapy at Memorial Industrial Rehabilitation from 9/8/15 through 10/17/16. When petitioner last followed up on 10/26/16 he had very little pain over his left shoulder. His range of motion and flexion was full. His external rotation was 60, and his supraspinatus strength was 4/5. Dr. Wottowa noted that he had gotten a note from petitioner's therapist demonstrating an excellent recovery for petitioner. Dr. Wottowa gave petitioner a full release. He allowed petitioner to resume kayaking. He also told petitioner that he should do strengthening indefinitely. Dr. Wottowa released petitioner from his care on an as needed basis.

On 10/26/16 petitioner completed an Oxford Shoulder Score. He reported his worst pain as moderate. He reported trouble dressing, getting in and out of the car, and household shopping. He stated that his pain was usually mild. He reported moderate difficulty drying himself after a shower. He also noted pain in his left shoulder every night.

On 1/29/18 the evidence deposition of Dr. Wottowa, an orthopedic surgeon, was taken on behalf of the petitioner. Dr. Wottowa was of the opinion that petitioner had no left shoulder complaints before the injury on 8/27/15. Dr. Wottowa opined that the surgery and all treatment he provided or directed for petitioner's left arm was reasonable and necessary. He opined that petitioner's mechanism of injury, as described by him, brought on his symptoms in his left arm and his need for surgery. He further opined that the type of lifting and incident described by petitioner would be consistent with an aggravation of an asymptomatic degenerative condition that caused petitioner to become symptomatic. He was of the opinion that petitioner's recovery bordered on exceptional when he saw him on 10/26/16. He opined that whatever symptoms petitioner has currently, he is at

maximum medical improvement. He was of the opinion that if petitioner has continued complaints of pain in his left shoulder they would be intermittent in nature and consistent with the type of injury he had.

On cross examination Dr. Wottowa confirmed that on 10/7/15 he released petitioner from his care on an as needed basis with no restrictions, but petitioner did return on 11/18/15. Dr. Wottowa was of the opinion that bone spur he found while operating on petitioner's left shoulder was not caused by the injury. Dr. Wottowa was of the opinion that the activities petitioner was engaged in on 8/27/15 apparently aggravated his symptomatology, and that aggravation persisted through surgery. Dr. Wottowa testified that the appointment on 9/2/15 was not a regularly scheduled followup appointment for his right arm. That was not until 10/7/15. He believed the appointment on 9/2/15 was a special appointment for petitioner's left shoulder complaints.

On cross examination Dr. Wottowa stated that he did not have specific dates for when petitioner kayaked or canoed. Dr. Wottowa was of the opinion that when someone is maneuvering a larger pole that increases the lever arm. He also noted that when he released petitioner from his care on 10/7/15 petitioner was still experiencing left shoulder problems and those continued until he had surgery. Dr. Wottowa was of the opinion that an aggravating event can cause a person with type 1-3 acromion to have symptoms. Dr. Wottowa was of the opinion that petitioner could have started having some problems with his left arm prior to 8/27/15 by using his left arm only per the restrictions on his right arm. He was of the opinion that this would be an explanation as to why petitioner was starting to have symptomatology.

On 4/3/18 Dr. Paletta drafted an addendum to his earlier report, after reviewing the MRI scan, additional records from Dr. Wottowa, and the accident report. Based on review of these records, Dr. Paletta indicated that his prior opinions remained unchanged. He did not believe the mechanism of injury would be typical for causing a rotator cuff tear, as there was no evidence of a distinct injury.

On 5/11/18 the evidence deposition of Dr. Paletta, an orthopedic surgeon, was taken on behalf of respondent. Dr. Paletta opined that the incident on 8/27/15 did not cause petitioner's left shoulder condition. He further opined that based on the mechanism of injury petitioner described, that injury could have increased petitioner's symptoms. He was of the opinion that petitioner had returned to baseline on 10/7/15 because Dr. Wottowa released him without restrictions. He was of the opinion that kayaking, canoeing and swimming can aggravate a left shoulder.

On cross examination Dr. Paletta testified that he did not review any medical records for petitioner prior to 8/27/15 that included any complaints of left shoulder pain. Dr. Paletta was of the opinion that petitioner's left rotator cuff tear predated the work accident. He noted that petitioner told him that he did not have symptoms

until after the accident. He noted that a trauma can cause someone to become symptomatic. He was of the opinion that if petitioner's symptoms were unabated from the precipitating event to the surgery then he would tie it to the precipitating event. Dr. Paletta had no idea the frequency of petitioner's kayaking, and agreed that petitioner never told him the kayaking made his symptoms worse. Dr. Paletta noted that petitioner told him that the only irritating factor to his shoulders was swimming. He was of the opinion that if the triggering event of petitioner's pain was the lifting on 8/27/15 and petitioner's pain continued from that date to surgery, that event necessitated his surgery. Dr. Paletta was of the opinion that activities below shoulder level tend not to likely aggravate the kind of condition that petitioner presented with.

On redirect Dr. Paletta testified that the medical record of 9/2/15 showed that petitioner had complaints of left shoulder symptoms for a couple months that had worsened when he moved the 21 foot pole. He believed that when Dr. Wottowa released him on 10/7/15 he was at the baseline prior to 8/27/15.

Petitioner testified that leading up to 8/27/15 he would kayak about three times a year on the river in Missouri. He was not kayaking in Florida. He testified that kayaking before the injury did not bother his shoulder.

Currently, petitioner still has popping if he extends his left arm outward or lifts it overhead. He stated that he gets fatigued with moderate use to the side or overhead. Petitioner testified that he cannot lift his left arm as high behind his back as he can his right arm. The difference appeared to be a difference of a few inches in the thoracic area.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

It is unrebutted that prior to 8/27/15 petitioner had sustained an unrelated injury to his right shoulder for which he was on light duty restrictions on 8/27/15, the date of petitioner's injury to his left shoulder. Petitioner had told Dr. Wottowa on 9/2/15 that his left shoulder had been bothering him for a couple months, but that he noticed increased discomfort over the anterior aspect while moving a 21 foot pole on 8/27/15. Prior to 8/27/15 petitioner had been working under light duty restrictions for his right shoulder injury. Although petitioner experienced some left shoulder symptoms prior to 8/27/15 it was not until after he moved the 21 foot pole on 8/27/15 that petitioner's left shoulder symptoms required medical attention.

Although petitioner did not have a regularly scheduled follow-up for his right shoulder with Dr. Wottowa on 9/2/15, petitioner presented to Dr. Wottowa's physician's assistant Purves on 9/2/15 with left shoulder complaints. Petitioner gave a consistent history of the injury and his left shoulder complaints prior to and after the injury on 8/27/15. Petitioner reported that he still had pain over the anterior aspect, and more pain laterally

over the shoulder. He noted that most of his pain occurred with activity away from his body, overhead, and at night. Petitioner had never made any such complaints regarding his left shoulder prior to 9/2/15. Purves was of the opinion that although petitioner had some irritation in his left shoulder for a while, this pain was made worse with the injury at work on 8/27/15.

Petitioner retired on 9/11/15, and thereafter worked for 2 weeks doing carpentry cleanup and prep work for Ricardi Floor Company. Petitioner testified that none of this work involved any overhead work. Based on Dr. Paletta's opinions that activities below shoulder level tend not to aggravate the kind of condition petitioner presented with, the arbitrator finds the petitioner's 2 weeks of work with Ricardi Floor Company did not aggravate the condition he presented with to Purves on 9/2/15.

Following his visit to Dr. Wottowa's office on 9/2/15 petitioner next returned on 10/7/15. At that time petitioner stated that he only had received 6 days of relief following the injection into his left shoulder on 9/2/15. On this date, Dr. Wottowa instructed petitioner to perform more supraspinatus strengthening for his left arm. Dr. Wottowa released petitioner to full duty work on 10/12/15, and released him on an as needed basis with respect to his right arm. He also placed petitioner at MMI with respect to his right arm.

Petitioner returned to Dr. Wottowa on 11/8/15 with ongoing left shoulder complaints. Petitioner continued with these complaints up to his surgery on 7/26/16.

The threshold issue here is whether or not petitioner's current condition of ill-being as it relates to his left shoulder is causally related to the injury on 8/27/15. Opinions on this issue were offered by Dr. Wottowa and Dr. Paletta.

Dr. Wottowa was of the opinion that the activities that petitioner was engaged in on 8/27/15 aggravated petitioner's preexisting left shoulder symptomatology, and that aggravation persisted through surgery. Dr. Wottowa even stated that when petitioner presented on 9/2/15 that was not a regularly scheduled visit for his right shoulder followup, but was rather a special visit for his left shoulder condition following the injury on 8/27/15.

Dr. Paletta opined that the incident on 8/27/15 did not cause petitioner's left shoulder condition, but that injury could have increased petitioner's symptoms. But Dr. Paletta was of the opinion that any aggravation of petitioner's symptoms had returned to baseline on 10/7/15. The arbitrator does not find this opinion supported by the credible evidence. On 10/7/15 petitioner reported to Dr. Wottowa that the benefits of the injection on

9/2/15 into his left shoulder had only lasted for 6 days. Based on this report, the arbitrator reasonably infers that after those 6 days passed, the symptoms petitioner reported on 8/27/15 returned and remained. Additionally, the arbitrator finds that on 10/7/15 Dr. Wottowa instructed petitioner to do more supraspinatus strengthening exercises for his left arm. Dr. Wottowa also noted in his deposition that when he released petitioner from his care on 10/7/15 petitioner was still experiencing left shoulder problems and those problems continued until he underwent his left shoulder surgery. For this reason, the arbitrator finds the petitioner was not back to "baseline" on 10/7/15 as Dr. Paletta believed. For this reason, the arbitrator gives little weight to Dr. Paletta's opinion that petitioner had a temporary aggravation to his left shoulder as a result of the injury on 8/27/15, but that he had returned to "baseline" on 10/7/15. The arbitrator finds the petitioner's left shoulder symptoms following the accident on 8/27/15 were relieved for 6 days following the injection on 9/2/15, and then continued until the date of surgery.

The next issue the experts discussed was the impact petitioner's kayaking, canoeing, and swimming had on his left shoulder and the causal connection between the injury on 8/27/15 and petitioner's current condition of ill-being as it relates to his left shoulder. Dr. Paletta was of the opinion that petitioner's kayaking, canoeing and swimming could aggravate his shoulder. However, he admitted that he did not know when petitioner actually kayaked, canoed or swam after his injury on 8/27/15. Additionally, he noted that petitioner indicated that only swimming would irritate his shoulders. He did not report that kayaking or canoeing would aggravate his shoulders. However, the arbitrator finds no medical records prior to 8/27/15 that show petitioner sought any treatment for his left shoulder, for any reason, be it an injury, kayaking, canoeing, or swimming.

Dr. Wottowa admitted that if petitioner's symptoms were unabated from the precipitating event to the surgery, he would tie it to the precipitating event. Given that the symptoms petitioner presented to Purves on 9/2/15 as a result of the injury on 8/27/15, did not abate, other than for the 6 days after the injection, until the date of surgery, the arbitrator finds the petitioner's symptoms are tied to the injury on 8/27/15. Dr. Paletta was also of the opinion that if the precipitating event was the injury on 8/27/15, and petitioner's pain continued from that date to surgery, which the credible evidence supports in this case, then the injury on 8/27/15 necessitated the surgery. Therefore, the arbitrator fins the injury of 8/27/15 necessitated the surgery.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner's symptoms in his left shoulder from 9/2/15 through the surgery persisted, despite a 6 day relief following an injection and other conservative modalities, through petitioner's surgery on 7/28/16. For this reason, the arbitrator adopts the opinions of both Dr. Wottowa and Dr. Paletta that if petitioner's left shoulder symptoms persisted from the date

of injury to surgery, which the credible record shows they did, then there would be a causal connection between the petitioner's current condition of ill-being as it relates to his left shoulder and the injury on 8/27/15.

The arbitrator finds a causal connection between the petitioner's current condition of ill-being as it relates to his left shoulder and the injury on 8/27/15. The arbitrator further finds that the injury on 8/27/15 did not cause the pathology in petitioner's left shoulder, but certainly aggravated the preexisting condition in petitioner's left shoulder.

J. WERE 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 a causal connection between the petitioner's current condition of ill-being as it relates to his left shoulder and the injury on 8/27/15, the arbitrator finds all treatment petitioner received for his left shoulder from 8/27/15 through 10/26/16 was reasonable and necessary to cure or relieve petitioner from the effects of his injury on 8/27/15.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

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 petitioner was a carpenter foreman at the time of the injury. After the injury petitioner reported difficulty performing any overhead work, or work out in front of him. However, on 9/11/15 petitioner retired and removed himself from the workforce. The Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 58 years old at the time of the accident. When petitioner was released from care by Dr. Wottowa on 10/26/16 he reported very little pain in his left shoulder. His range of motion and flexion were full. His external rotation was 60, and his supraspinatus strength was 4/5. At trial, petitioner reported that he still has popping if he extends his left arm outward or lifts it overhead. He stated that he gets fatigues with moderate use of the left arm to the side or overhead. Petitioner has difficulty reaching his left arm behind his back as far as he can his right arm. Although petitioner is retired he will continue to experience pain in his left arm with certain activities. Being 58 years old, petitioner may experience these problems for the remainder of his life. Therefore, the arbitrator gives greater weight to this factor.

19IWCC0214

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the arbitrator notes that the petitioner offered no evidence regarding his future earnings capacity. The arbitrator further notes that petitioner retired on 9/11/15, and took himself out of the labor market. Therefore, the arbitrator 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 finds petitioner was discharged from care by Dr. Wottowa on 10/26/16. At that time he had very little pain over his left shoulder. His range of motion and flexion was full. His external rotation was 60, and his supraspinatus strength was 4/5. Dr. Wottowa noted that he had gotten a note from petitioner's therapist demonstrating an excellent recovery for petitioner. Dr. Wottowa gave petitioner a full release. He allowed petitioner to resume kayaking. He also told petitioner that he should do strengthening indefinitely. Dr. Wottowa released petitioner from his care on an as needed basis.

On 10/26/16 petitioner also completed an Oxford Shoulder Score. He reported his worst pain as moderate. He reported trouble dressing, getting in and out of the car, and household shopping. He stated that his pain was usually mild. He reported moderate difficulty drying himself after a shower. He also noted pain in his left shoulder every night.

At trial, petitioner reported that he still has popping if he extends his left arm outward or lifts it overhead. He stated that he gets fatigues with moderate use of the left arm to the side or overhead. Petitioner has difficulty reaching his left arm behind his back as far as he can his right arm.

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 a permanent partial disability to the extent of 10% loss of use of his person as a whole pursuant to Section 8(d)2 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Naughton,
Petitioner,

vs. No: 18 WC 04024

19IWCC0215

Michael's Cartage,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, accident, temporary total disability, medical expenses 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 on June 14, 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 shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

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

DATED: MAY 1 - 2019

Marc Parker

o-04/18/19
mp-sj
68

Deborah L. Simpson

Barbara N. Flores

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

NAUGHTON, JAMES
Employee/Petitioner

Case# **18WC004024**
17WC013408
17WC016570

19IWCC0215

MICHAEL'S CARTAGE
Employer/Respondent

On 6/14/2018, 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 2.07% 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:

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

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

19IWCC0215

- [ ] 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)

James Naughton
Employee/Petitioner

Case # 18 WC 4024

v.

Consolidated cases: 17 WC 13408 & 17 WC 16570

Michael's Cartage
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 **Gregory Dollison**, Arbitrator of the Commission, in the city of **Kankakee, Illinois**, on **April 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

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

K. [ ] Is Petitioner entitled to any prospective medical care?

L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD

M. [ ] Should penalties or fees be imposed upon Respondent?

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On the date of accident, **July 22, 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 **$47,301.28**; the average weekly wage was **$909.64**.

On the date of accident, Petitioner was **44** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$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

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

6/13/18
Date

ICArbDec19(b)

JUN 14 2018

FINDINGS OF FACT:

James Naughton (hereinafter "Petitioner") injured his bilateral shoulders and cervical spine on March 25, 2009. He received medical treatment from Meridian Medical Associates from March 25, 2009 through April 7, 2009. (Respondent's Exhibit #6). Petitioner then received medical treatment from Dr. Kevin W. Luke and Dr. Anis O. Mekhail at Parkview Orthopaedic Group, S.C. Dr. Luke provided Petitioner with a left shoulder injection on May 8, 2009 and specifically opined that he felt that Petitioner's symptoms were related to his neck. Dr. Mekhail treated Petitioner's cervical spine symptoms and referred Petitioner for cervical epidural steroid injections on July 29, 2009, August 12, 2009 and August 26, 2009. On January 21, 2010, Dr. Mekhail released Petitioner to return to full duty work and directed him to return as needed. (Respondent's Exhibit #4).

From 2010 through March 23, 2016, Petitioner did not have any injuries to either of his shoulders. In addition, Petitioner did not receive any medical treatment for either of his shoulders from early in 2010 through March 23, 2016. Lastly, Petitioner worked full duty as a truck driver and did not miss any time from work from early in 2010 through March 23, 2016. Petitioner had never injured his lower back prior to March 24, 2016 and had never received medical care of any kind for his lower back prior to March 24, 2016. In addition, Petitioner had never missed any time from work due to lower back problems prior to March 24, 2016.

Petitioner testified that he had worked for Michael's Cartage (hereinafter "Respondent") as a truck driver for four years. Petitioner testified that he is a regional truck driver and traveled between the tri-states. Petitioner testified that his hours varied between 8 to 14 hours depending on the work. Petitioner testified that he worked nights and usually began his routes between 2 pm and 6 pm. Petitioner testified that on March 24, 2016, he was working for Respondent when he fell off the catwalk of a semi-tractor trailer. Petitioner stated he fell approximately three (3) to four (4) feet, landing on the ground below with outstretched hands. Petitioner Petitioner testified that he immediately experienced pain and soreness in both of his palms, and his left and right shoulders. That same evening, Petitioner reported his work accident via telephone to his supervisor, Tawfic Ibrahim, who is the night dispatcher for Respondent. Petitioner stated he continued to work and finished his work shift for Respondent.

Petitioner testified that over the ensuing two weeks, he experienced gradual increase in the pain on the outside of his shoulders, left worse than right. The pain also began to affect his sleep pattern. Petitioner testified that his symptoms in 2009 and 2010 started in his neck and radiated into his arms. After his accident on March 24, 2016, his symptoms were located on the outside of his shoulders. Petitioner testified that he advised Mr. Ibrahim of his symptoms and that he was going to seek medical treatment. Petitioner indicated Mr. Ibrahim directed him to go to the company medical clinic, Concentra.

Records submitted show Petitioner presented at Concentra on April 8, 2016 and was first examined by Dr. Al-Saraf. The history provided by Petitioner states, "This is the result of a fall [and] from back of truck to ground, landed on hands, felt pain at lt shoulder, milder pain at rt shoulder and felt achy. Occurred while at work." (Petitioner's Exhibit #2, p.4) Dr. Abbas examined Petitioner's left shoulder and found tenderness in the AC joint, distal clavicle and deltoid and painful range of motion with forward flexion, extension abduction, internal rotation and external rotation. (Petitioner's Exhibit #2, p. 10) Dr. Abbas diagnosed Petitioner with a left shoulder strain, directed him to begin a physical therapy program, prescribed Ibuprofen, and directed him to return to modified work with occasional lifting limited to 10 pounds, occasional pushing and pulling limited to 20 pounds and no reaching above shoulder level with the left arm. (Petitioner's Exhibit #2, p. 11)

Petitioner began the physical therapy program that was recommended by Dr. Abbas at Concentra on April 8, 2016. (Petitioner's Exhibit #2, p. 12) In addition, Petitioner continued to work for Respondent after April 8, 2016. On April 11, 2016, Petitioner returned to Dr. Abbas. According to the records, Petitioner reported that his left shoulder was improving with better range of motion. Petitioner reported mild soreness in the right shoulder occasionally. According to the doctor, Petitioner was "not worried about it". The examination findings continued to reveal tenderness at the deltoid as well as painful range of motion with forward flexion, extension abduction, internal rotation and external rotation. The doctor diagnosed Petitioner with a left shoulder strain and directed him to continue his medication, physical therapy, and work restrictions. (Petitioner's Exhibit #2, pp. 23-25)

On April 18, 2016, Petitioner returned to Concentra and was examined by Nurse Practitioner, Jan Pitts. The records note that Petitioner's left shoulder was improving. Petitioner reported mild soreness in the right shoulder. Petitioner was again diagnosed with a left shoulder strain. Physical therapy and work restrictions were continued. (Petitioner's Exhibit #2, pp. 46-48)

Petitioner returned to Concetra on April 25, 2016, at which time he was examined by Dr. Eric Griffin. It was noted that Petitioner was still experiencing pain in his left shoulder at night and experienced painful range of motion with forward flexion, abduction, internal rotation and external rotation. Dr. Griffin diagnosed Petitioner with a left shoulder strain and directed him to continue his physical therapy program and medication. In addition, Dr. Griffin released Petitioner to return to modified work with frequent lifting limited to 20 pounds and frequent pushing/pulling limited to 40 pounds. (Petitioner's Exhibit #2, pp. 75-77) On May 2, 2016, Petitioner was examined by Laura K. White, Physician's Assistant at Concentra. Petitioner reported that although his symptoms were improving, he still experienced left shoulder pain. Petitioner described the symptoms as intermittent with pain levels at 5 out of 10. Aggravating factors were arm elevation, overhead use and lifting. Petitioner also reported right arm pain but the left was worse. Ms. White diagnosed shoulder strain, directed Petitioner to continue his physical therapy program and his modified work restrictions. Ms. White also prescribed Cyclobenzaprine and Naproxen. (Petitioner's Exhibit #2, pp. 97-99)

On May 9, 2016, Petitioner was again examined by Ms. White. Ms. White noted that Petitioner complained of pain in the anterior shoulders bilaterally and in the right lateral shoulder. Ms. White also noted that Petitioner experienced increased pain with heavy lifting and repeated activity. Ms. White diagnosed left and right shoulder strains. She directed him to continue his physical therapy program and medication. In addition, Ms. White recommended Petitioner obtain MRIs of his left and right shoulder and referred Petitioner to an orthopedic specialist. (Petitioner's Exhibit #2, pp. 120-123)

On May 16, 2016, Petitioner completed MRIs of his left and right shoulders at Accelerated Open MRI and Imaging. According to the radiologist's report, the right shoulder MRI revealed AC joint arthropathy with mild subacromial impingement of the rotator cuff. Small cystic changes were noted at the posterolateral aspect of the humeral head. There were also findings of supraspinatus tendinosis without evidence of tear. The remainder of the rotator cuff was normal. Lastly, there was a possible small tear at the anterior margin of the glenoid labrum. The MRI of the left shoulder was interpreted to reveal AC joint arthropathy causing mild subacromial impingement of the rotator cuff. There were small cystic changes of the posterolateral aspect of the humeral head. Supraspinatus tendinosis without evidence of tear was also indicated. The remainder of the rotator cuff was normal. (Petitioner's Exhibit #3)

Petitioner returned to Concentra on May 17, and was again examined by Ms. White. Petitioner reported bilateral shoulder pain, with the left should pain being worse. It was noted that he had constant residual pain but experienced increased pain with heavy lifting and repeated activity. Ms. White reviewed the MRIs of Petitioner's shoulders noting supraspinatus tendinosis and a mild anterior labral tear in Petitioner's right shoulder and supraspinatus tendinosis in Petitioner's left shoulder. Petitioner was diagnosed with right and left

shoulder strains and was directed to continue his physical therapy and to continue modified work. Additionally, Petitioner was directed to have his care assumed by a specialist. (Petitioner's Exhibit #2, pp. 140-142)

On May 23, 2016, Petitioner was examined by Dr. David Garelick. The doctor documented a history of accident at work. Petitioner complained of bilateral shoulder pain subsequent to a fall onto his outstretched hands. Petitioner reported that his right side was getting better in therapy but they both ached all the time. The notes indicate Petitioner was working regular duty and that Petitioner complained of fatigue at the end of the work week. Dr. Garelick examined both shoulders. The exam findings revealed more tenderness at the AC joint on the left than the right. Range of motion was noted to be symmetric. Petitioner had a positive Hawkins test on the left and equivocal on the right. In the supine position, there was some tenderness over the AC joint. Dr. Garelick reviewed both MRI studies. Dr. Garelick opined that Petitioner had a fair amount of degenerative changes in the AC joint on the left shoulder. Dr. Garelick indicated the remainder of the studies for both shoulders were unremarkable. Dr. Garelick diagnosed Petitioner with a bilateral shoulder sprain. The doctor felt there was no indication for surgical intervention or injections at that time. Dr. Garelick recommended Petitioner return to therapy and released him to full duty work. (Petitioner's Exhibit #2, pp. 159-161)

Petitioner returned to Dr. Garelick on June 27, 2016. Petitioner reported that his right shoulder was much better. He still reported slight pain on the lateral aspect of his left shoulder. Range of motion was relatively symmetrical with full rotator cuff strength. There was some residual pain noted with Neer and Hawkins testing on the left side. Dr. Garelick diagnosed resolved right shoulder pain contusion and left shoulder contusion with mild residual impingement syndrome. Dr. Garelick recommended no intervention for the right shoulder. Dr. Garelick recommended and completed an injection to the left shoulder. Petitioner was returned to work regular duty. Dr. Garelick also advised Petitioner to return in one month for follow up. (Petitioner's Exhibit #2, p. 192)

Petitioner testified that on July 22, 2016, he was working for Respondent. At approximately 9:30 p.m., he was cranking the "dolly legs" of a semi-tractor trailer when he felt a burning sensation in his lower back. Petitioner testified that the crank was not operating properly and, as a result, he was required to apply more force to the crank than was usually required. Petitioner reported his work injury to Respondent's operations manager Joe Spina and finished his work shift.

Petitioner was not scheduled to work on Saturday, July 23, 2016, or Sunday, July 24, 2016. Petitioner stated that because his lower back symptoms continued over the weekend, he returned to Concentra on Monday, July 25, 2016. Petitioner was examined by Ms. White. The history provided by Petitioner states, "Patient states he was cranking the damaged gear box when he started to feel pain in his lower back. Injury occurred at 10:00 p.m." The date of accident was recorded as "07/22/16". Petitioner reported bilateral low back pain described as burning in nature. Petitioner also reported radiating pain to the buttocks. Examination findings revealed tenderness in the lumbar spine. Petitioner exhibited a negative straight leg raise test. Petitioner also had some decreased extension of the lumbar spine with range of motion testing. Ms. White diagnosed Petitioner with back pain and a strain of the lumbar region and prescribed Cyclobenzaprine and Ibuprofen. Petitioner was also directed to treat his injury with ice 4 times a day. Petitioner was advised to begin physical therapy and given work restrictions of occasional lifting up to 20 pounds and pushing/pulling up to 20 pounds. Petitioner was also advised not drive a company vehicle due to functional limitations. (Petitioner's Exhibit #2, pp. 194-197)

That same day, July 25, 2016, Petitioner was also examined by Dr. Garelick for the final time. Petitioner reported that he believed his left shoulder was doing better post-injection. He still had some discomfort at night. Petitioner reported that although his right shoulder was "doing pretty good," both shoulders continued to bother him everyday. Examination findings revealed symmetric range of motion. Dr. Garelick noted no pain with resisted supraspinatus testing on the left shoulder. Petitioner exhibited a mildly positive Neer and Hawkins sign on the left. Dr. Garelick diagnosed resolving impingement syndrome, left still somewhat more marked than

right. Dr. Garelick placed Petitioner at maximum medical improvement and encouraged him to continue to work on his home exercises. Petitioner was released to return to work regular duty. (Petitioner's Exhibit #2, p. 207) Petitioner testified that although he was released full duty, he continued with shoulder symptoms, left worse than right.

On July 27, 2016, Petitioner was again examined by Ms. White for his lumbar spine. Petitioner reported that he was getting better. Petitioner requested that he be cleared to return to work regular duty. Petitioner was diagnosed with low back pain and a lumbar strain. Petitioner was released to return to work regular duty with the caveat of avoiding any cranking of broken dolly legs or opening corroded doors. Petitioner was also directed to participate in a physical therapy program 3 times per week for 2 weeks and to continue full duty work. (Petitioner's Exhibit #2, pp. 210-212)

Petitioner returned to Concentra again on August 3, 2016 and was examined by Ms. White. Petitioner's symptoms were improving. His pain levels were 3/10. Petitioner was directed to begin taking Naproxen and to continue full duty work. (Petitioner's Exhibit #2, pp. 217-219). Petitioner was last seen at Concentra for his lower back pain on August 11, 2016. Petitioner reported back stiffness but no pain. Petitioner denied any lower extremity symptoms. Petitioner reported his current level of pain as a 1 out of 10. The records noted that Petitioner was doing "overall well". Examination findings were normal. Petitioner was diagnosed with back pain and a lumbar strain. Petitioner was released from care and placed at maximum medical improvement for his back injury. (Petitioner's Exhibit #2, pp. 224-225)

Petitioner testified that he continued to work for Respondent. He stated that he continued to experience ongoing bilateral shoulder pain with greater symptoms on the left than the right. As a result of same, he elected to obtain a second opinion from Dr. Daniel Troy on September 16, 2016. Records submitted show Petitioner reported that he had been undergoing treatment since March 24, 2016 for bilateral shoulder pain. Petitioner reported that both of his shoulders were better but not 100%. He was still having difficulty with both. Also noted was that Petitioner had tried physical therapy and was performing a home exercise program. On examination, Petitioner had full flexion and abduction with pain in the left shoulder and slight pain in the right. Petitioner exhibited a positive Hawkins test and negative Neer on the left. Petitioner had no pain in the AC joint on the left. He had slight pain over his biceps tendon but no pain bilaterally. Petitioner had minimal symptoms in the right shoulder with mild to moderate Neer impingement. He also had minimal Hawkins. Bilateral shoulder x-rays were obtained revealing moderate degenerative changes of the bilateral AC joints. Dr. Troy reviewed the prior MRI studies of the left and right shoulder. Dr. Troy diagnosed bilateral shoulder impingement, left greater than right. Dr. Troy performed a repeat cortisone injection to Petitioner's left shoulder, this time with ultrasound guidance. After the injection, Dr. Troy prescribed Voltaren Gel, returned Petitioner to full duty work and directed him to return in 6 weeks. (Petitioner's Exhibit #4) Petitioner testified that he experienced relief of his left shoulder symptoms following the injection for approximately 2 weeks, and then the symptoms returned.

Petitioner testified that he continued to work for Respondent. He returned to see Dr. Troy on October 28, 2016. Petitioner reported that the injection to the left shoulder helped for about two weeks. Petitioner also reported symptoms in the right shoulder. Petitioner reported overall frustration. Petitioner complained of re-aggravation of his shoulder pain with truck driving. Dr. Troy noted that the examination findings were unchanged from the prior visit. The doctor noted that Petitioner continued with positive signs for bilateral impingement syndrome and bilateral positive Hawkins' sign. Dr. Troy diagnosed bilateral shoulder impingement, left greater than right and provided him with a right shoulder cortisone injection with ultrasound guidance. Dr. Troy directed Petitioner to continue full duty work and to return in 3 to 4 months. (Petitioner's Exhibit #4) Petitioner testified that he experienced relief of his right shoulder symptoms for approximately 2 weeks and then his symptoms returned.

Petitioner testified that he continued to work for Respondent while experiencing continual symptoms of soreness on the outside portion of both shoulders. On March 22, 2017, Petitioner returned to Dr. Troy. Petitioner continued to report difficulty with the left and right shoulder. Examination findings revealed positive impingement signs on the left greater than right. Dr. Troy again reviewed the prior MRI studies. Dr. Troy continued to diagnose bilateral shoulder impingement, left being more symptomatic than right. Dr. Troy recommended Petitioner proceed with diagnostic left shoulder arthroscopy and subacromial decompression. (Petitioner's Exhibit #4)

Petitioner testified that on May 12, 2017, he was working for Respondent in the truck depot parking area. As Petitioner was walking through the parking area, he stepped in a depression in a gravel surface, causing him to lose his balance. When Petitioner lost his balance, he struck his left shoulder on the chassis of a semi-tractor trailer. Petitioner stated he immediately felt severe pain on the outside of his left shoulder. Because of his symptoms of pain, Petitioner did not finish his work shift on May 12, 2017. Petitioner was not scheduled to work on Saturday, May 13, 2017, or Sunday, May 14, 2017. On Monday, May 15, 2017, Petitioner's symptoms remained. As a result, he reported his work injury to Joe Spina, the operations manager for Respondent.

On May 16, 2017, Petitioner retuned to Dr. Troy. Petitioner provided a history that states, "…he reports that Friday, 5/12/2017, at work he was walking and not paying attention. He subsequently ended up walking into a steel beam directly over the anterior aspect of his shoulder." Examination findings revealed ecchymosis over the anterior aspect of the left humerus. There was mild tenderness to palpation over the left AC joint. Petitioner had a positive Neer's and Hawkin's sign bilaterally. Petitioner had full strength in both arms. X-rays of the left shoulder demonstrated a mild amount of GH arthritis and a mild amount of arthritic changes in the AC joint. There were no other abnormalities seen on the imaging studies. Dr. Troy diagnosed bilateral shoulder pain and impingement syndrome. Dr. Troy prescribed Tramdol due to Petitioner's moderate to severe pain. Petitioner was advised that he should not operate a truck while taking the medications. Dr. Troy also restricted Petitioner to no lifting, carrying, pushing or pulling greater than 20 pounds. Dr. Troy continued to recommend a diagnostic left shoulder arthroscopy. (Petitioner's Exhibit #4)

Petitioner testified that after his May 16, 2017 appointment with Dr. Troy, he requested light duty work from Respondent's operations manager, Joe Spina. Petitioner stated that Respondent has not offered light duty work since May 16, 2017.

At the request of Respondent, Petitioner underwent a Section 12 examination with Dr. Joseph T. Monaco on May 23, 2017. In his report dated same, Dr. Monaco noted that he obtained a history of work incidents on March 24, 2016 and July 22, 2016. In addition to performing an examination, the doctor reviewed Petitioner's medical records and diagnostic studies. Upon examination, Dr. Monaco noted bruising over the anterolateral aspect of the left shoulder. O'Brien test was negative bilaterally. There was positive Hawkins' and Empty Can test bilaterally. Cross body abduction at +2 on the left and negative on the right. Dr. Monaco diagnosed 1.) resolved left and right shoulder strains; and 2.) degenerative changes of the acromioclavicular joints with impingement with both shoulders. Dr. Monaco opined that the bilateral shoulder strains suffered by Petitioner were related to his work accident on March 24, 2016, but that the strains resolved in a "couple of weeks." Dr. Monaco also opined that Petitioner suffered a temporary exacerbation of pre-existing impingement syndrome which returned to baseline within four (4) months after Petitioner's work injury on March 24, 2016. Dr. Monaco found that Petitioner had reached maximum medical improvement on July 25, 2016 when released by Dr. Garelick. He specifically opined the right shoulder condition had resolved by April 18, 2016 and the left had resolved by July 25, 2016. Dr. Monaco opined that Petitioner's conditions of ill-being at the time of his evaluation were unrelated to the work incident and any further treatment was not related to the March 26, 2016 accident. Dr. Monaco opined that as a result of his March 24, 2016 work injury, Petitioner was cable of returning to full duty work. Lastly, Dr. Monaco opined that treatment through the date of his evaluation was

reasonable and necessary. Dr. Monaco also performed an AMA Impairment Rating. (Respondent's Exhibit #2)

On June 13, 2017, Petitioner returned to Dr. Troy. Dr. Troy diagnoses remained the same and he continued his surgical recommendation. At this visit, Dr. Troy also took Petitioner off work (Petitioner's Exhibit #4). When Petitioner returned to Dr. Troy on June 30, 2017, the doctor noted Petitioner's continued complaints of pain in the left shoulder. Petitioner continued to exhibit positive results from Neer's and Hawkins' tests bilaterally. The doctor reviewed the report of Dr. Monaco dated May 23, 2017, noting Dr. Monaco felt Petitioner had achieved maximum medical improvement. Dr. Troy directed Petitioner to remain off work and to return in 4 to 6 weeks. (Petitioner's Exhibit #4) On August 16, 2017, Dr. Troy noted Petitioner continued to exhibit positive Neer's and positive Hawkins' tests for impingement. The doctor directed Petitioner to continue using Tramadol for his symptoms. On August 21, 2017, Dr. Troy completed a note confirming that Petitioner was to remain off work. (Petitioner's Exhibit #4)

At Respondent's request, Dr. Monaco authored an addendum report on September 21, 2017. In his report, Dr. Monaco noted he reviewed medical records for treatment received by Petitioner in 2009 as well as additional records from Dr. Troy since the doctor's last report in May of 2017. Dr. Monaco stated that his opinion remained the same, i.e., Petitioner sustained resolved bilateral shoulder strains as a result of the accident sustained on March 24, 2016. With respect to the May 12, 2017 accident, Dr. Monaco opined Petitioner sustained a contusion to the soft tissue of the left shoulder. The doctor opined that Petitioner's work injury on May 12, 2017 did not change his opinion regarding causation in any way. The doctor felt the May 2017 injury was nothing more than a minor soft tissue contusion of the left upper arm and shoulder area with no acute injury or internal derangement to the left shoulder joint. (Respondent's Exhibit #3)

Dr. Monaco opined that the degenerative changes of the AC joint of both shoulders pre-existed and were not caused by either work-related incident. Dr. Monaco stated the additional medical records show similar complaints and findings involving the left shoulder in 2009. He noted the diagnostic studies at that time showed findings similar to the MRI scans done in 2016. The doctor provided that Petitioner's symptoms in 2009 were consistent with temporary exacerbation of the pre-existing degenerative changes of the AC joint of the left shoulder with subsequent return to baseline. He opined that the work-related incidents of March 24, 2016 and May 12, 2017 resulted in temporary exacerbation of the pre-existing degenerative changes of the left shoulder AC joint. Dr. Monaco opined that Petitioner was at maximum medical improvement for both his March 24, 2016 accident and his May 12, 2017 accident. (Respondent's Exhibit #3)

Petitioner last saw Dr. Troy on October 14, 2017. The doctor noted Petitioner's examination remained unchanged, i.e., Petitioner exhibited positive Neer's and positive Hawkin's impingement tests, left "much more significant that right." Dr. Troy's diagnosis at that time was impingement syndrome of the left and right shoulder. The doctor repeated his recommendation that Petitioner proceed with diagnostic left shoulder arthroscopy. Dr. Troy also directed Petitioner to remain off work and advised Petitioner to return after obtaining approval for the proposed procedure. (Petitioner's Exhibit #4) Petitioner testified that he would like to proceed with the surgery recommended by Dr. Troy.

Petitioner testified that other than the work accidents on March 24, 2016 and May 12, 2017, he has not suffered any new injuries to his left or right shoulders. In addition, Petitioner has not suffered any injuries to his lower back since July 22, 2016.

Petitioner testified that prior to the March 24, 2016 accident, he sustained work-related injuries to his left shoulder and neck in February and March of 2009. Petitioner stated he was not an employee of Respondent at the time of his 2009 accidents. Petitioner testified that he received medical treatment at Parkview Orthopedics and Meridian Medical Associates. Petitioner testified that the symptoms he experienced following his 2009

accidents began in his neck and consisted of shooting pains down his arms. Petitioner testified that the shooting pains down his left arm were worse than his right arm. Petitioner testified that he did not receive any further medical treatment for his shoulders from 2010 up to the March 24, 2016 accident. Petitioner further testified that he did not lose any time from work subsequent to 2010 but before the March 24, 2016 accident. Petitioner denied any further injuries to his shoulders during that same time period.

Mr. Joseph Spina was called to testify by Respondent. Mr. Spina testified that he has worked for Respondent for approximately seven years as the safety director. Mr. Spina testified that he was in charge of Department of Transportation compliance as well as any workplace injuries. Mr. Spina testified that he would speak with the dispatchers, including Mr. Ibrahim, on a daily basis. Mr. Spina testified that he did not learn of Petitioner's first work accident of March 24, 2016 until April 8, 2016. Mr. Spina testified that Petitioner continued to work full duty up until the date he was placed on light duty. Mr. Spina testified that he was never made aware of any of Petitioner's ongoing problems while driving a truck or safety concerns that Petitioner testified to on direct examination. Mr. Spina stated that he could not recall if Petitioner requested light duty work. Mr. Spina also indicated that Respondent does not have light duty work for truck drivers.

Dr. Troy testified via deposition in this matter on December 4, 2017. (Petitioner's Exhibit #5) Dr. Troy testified that he first saw Petitioner on September 16, 2016. At that time Petitioner had bilateral shoulder pain complaints, left worse than right. Dr. Troy stated that Petitioner's rotation to his left was slightly diminished compared to the right. Both shoulders had positive impingement symptomatology. He had slight pain over the anterior aspect to the shoulder in the region of the biceps tendon. His right shoulder was symptomatic, but minimal. He had mild to moderate Neer impingement symptoms and minimal Hoffman's. Dr. Troy stated he assessed Petitioner with bilateral shoulder impingement, left greater than right. Dr. Troy recommended therapy, suggested and performed a second steroid injection to the left shoulder. The doctor testified that he later performed an injection to Petitioner's right shoulder. The doctor stated Petitioner only received short-term relief from both injections stating Petitioner kept having rebound symptomatology. (Petitioner's Exhibit #5, pp. 10-14)

Dr. Troy testified that he ultimately recommended surgical intervention of the left shoulder. Dr. Troy explained that Petitioner had been having symptoms since March of 2016. Dr. Troy stated, "…It's been a year. He's already did therapy. He's received two steroid injections. He's been using anti-inflammatories…So there is nothing further I can offer him except continue to live with the symptoms or to go in and surgically remove the inflamed bursa… which is part of the impingement process…" (Petitioner's Exhibit #5, pp. 15,16)

With respect to the May 12, 2017 incident, Dr. Troy testified that Petitioner sustained a left shoulder contusion. Dr. Troy did not believe that this second injury changed Petitioner's impingement diagnosis in any significant way. (Petitioner's Exhibit #5, p. 18)

Dr. Troy testified that he kept Petitioner off work following the June 30, 2017 visit. The doctor provided that Petitioner's symptoms were increasing and he reported being uncomfortable while driving. (Petitioner's Exhibit #5, p. 19) Dr. Troy testified that he continued to diagnose Petitioner with bilateral shoulder impingement syndrome left greater than right. Dr. Troy testified that Petitioner required a diagnostic left shoulder arthroscopy. (Petitioner's Exhibit #5, p. 20)

Dr. Troy offered an opinion on causal connection. Dr. Troy testified that he believed the impingement syndrome was related to the March 24, 2016 work accident. Dr. Troy based this opinion on Petitioner's reports that he became symptomatic in shoulders after the accident of March 24, 2016. Dr. Troy further based his opinions on Petitioner's reports of continuing shoulder symptoms post-March 24, 2016 accident. Dr. Troy believed that the May 12, 2017 accident represented a contusion that exacerbated Petitioner's pain in the left shoulder. Dr. Troy noted Petitioner was already symptomatic in the left shoulder before the May 12, 2017

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incident and remained symptomatic thereafter. Dr. Troy did not believe that the May 12, 2017 incident changed the course of Petitioner's impingement syndrome. (Petitioner's Exhibit #5, pp. 21-23)

When asked what type of mechanism of injury would be required to cause impingement syndrome, Dr. Troy stated, "...the impingement syndrome is a constellation of rotator cuff tendinitis, associated bursitis of the shoulder and possible spurring. So any injury – a direct blow could. It's very atypical, but it could. A fall on an outstretched extremity also could. But one of those two things occurred when of course he fell off the truck." He testified that the fall off the truck could cause impingement syndrome. (Petitioner's Exhibit #5, p. 22) Dr. Troy testified that the diagnostic left shoulder arthroscopy appears to be causally related to the March 2016 event. The doctor explained that there was no evidence Petitioner was experiencing symptoms involving the left shoulder before the March 24, 2016 accident. He added that Petitioner remains symptomatic and has not returned to his pre-injury status. Dr. Troy testified that he was aware of the medical records regarding Petitioner's 2009 treatment and the prior left shoulder MRI from May 4, 2009. Dr. Troy testified that the records did not change his opinions. Dr. Troy noted that Petitioner had a series of approximately six (6) years of functioning well with no office visits or treatments to his left or right shoulder nor did he have any subjective statements that he was having symptoms to his left nor right shoulder during that time period. (Petitioner's Exhibit #5, pp. 25-26)

With respect to the right shoulder, Dr. Troy testified that Petitioner may or may not need right shoulder surgery. Dr. Troy was hopeful that the right shoulder symptoms would resolve on their own post-left shoulder surgery. Dr. Troy causally related Petitioner's right shoulder condition to the March 2016 incident. (Petitioner's Exhibit #5, p. 27)

Dr. Troy testified that he disagreed with the opinion of Dr. Monaco, Respondent's Section 12 examiner, that Petitioner merely sustained strains of the left and right shoulder. Dr. Troy stated, "If one suffered a strain, one would imply that he was returned back to his pre-work injury status, which based on his subjective statements of [Petitioner], he has not been…[T]hat would imply that the patient is now asymptomatic from the shoulder, which, based on his continued follow-up with myself, proves that he is not – that he did not have an exacerbation, which implies a temporary injury to his shoulder. He had more of an aggravation, and the proof of that is the patient's continued treatment of the left shoulder, and to a minimal degree, the right shoulder…" (Petitioner's Exhibit #5, pp.27-28) Dr. Troy believed that because of his ongoing symptoms, Petitioner was not at maximum medical improvement. (Petitioner's Exhibit #5, p. 29)

On cross-examination, Dr. Troy testified that he reviewed the records from Parkview Orthopedics relating to the 2009-2010 treatment. Dr. Troy testified that he did not review any of the medical records from Concentra or Dr. Garelick. Dr. Troy testified that it's possible his opinions on causation could change based upon review of the Concentra medical records. (Petitioner's Exhibit #5, pp. 31-32) Dr. Troy testified that the May 2009 MRI of the left shoulder revealed AC degenerative joint changes with bone spurring. Dr. Troy testified that those degenerative changes would progress over time. Dr. Troy testified that AC degeneration and bone spurs are one of the etiologies of impingement syndrome. Dr. Troy testified that a review of Petitioner's chart notes from July 6, 2009 appear to show Petitioner was having more problems in his neck than his shoulders with a possible left upper extremity radiculopathy and that any restrictions back then was related to the neck and not the shoulder. (Petitioner's Exhibit #5, pp. 34-36)

Dr. Troy testified that both the pre and post accident MRI studies of the left shoulder revealed AC joint arthropathy or bone spurring. Dr. Troy testified that that AC arthropathy or bone spurring was not caused by the March 24, 2016 work accident. Dr. Troy testified that AC arthropathy can cause pain in one shoulders. Dr. Troy also testified that arthropathy is one of the causes of shoulder impingement. Dr. Troy testified that these conditions will degenerative over time and not reverse course. (Pet. Ex. #5, 44 & 46). Dr. Troy testified that degenerative conditions can be exacerbated or aggravated. He believed Petitioner sustained a permanent

aggravation of his left shoulder condition as a result of the March 2016 work accident. The doctor added that although it was possible that the shoulder impingement and inflammation of the bursa was caused by the pre-existing bone spurring, it was not the absolute sole cause. The doctor stated that other causes are repetitive activity and traumatically induced rotator cuff tendinitis that fails to resolve and, "...we only have evidence of the traumatically induced trauma." (Petitioner's Exhibit #5, pp. 46-47) Dr. Troy testified that there was nothing on the May 16, 2016 MRI studies that were acutely caused by the March 24, 2016 accident. (Petitioner's Exhibit #5, p. 49)

Dr. Troy testified that the right shoulder MRI revealed mostly the same degenerative findings as the left shoulder study. Dr. Troy testified that it was likely that the findings on the right shoulder MRI in May of 2016 all pre-dated the March 24, 2016 work accident. (Petitioner's Exhibit #5, p. 51)

On redirect, Dr. Troy reviewed the final record of Dr. Garelick dated July 25, 2016. Dr. Troy testified that there was nothing in the record that was inconsistent with his findings when he examined Petitioner on September 16, 2016, outside of the fact Petitioner was more asymptomatic at the time of his September 2016 examination. The doctor provided that the report does not change his opinions on causation. The doctor stated, "I believe it does support the opinion…There's an event that caused a traumatically-induced inflammatory episode to his shoulder. It started the process of the inflamed bursal tissue, the rotator cuff tendinitis. He does have the spurring, but he has mild AC changes with palpation, but it started this impingement syndrome to his shoulder which has failed to resolve with conservative treatment." Dr. Troy added that it's a combination of both the degenerative condition and the trauma sustained. Dr. Troy stated, "…because degenerative changes could increase someone's risk for having impingement syndrome. So if one develops traumatically-induced bursitis to the shoulder, you're going to be at that much more risk for that to fail to resolve because you have preexisting degenerative changes of the AC joint and encroachment to the subacromial space. (Petitioner's Exhibit #5, pp. 55-58)

Dr. Joseph Monaco, Respondent's Section 12 examiner, was called to testify via evidence deposition on January 25, 2018. (Respondent's Ex. #1). Dr. Monaco testified that he examined Petitioner at the request of Respondent on May 23, 2017. Dr. Monaco testified that he reviewed Petitioner's medical records from Concentra as well as the records of Dr. Daniel Troy in preparation of his May 23, 2017 report. Dr. Monaco testified that he also reviewed the May 2016 MRI reports and films of Petitioner's bilateral shoulders. Dr. Monaco testified that he took a history of Petitioner's March 24, 2016 fall from a crosswalk approximately 3.5 feet above ground, landing on both of his upper extremities. Dr. Monaco testified that Petitioner also reported sustaining a second incident on May 16, 2017 resulting in a contusion to the left shoulder due to walking into a steel beam at work. (Respondent's Ex. #1, pp. 10-17)

Dr. Monaco testified that he reviewed the MRI films of Petitioner's left and right shoulders obtained in May of 2016. Dr. Monaco testified that his impression were that the findings were mostly age-related changes. Dr. Monaco testified that he believed there were degenerative changes of the AC joint with mild hypertrophy and mild marginal spurring with signs of impingement. (Respondent's Ex. #1, p.19) Dr. Monaco testified that those findings can be found on individuals who are asymptomatic. Dr. Monaco testified that there was no evidence of any acute injury on the films. (Respondent's Ex. #1, pp.19-20) Dr. Monaco testified that he compared the pre-accident MRI of Petitioner's shoulder to the post-accident studies. Dr. Monaco testified that the two studies were remarkably similar in regards to the changes due to age, with no evidence of acute injury. (Respondent's Ex. #1, pp. 21-22)

Dr. Monaco testified that he examined Petitioner. Dr. Monaco testified that the time of his first report, his opinion was that Petitioner sustained strains of left and right shoulders. Dr. Monaco opined that both strains had resolved. Dr. Monaco also diagnosed Petitioner with degenerative changes of the AC joint with impingement in both shoulders. Dr. Monaco opined that the strains of the left and right shoulder were a result of

the March 24, 2016 work accident. Dr. Monaco testified that the degenerative changes of the AC joint that were signs of impingement syndrome were a result of a temporary exacerbation of pre-existing condition. Dr. Monaco stated, "…[I]n this case there was no evidence of any acute injury as a result of the incident. He did have the preexisting degenerative changes…that are common, can be commonly found on asymptomatic individuals. So those degenerative changes can be involved in the provocation of bursitis, tendonitis and impingement of the shoulder, and that can happen as a result of an injury like a strain. But the absence of an acute injury the expectation would be this would return to baseline." Dr. Monaco testified that he based his opinion on the medical records he reviewed, most notably the findings of Dr. Garelick. (Respondent's Ex. #1, pp. 26-28) Dr. Monaco also explained that baseline is not the equivalent of being asymptomatic. Dr. Monaco explained that in cases of degenerative underlying osteoarthritis of the AC joint and signs of impingement, the expectation over time would be that the condition would worsen. "…so that you would not expect return to baseline to be returning to asymptomatic. You would expect it to return to where you expect it to be based upon the natural history of the condition you're dealing with." Dr. Monaco testified that he believed Petitioner was capable of working full duty without restrictions as it related to the March 2016 accident. Dr. Monaco again based his opinions on the findings and conclusions of Dr. Garelick. Dr. Monaco testified that he believed Petitioner reached MMI for both shoulder conditions at the time of the May 23, 2017 exam. (Respondent's Ex. #1, pp. 28-30)

Dr. Monaco testified that he also authored an addendum report which was dated September 21, 2017. Dr. Monaco testified that he reviewed additional medical records which included Petitioner's records from 2009 and updated records from Dr. Troy. (Respondent's Ex. #1, pp. 33-34) Dr. Monaco testified that he reviewed the 2009 MRI report of the left shoulder. Dr. Monaco testified that the findings were very similar on the pre-accident MRI versus the post-accident study. Dr. Monaco testified that Petitioner's present complaints and symptoms were very similar to his complaints and symptoms in 2009. Dr. Monaco noted that Petitioner claimed injuries in 2009 to both shoulders, with the right shoulder becoming less of an issue within weeks after the accident. Dr. Monaco found this to be similar to Petitioner's symptoms subsequent to the March 24, 2016 accident. Dr. Monaco also noted the similarities in Petitioner's treatment in 2009 versus post-March 24, 2016. (Respondent's Ex. #1, pp. 36-38) Dr. Monaco opined that the additional records revealed "… just almost a complete replay of the same course of action and complaints from 2009 to 2016." (Respondent's Ex. #1, pp. 39-40) Dr. Monaco testified that his prior IME opinions did not change after his review of the additional pre-accident medical records. Dr. Monaco testified that the pre-accident records confirmed his prior opinions. (Respondent's Ex. #1, pp. 42-43)

On cross-examination, Dr. Monaco testified that he generally agreed with the radiologists' findings with respect to the 2016 MRIs, with the exception of possible small tear of the labrum on the right. It was Dr. Monaco's opinion that the labrum was normal. (Respondent's Ex. #1, pp. 47-49) Dr. Monaco testified that he has performed the surgery proposed by Dr. Troy. Dr. Monaco stated that Petitioner's condition did not result from an acute injury and the surgery would not be related to the strain of the shoulders that Petitioner sustained with the fall onto his hands. He indicated the proposed surgery would address Petitioner's impingement syndrome. Dr. Monaco suggested that surgery would be a last option. Dr. Monaco opined that the surgery proposed by Dr. Troy was not inappropriate. Dr. Monaco had reservations about success. Dr. Monaco was concerned about the lack of objective findings on MRI studies and the ongoing subjective complaints of Petitioner. He felt Dr. Troy might be "backed into a corner and nothing else was helping." The doctor stated, "…if you take into account what happened in 2009, which is almost the same as what happened in 2016 as far as mechanism of injury and completely negative diagnostic findings and only positive findings, complaints of pain and the findings of provocative shoulder tests…and that went on for about a year and then I have no more records to review so I don't know what happened after that…So he had a significant problem with that left shoulder and also had some problem with his neck too, and you have to assume it eventually got better because he was back at work in 2016 and actually denying any problems with his shoulders prior to that. It's possible he

didn't recall it. It seems a little farfetched. Dr. Monaco testified that he did not disagree with Dr. Troy's treatment; but disagreed with the cause of Petitioner's problem. (Respondent's Ex. #1, pp. 54-60)

Dr. Monaco testified that impingement syndrome very often develops idiopathically. Dr. Monaco testified that oftentimes patient will come to him and not know the cause of shoulder problems other than the patient simply has pain. Dr. Monaco also stated there are instances when he's determine an individual has impingement syndrome, after the person had an injury and subsequently complain of symptoms similar to Petitioner. The doctor stated he considered impingement syndrome to be more of a symptom conglomeration than an actual pathology. (Respondent's Ex. #1, pp. 61-63) Dr. Monaco testified that a fall from a height can aggravate a previously asymptomatic condition such as impingement syndrome and cause it to become symptomatic. Dr. Monaco testified that he believed that Petitioner temporarily aggravated his condition but returned to baseline. Dr. Monaco testified that Petitioner had a preexisting condition which was temporary exacerbated by the fall but got better when he reached MMI with Dr. Garelick. Dr. Monaco added, "…if there's underlying degenerative changes such as this which can cause impingement, then they can cause impingement without necessarily having another injury…So it doesn't mean that once –that just because he's saying he didn't have any pain before the fall and now he has pain that all pain in the shoulder after that is related to the fall…It appeared there wasn't any sign of any acute injury, so it's my feeling there was an exacerbation of this preexisting condition which got better, but it's not my opinion that it was all caused by the fall…So just because he has pain after the fall, a year and a half later…that temporal relationship is not felt to be a very good approach to determining causation, just because something happened and something happens following it. So I think that what happened following it because of the strain he had some pain which eventually got better, maybe not completely 100 percent as far as he's concerned but better and no further treatment was needed, and then it got worse." (Respondent's Ex. #1, pp. 66-69) Dr. Monaco agreed that Petitioner's treatment was reasonable, necessary and causally related up to the July 25, 2016 MMI date. Dr. Monaco agreed with the reasonableness of the shoulder treatment thereafter, but disagreed that it was related. (Respondent's Ex. #1, pp. 70-71)

Dr. Monaco testified that he was not provided with any medical treatment records between March 2010 and March of 2016. When asked "…what, if any conclusion can you draw from that fact," Dr. Monaco replied, "I can conclude that he has not sought medical care somewhere where the records would be available and that the shoulders got – that undergoing almost a year's worth of treatment before I had no more records he was still having some complaints but apparently would mean he got better." (Respondent's Ex. #1, p. 72) Dr. Monaco clarified his earlier statement that the mechanism of injury in 2009 and the mechanism of injury in March 2016 were similar. He admitted that the 2009 mechanism of injury involved Petitioner attempting to lower dollies on a truck and he was "pulling something." Dr. Monaco also admitted that majority of medical treatment noted in Petitioner's post-accident medical records after July 6, 2009 pertained to mainly cervical spine treatment. (Respondent's Ex. #1, pp. 72-76) Lastly, Dr. Monaco testified that Petitioner had preexisting impingement in his shoulders as opposed to impingement syndrome. The doctor stated that the concept of impingement syndrome requires symptoms. He indicated that Petitioner developed symptomatology consistent with impingement syndrome after the March 2016 accident. When asked "…[O]ther than the normal progression from aging has, in your opinion, [Petitioner's] baseline condition of his left shoulder changes since his work injury in March of 2016?," Dr. Monaco replied, " I think his symptoms have ebbed and flowed, but my thought, my feeling is he returned to baseline by July 2016." (Respondent's Ex. #1, pp. 78-79)

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

The Findings of Fact and Conclusions of Law, as stated above, are adopted herein.

Petitioner testified that he was working for Respondent on July 22, 2016, at approximately 9:30 p.m., and was cranking the "dolly legs" of a semi-tractor trailer when he felt a burning sensation in his lower back.

Petitioner testified that the crank was not operating properly and, as a result, he was required to apply more force to the crank than was usually required. Immediately after using the crank apparatus, Petitioner felt a severe burning sensation in his lower back. Petitioner reported his work injury to Respondent's operations manager Joe Spina and finished his work shift.

Petitioner's testimony is also supported by the history provided to his medical provider immediately after the accident and the objective findings noted by the medical providers upon examination of Petitioner. Petitioner was not scheduled to work on Saturday, July 23, 2016, or Sunday, July 24, 2016. However, because his lower back symptoms continued over the weekend, Petitioner was examined at the company clinic, Concentra, on Monday, July 25, 2016. The history provided by Petitioner states, "Patient states he was cranking the damaged gear box when he started to feel pain in his lower back. Injury occurred at 10:00 p.m." The date of accident was recorded at "07/22/16". Ms. White, the Physician's Assistant at Concentra, noted that Petitioner had 5/10 pain radiating to his buttocks along with back stiffness, decreased extension, decreased flexion, and tenderness at the L4-L5 level paraspinals and sciatic notch on the left and right. Ms. White diagnosed Petitioner with back pain and a strain of the lumbar region and prescribed Cyclobenzaprine and Ibuprofen. Petitioner was advised to begin physical therapy and given work restrictions of occasional lifting up to 20 pounds and pushing/pulling up to 20 pounds. Petitioner was also advised not drive a company vehicle due to functional limitations. On July 27, 2016, Petitioner reported that he was getting better. Petitioner requested that he be cleared to return to work regular duty. Petitioner was released to return to work regular duty with the caveat of avoiding any cranking of broken dolly legs or opening corroded doors. Petitioner was last seen at Concentra on August 11, 2016. Petitioner reported back stiffness but no pain. Petitioner reported his current level of pain as a 1 out of 10. The records noted Petitioner was doing "overall well." Examination findings were normal. Petitioner was released from care and placed at maximum medical improvement.

Based on the foregoing, the Arbitrator finds that Petitioner has proved, by a preponderance of the evidence, that his condition of ill-being, in relation to his lumbar spine is causally related to his work accident on July 22, 2106.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Margaret Fritz,

Petitioner,

vs.

NO. 10WC 45398

First Student, Inc.,

19IWCC0216

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 25, 2018 is hereby affirmed and adopted.

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

No bond is required for 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: MAY 1 - 2019
MP/sj
4/18/2019
68

Marc Parker

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FRITZ, MARGARET
Employee/Petitioner

Case# **10WC045398**

FIRST STUDENT INC
Employer/Respondent

19IWCC0216

On 7/25/2018, 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 2.14% 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:

2687 KROCKEY CERNUGEL COWGILL ET AL
THOMAS E COWGILL
1000 ESSINGTON RD SUITE 108
JOLIET, IL 60435

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

19IWCC0216

STATE OF ILLINOIS)

) SS.

COUNTY OF LASALLE)

- [ ] 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

Margaret Fritz
Employee/Petitioner

v.

First Student Inc.
Employer/Respondent

Case # **10** WC **45398**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city of **Kankakee on July 19, 2017** and **Ottawa on September 25, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

Findings

On **March 1, 2008**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

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

Timely notice of this accidents ***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 **$18,200.00**; the average weekly wage was $**350.00**.

On the date of accident, Petitioner was **53** years of age, **married** with **0** dependent children.

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

Respondent ***does not owe*** for all appropriate charges for all reasonable and necessary medical services for which they are liable.

To date, Respondent has paid $ **0** in TTD and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid.

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

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

Order

Petitioner failed to prove she sustained an accident on March 1, 2008, or any time, that arose out of and in the course of hier employment with respondent.

Petitioner's claim is hereby denied and case is dismissed.

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

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

Christine M Ory

Signature of Arbitrator

July 24, 2018

Date

ICArbDec p. 2

JUL 25 2018

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Margaret Fritz	)	
Petitioner,	)	
	)	
vs.	)	**No. 10 WC 45398**
	)	
First Student, Inc.	)	
Respondent.	)	
	)	

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

This matter was heard in Kankakee on July 19, 2017 and closed proofs in Ottawa on September 25, 2017. The parties agree that on March 1, 2008, petitioner and respondent were operating under the provisions of the Illinois Workers' Compensation Act. The parties agree that in the year predating the claimed accident petitioner earned $18,200.00, and her average weekly wage, as calculated pursuant to §10 of the Act, was $350.00.

At issue in this hearing is as follows:

1. Whether the petitioner sustained accidental injuries that arose out of and in the course of her employment with respondent;
2. Whether petitioner gave timely notice of the accident.
3. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
4. Whether respondent is liable for the unpaid medical bills.
5. Whether petitioner is due temporary total disability.
6. What is the nature and extent of injury?

STATEMENT OF FACTS

Petitioner, Margaret Fritz, Testimony

Petitioner was employed by respondent beginning in 1997 driving a school bus for respondent. She would drive during the school year and sometimes during the summer.

Petitioner was assigned a main bus at the beginning of the year. Petitioner noticed the suspension system was clumpy and when it hit holes it felt like the bus jumped. Petitioner testified that the replacement bus, when the main bus was in for repairs, was worse than the main bus.

On September 19, 2005, petitioner had been involved in a non-work related automobile accident wherein she injured her neck and lumbar area. She sought treatment from a chiropractor, Dr. Pendolino. She then came under the care of Dr. Malek for the automobile accident injuries, which was on November 23, 2005. She underwent a MRI on December 27, 2005 at the direction of Dr. Malek. She continued to treat with Dr. Malek and had three more MRIs; in February, March and April, 2006.

In April, 2006, petitioner received an epidural steroid injection by Dr. Martini. She returned to Dr. Malek on February 5, 2007. She received another cervical and lumbar MRI on February

12, 2007. The last time petitioner saw Dr. Malek was on February 19, 2007. Her condition got better after the period from 2005 to 2007. She continued to drive the school bus for respondent.

She testified her condition worsened during the 2007 to 2008 school year in her lumbar spine. She estimated she hit 20 bumps a day. She returned to Dr. Malek on February 25, 2008 with complaints of increase pain from driving the school bus. Dr. Malek prescribed another MRI, which was done on March 8, 2008. He prescribed a discogram. She was seen again by Dr. Malek on May 12, 2008 and November 24, 2008.

On December 30, 2009, petitioner fell and injured her foot. She did not fall on her back. The next time she saw Dr. Malek was on February 11, 2009. At that point she stopped driving the school bus for respondent as of December, 2008 as she couldn't stand the feelings in her back and managing the kids.

She did not see Dr. Malek again until February 3, 2010. He recommended a discogram. Petitioner walked in a parade in June 2010. On August 4, 2010, Dr. Malek recommended another MRI, which was performed on August 11, 2010. She saw Dr. Malek again on August 25, 2010. She was also referred for an EMG which was done on August 31, 2010. On September 10, 2010 she underwent a discogram by Dr. Malek. She saw Dr. Malek on September 22, 2010 and again in October, 2010. She did not see Dr. Malek again until April 13, 2011. The next time she saw r. Malek was not until October 12, 2011. Despite not working, petitioner's condition worsened in 2010 and 2011.

Dr. Malek referred petitioner to Dr. DePhillips, for a second opinion, whom she saw on October 20, 2011. Petitioner saw Dr. Malek again on May 31, 2012. Her condition was worsening: Dr. Malek recommended surgery. Petitioner underwent surgery by Dr. Malek on June 19, 2012 at Provena St. Joseph's Hospital in Joliet. She returned to Dr. Malek and noted her condition had improved. He prescribed water therapy; which she received. She returned to Dr. Malek on September 12, 2012, October 22, 2012 and February 25, 2013.

In late 2012 and early 2013, petitioner noticed she had pain going down her leg from her lumbar spine. Dr. Malek prescribed pain pills. She saw Dr. Malek on March 11, 2013 and kept up the same medication regimen. The next time and last time petitioner saw Dr. Malek was on March 19, 2014. Petitioner has not seen any physician since this time.

She fixed her bathrooms to assist her, she uses rolling chairs and a gripper. She can drive, but feels pressure in her back like a brick. She is cautious getting in and out of the car.

After seeing Dr. Malek on February 25, 2008, petitioner spoke with Linda Brewer (sic). Specifically, on April 4, 2008, petitioner had a meeting with Linda Brewer (sic) and a man. Petitioner advised Brewer and the man about her discussion with Dr. Malek regarding her back.

On cross-examination, petitioner said she told respondent she would not return to work in 2009. Petitioner believed she told Brewer (sic) before her physical exam in May [2008].

Petitioner confirmed she was not prescribed remodeling for her bathroom, the gripper or rolling chair. Dr. Malek only prescribed a brace.

Petitioner confirmed she quit at the end of 2008 when she realized the union was not voted in and, therefore, there would be no insurance.

Petitioner believed the back brace was actually prescribed by Dr. Pendolino on February 5, 2007.

On redirect, petitioner refreshed her recollection, of when she spoke with Ms. Brunner regarding her back condition, with Petitioner's Exhibit 12: which showed she underwent the physical on April 4, 2008.

Nicole Mattox Testimony

Nicole Mattox, employed as respondent's safety manager, was called upon to testify in behalf of respondent. In March, 2008, Mattox was employed by respondent as a driver. As safety manager, she held meetings with the drivers in October, November, December, January and April.

If an employee complains of a problem, he or she will be sent for a fit for duty physical exam. A driver must complete a DOT physical exam to renew his or her permit each year. Mattox confirmed these were the same procedures were followed in March, 2008. Mattox reviewed respondent's document and did not find any incident report about petitioner's back or complaint regarding the bus.

Mattox confirmed that any complaint of injury would be kept in the employee's personnel file, but the problem with the bus itself would be kept by the maintenance department.

Sharon Palionis Testimony

Sharon Palionis was called upon to testify in behalf of respondent. She is employed by Alpha School Bus as a safety compliance officer. She had been employed by respondent from 2000 to 2012; in 2008 was employed as location safety manager. At that time the location manager was Linda Brunner.

As safety manager, Palionis, was responsible for compliance with driver's license, safety meetings, workers' comp, auto accident and training. Respondent's protocol indicated if the employee was injured, they should report it to her. If someone reported an injury to the location manager, Linda Brunner, she would send them back to Palionis to investigate.

If someone came to Palionis with back complaints. She would speak with them, complete an incident report and offer medical treatment. Petitioner never reported to Palionis that her back hurt from driving a bus. Brunner never sent petitioner to Palionis to report the complaints she had with her back. The first notice Palionis had of petitioner's injury was the receipt of petitioner's Application of Adjustment of Claim dated November 10, 2010.

Palionis spoke with petitioner after receiving the Application for Adjustment of Claim. Petitioner reported the injury occurred on March 1, 2008 as a result of a personal auto accident. Petitioner did not indicate the back injury was because of, or aggravated by, driving a bus.

Palionis did not note anythig about witnesses or medical treatment because petitioner never told her.

Dr. Michael Malek MD Records (PX.1)

Petitioner was first seen by Dr. Malek on November 23, 2005. She had been involved in an automobile accident and low back and neck pain. She had numbness in her upper extremities.

She had a cervical and lumbar MRIs done on December 27, 2005. The cervical MRI showed mild stenosis at the C5-C6 and C6-C7he lumbar spine showed disc bulges at L4-5 and L5-S1. The EMG of December 27, 2005 was negative. Dr. Malek referred her back to Dr. Pendolino on January 23, 2006.

On March 6, 2006, Dr. Malek referred her to Dr. Martini for an injection, which was performed on April 24, 2006.

Petitioner returned to Dr. Malek on February 5, 2007 and said her condition was worse. She reported having problems at work; therefore, she was put on restrictions.

On February 12, 2007 she had cervical MRI and lumbar MRI; the lumbar MRI showed disc bulges. On February 19, 2007 suggested a FCE to determine her limitations.

On February 25, 2008, petitioner returned to Dr. Malek. Petitioner reported her lower back symptoms were aggravated especially with driving the bus with associated bouncing. The number one diagnosis was: "S/P MVA 09/19/15". A repeat lumbar MRI was ordered, which was done on March 8, 2008 and showed a protrusion at L3-L4, which may be a new finding. On March 17, 2008, Dr. Malek recommend a discogram.

On April 4, 2008, a note from Med Works Occupational Health Program to Dr. Malek asked Dr. Malek's opinion regarding petitioner's ability to drive a school bus given her back condition.

On May 12, 2008, petitioner complained her back pain was miserable. Dr. Malek again recommended a discogram; and, if positive, surgery.

On May 19, 2008, Dr. Malek authored a letter to Attorney Daniel Kordik advising him that petitioner's present neck and lumbar condition, for which she will likely need a cervical and lumbar fusion, was the result of the September 19, 2005 automobile accident.

Dr. Malek also authored a May 21, 2008 letter to Steven Epner, D.C. advising petitioner's condition for which he is treating petitioner, is the result of the automobile auto accident of September 19, 2005.

On June 25, 2008, petitioner continued to have pain, but was waiting for authorization for treatment.

On November 24, 2008, petitioner returned and asked that the discogram be scheduled while she is off work over the holidays. Again, the diagnosis was S/P automobile accident of September 19, 2005.

On February 11, 2009, petitioner reported she slipped and fell on December 30, 2008, but twisted so she would not fall on her back. Petitioner was still awaiting authorization for the discogram. Dr. Malek wrote a letter on February 11, 2009, again stating petitioner was under his care for incapacitating back pain due to the September 19, 2005 motor vehicle accident.

She did not return to Dr. Malek on February 3, 2010, advising her symptoms were stable. She was ambulating with a cane. On August 4, 2010, another lumbar MRI was ordered. The August 11, 2010 lumbar MRI showed marginal osteophytes at L5-S1 encroaching slightly on the exiting L5 nerve root.

On August 25, 2010, Dr. Malek now includes the fact petitioner believes her back condition had been aggravated by driving a school bus to the point she had to quit on January 1, 2009.

The August 31, 2010 EMG, was negative. The September 10, 2010 discogram was positive at L5-S1 level. The CT scan post discogram was negative.

She was seen again on September 22, 2010 and surgical intervention was discussed or a referral for a second opinion.

She returned on October 20, 2010. At this point she stated: "it is unquestionable that her condition worsened after driving the bus constantly going up and down three steps, 20 times a day as the bouncing with the bus aggravated her condition."

On April 13, 2011, petitioner's exam remained the same. She had not yet obtained the second opinion. She was ambulating with a cane.

She returned on October 12, 2011; her condition remained the same. She reported workers' compensation denied her second opinion or any treatment.

On October 20, 2011, Dr. De Phillips reported he saw petitioner for a second opinion. Her history was that she injured her back in a motor vehicle in September, 2005 and work related injury of January 1, 2009. However, she listed the work accident actually occurred in March, 2008. Dr.

De Phillips agreed surgery was warranted but discussed the risks and benefits of same. She was returned back to Dr. Malek for further treatment.

She did not return to Dr. Malek again until May 31, 2012. Dr. Malek ordered an updated MRI, which was done on June 8, 2012. There were no gross changes compare to the August 11, 2010 MRI.

On June 12, 2012, petitioner underwent a spinal fusion at L5-S1 level by Dr. Malek. She followed up with Dr. Malek on June 25, 2012, June 26, 2012, July 12, 2012, August 12, 2012, September 10, 2012, October 22, 2012, December 19, 2012, and March 11, 2013, at which time she was deemed to have reached MMI. She was seen again on May 13, 2013, August 7, 2013 and March 19, 2014.

Dr. George De Phillips Records (PX.2)

Dr. De Phillips report was included in Petitioner's Exhibit 1. On the Patient Registration form, petitioner indicated under how the accident occurred: "after a car accident September 19, 2005, than I continued to work driving a school bus until I could not anymore because of excruciating pain in lower back and excruciating work responsibilities. (bouncing) getting up and down and up and down bus steps. ? seat (20) a day."

Provena Saint Joseph Medical Center Records (PX.3)

The records show petitioner received only two physical therapy session; April 28, 2009 and April 30, 2009, and then discontinued therapy as it was causing too much pain.

The records include the Operative Report of June 12, 2012 is including in Petitioner's Exhibit 1.

Petitioner was seen in the emergency room on June 26, 2012 for a wound check due to leaking from incision [after surgery].

Presence Rehab and Sports Injury Center Records (PX.4)

Reports of petitioner's physical therapy from April, 2009 and August 2012.

Dr. Michael Malek September 24, 2014 Deposition (PX.5)

Dr. Michael Malek testified via deposition in behalf of petitioner. Dr. Malek testified the automobile accident in September, 2005 and petitioner's regular job with respondent of sitting, and driving a school bus and walking up and down stairs in the bus, as the cause of petitioner's low back condition resulting in the fusion of June 12, 2012.

Dr. Michael Malek September 9, 2015 Continued Deposition (PX.6)

Dr. Malek testified that although he authored a letter on May 12, 2008 to Attorney Daniel Kordik indicating petitioner will likely need surgery because of the September 19, 2005 auto accident, and did not mention the "work accident", did not mean the condition was not caused by petitioner's driving of the school bus.

Dr. Malek further stated any treatment before the manifestation date of the work injury in 2008 was not related.

Medical Bills (PX.7)

PX. 7 A - $1700.00 American MRI (06/8/12)

PX. 7 B - $3400.00 American MRI (03/08/08 & 08/11/10)

PX. 7 G - $250.00 Galilee Medical Center (06/06/12)
PX. 7 J - $100.289.00 Dr. Michael Malek (11/23/05 – 3/19/14)
PX. 7 M $111.263.33 Presence Health St. Joseph Medical Center (6/19/12-2/25/13)

Bus Photograph (PX.11)
The photograph purportedly shows steps petitioner had to ascend and descend in the bus.

April 4, 2008 Drug Test and Notes (PX.12)
This is the report of petitioner's periodic exam, and includes a request for information from Med Works to Dr. Tsai and Dr. Malek.

Application for Adjustment of Claim (RX.1)
On the Application for Adjustment of Claim dated November 17, 2010, petitioner claims she suffered repetitive trauma to her lower back from driving bus on March 1, 2008.

New Injury and Illness Notification Form (RX.2)
The form was completed on November 23, 2010 and shows respondent was notified on November 1, 2010 of petitioner's accident.

Dr. Avi Bernstein December 9, 2015 Deposition (RX.3)
Board certified Dr. Avi Bernstein testified in behalf of respondent via deposition. He had examined petitioner at respondent's request on February 27, 2012 and reviewed certain medical records and reports, as well as diagnostic MRI studies. He also took a history from the petitioner. Based upon his exam, including petitioner's history, as well as his review of the medical records and reports, Dr. Bernstein concluded petitioner's back condition was not caused or aggravated by petitioner's employment as bus driver. Dr. Bernstein did not find petitioner's driving of a school bus was any different than driving any other vehicle.

Dr. Bernstein also re-examined petitioner on June 9, 2014. Dr. Bernstein determined petitioner's surgery of June 12, 2012 was not reasonable, necessary or related to petitioner's low back condition.

Dr. Bernstein found petitioner was capable of working as a bus driver despite the 20-pound restriction.

Petitioner's Complete Exhibits (Joint Exhibit 1)
The complete set of petitioner's exhibits before portions of the records were redacted with the agreement of the parties. The exhibit was introduced for completeness.

CONCLUSIONS OF LAW

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

C. In regard to the issue of whether an accident occurred which arose out of and in the course of Petitioner's employment with Respondent, the Arbitrator makes the following conclusions of law:

The Arbitrator finds petitioner failed to prove that she suffered injuries of any kind in a work accident that arose out of and in the course of her employment with respondent on March 1, 2008 or any date. The Arbitrator bases this opinion on the fact that even petitioner's own physician, Dr. Malek, as late as May 19, 2008, stated petitioner's condition was the result of only the automobile accident of September 19, 2005. Furthermore, petitioner, by her own testimony, failed to show she was exposed to a greater risk than that of the general public who drives a bus, or any motor vehicle.

For these reasons, petitioner's claim is denied and her case is dismissed.

As the Arbitrator finds petitioner failed to prove his accident arose out of and in the course of her employment with respondent, all other issues are moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Naughton,

Petitioner,

vs. NO. 17 WC 16570

Michael's Cartage,

Respondent.

19IWCC0217

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, medical expenses 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 14, 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.

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

DATED: MAY 1 - 2019
o-4/18/19
MP/sj
68

Marc Parker

Deborah L. Simpson

Barbara N. Flores

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

NAUGHTON, JAMES
Employee/Petitioner

Case# **17WC016570**

17WC013408
18WC004024

MICHAEL'S CARTAGE
Employer/Respondent

19IWCC0217

On 6/14/2018, 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 2.07% 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:

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

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

STATE OF ILLINOIS)
COUNTY OF WILL)

19IWCC0217

- [ ] 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)

James Naughton
Employee/Petitioner

v.

Michael's Cartage
Employer/Respondent

Case # 17 WC 16570

Consolidated cases: 17 WC 13408 & 18 WC 4024

An *Application for Adjustment 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 **April 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. [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. [ ] 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

19IWCC0217

On the date of accident, **May 12, 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 **$47,301.28**; the average weekly wage was **$909.64**.

On the date of accident, Petitioner was **45** years of age, *single* with **0** dependent children.

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

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

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

6/13/18
Date

ICArbDec19(b)

JUN 14 2018

FINDINGS OF FACT:

James Naughton (hereinafter "Petitioner") injured his bilateral shoulders and cervical spine on March 25, 2009. He received medical treatment from Meridian Medical Associates from March 25, 2009 through April 7, 2009. (Respondent's Exhibit #6). Petitioner then received medical treatment from Dr. Kevin W. Luke and Dr. Anis O. Mekhail at Parkview Orthopaedic Group, S.C. Dr. Luke provided Petitioner with a left shoulder injection on May 8, 2009 and specifically opined that he felt that Petitioner's symptoms were related to his neck. Dr. Mekhail treated Petitioner's cervical spine symptoms and referred Petitioner for cervical epidural steroid injections on July 29, 2009, August 12, 2009 and August 26, 2009. On January 21, 2010, Dr. Mekhail released Petitioner to return to full duty work and directed him to return as needed. (Respondent's Exhibit #4).

From 2010 through March 23, 2016, Petitioner did not have any injuries to either of his shoulders. In addition, Petitioner did not receive any medical treatment for either of his shoulders from early in 2010 through March 23, 2016. Lastly, Petitioner worked full duty as a truck driver and did not miss any time from work from early in 2010 through March 23, 2016. Petitioner had never injured his lower back prior to March 24, 2016 and had never received medical care of any kind for his lower back prior to March 24, 2016. In addition, Petitioner had never missed any time from work due to lower back problems prior to March 24, 2016.

Petitioner testified that he had worked for Michael's Cartage (hereinafter "Respondent") as a truck driver for four years. Petitioner testified that he is a regional truck driver and traveled between the tri-states. Petitioner testified that his hours varied between 8 to 14 hours depending on the work. Petitioner testified that he worked nights and usually began his routes between 2 pm and 6 pm. Petitioner testified that on March 24, 2016, he was working for Respondent when he fell off the catwalk of a semi-tractor trailer. Petitioner stated he fell approximately three (3) to four (4) feet, landing on the ground below with outstretched hands. Petitioner Petitioner testified that he immediately experienced pain and soreness in both of his palms, and his left and right shoulders. That same evening, Petitioner reported his work accident via telephone to his supervisor, Tawfic Ibrahim, who is the night dispatcher for Respondent. Petitioner stated he continued to work and finished his work shift for Respondent.

Petitioner testified that over the ensuing two weeks, he experienced gradual increase in the pain on the outside of his shoulders, left worse than right. The pain also began to affect his sleep pattern. Petitioner testified that his symptoms in 2009 and 2010 started in his neck and radiated into his arms. After his accident on March 24, 2016, his symptoms were located on the outside of his shoulders. Petitioner testified that he advised Mr. Ibrahim of his symptoms and that he was going to seek medical treatment. Petitioner indicated Mr. Ibrahim directed him to go to the company medical clinic, Concentra.

Records submitted show Petitioner presented at Concentra on April 8, 2016 and was first examined by Dr. Al-Saraf. The history provided by Petitioner states, "This is the result of a fall [and] from back of truck to ground, landed on hands, felt pain at lt shoulder, milder pain at rt shoulder and felt achy. Occurred while at work." (Petitioner's Exhibit #2, p.4) Dr. Abbas examined Petitioner's left shoulder and found tenderness in the AC joint, distal clavicle and deltoid and painful range of motion with forward flexion, extension abduction, internal rotation and external rotation. (Petitioner's Exhibit #2, p. 10) Dr. Abbas diagnosed Petitioner with a left shoulder strain, directed him to begin a physical therapy program, prescribed Ibuprofen, and directed him to return to modified work with occasional lifting limited to 10 pounds, occasional pushing and pulling limited to 20 pounds and no reaching above shoulder level with the left arm. (Petitioner's Exhibit #2, p. 11)

Petitioner began the physical therapy program that was recommended by Dr. Abbas at Concentra on April 8, 2016. (Petitioner's Exhibit #2, p. 12) In addition, Petitioner continued to work for Respondent after April 8, 2016. On April 11, 2016, Petitioner returned to Dr. Abbas. According to the records, Petitioner reported that his left shoulder was improving with better range of motion. Petitioner reported mild soreness in the right shoulder occasionally. According to the doctor, Petitioner was "not worried about it". The examination findings continued to reveal tenderness at the deltoid as well as painful range of motion with forward flexion, extension abduction, internal rotation and external rotation. The doctor diagnosed Petitioner with a left shoulder strain and directed him to continue his medication, physical therapy, and work restrictions. (Petitioner's Exhibit #2, pp. 23-25)

On April 18, 2016, Petitioner returned to Concentra and was examined by Nurse Practitioner, Jan Pitts. The records note that Petitioner's left shoulder was improving. Petitioner reported mild soreness in the right shoulder. Petitioner was again diagnosed with a left shoulder strain. Physical therapy and work restrictions were continued. (Petitioner's Exhibit #2, pp. 46-48)

Petitioner returned to Concectra on April 25, 2016, at which time he was examined by Dr. Eric Griffin. It was noted that Petitioner was still experiencing pain in his left shoulder at night and experienced painful range of motion with forward flexion, abduction, internal rotation and external rotation. Dr. Griffin diagnosed Petitioner with a left shoulder strain and directed him to continue his physical therapy program and medication. In addition, Dr. Griffin released Petitioner to return to modified work with frequent lifting limited to 20 pounds and frequent pushing/pulling limited to 40 pounds. (Petitioner's Exhibit #2, pp. 75-77) On May 2, 2016, Petitioner was examined by Laura K. White, Physician's Assistant at Concentra. Petitioner reported that although his symptoms were improving, he still experienced left shoulder pain. Petitioner described the symptoms as intermittent with pain levels at 5 out of 10. Aggravating factors were arm elevation, overhead use and lifting. Petitioner also reported right arm pain but the left was worse. Ms. White diagnosed shoulder strain, directed Petitioner to continue his physical therapy program and his modified work restrictions. Ms. White also prescribed Cyclobenzaprine and Naproxen. (Petitioner's Exhibit #2, pp. 97-99)

On May 9, 2016, Petitioner was again examined by Ms. White. Ms. White noted that Petitioner complained of pain in the anterior shoulders bilaterally and in the right lateral shoulder. Ms. White also noted that Petitioner experienced increased pain with heavy lifting and repeated activity. Ms. White diagnosed left and right shoulder strains. She directed him to continue his physical therapy program and medication. In addition, Ms. White recommended Petitioner obtain MRIs of his left and right shoulder and referred Petitioner to an orthopedic specialist. (Petitioner's Exhibit #2, pp. 120-123)

On May 16, 2016, Petitioner completed MRIs of his left and right shoulders at Accelerated Open MRI and Imaging. According to the radiologist's report, the right shoulder MRI revealed AC joint arthropathy with mild subacromial impingement of the rotator cuff. Small cystic changes were noted at the posterolateral aspect of the humeral head. There were also findings of supraspinatus tendinosis without evidence of tear. The remainder of the rotator cuff was normal. Lastly, there was a possible small tear at the anterior margin of the glenoid labrum. The MRI of the left shoulder was interpreted to reveal AC joint arthropathy causing mild subacromial impingement of the rotator cuff. There were small cystic changes of the posterolateral aspect of the humeral head. Supraspinatus tendinosis without evidence of tear was also indicated. The remainder of the rotator cuff was normal. (Petitioner's Exhibit #3)

Petitioner returned to Concentra on May 17, and was again examined by Ms. White. Petitioner reported bilateral shoulder pain, with the left should pain being worse. It was noted that he had constant residual pain but experienced increased pain with heavy lifting and repeated activity. Ms. White reviewed the MRIs of Petitioner's shoulders noting supraspinatus tendinosis and a mild anterior labral tear in Petitioner's right shoulder and supraspinatus tendinosis in Petitioner's left shoulder. Petitioner was diagnosed with right and left

shoulder strains and was directed to continue his physical therapy and to continue modified work. Additionally, Petitioner was directed to have his care assumed by a specialist. (Petitioner's Exhibit #2, pp. 140-142)

On May 23, 2016, Petitioner was examined by Dr. David Garelick. The doctor documented a history of accident at work. Petitioner complained of bilateral shoulder pain subsequent to a fall onto his outstretched hands. Petitioner reported that his right side was getting better in therapy but they both ached all the time. The notes indicate Petitioner was working regular duty and that Petitioner complained of fatigue at the end of the work week. Dr. Garelick examined both shoulders. The exam findings revealed more tenderness at the AC joint on the left than the right. Range of motion was noted to be symmetric. Petitioner had a positive Hawkins test on the left and equivocal on the right. In the supine position, there was some tenderness over the AC joint. Dr. Garelick reviewed both MRI studies. Dr. Garelick opined that Petitioner had a fair amount of degenerative changes in the AC joint on the left shoulder. Dr. Garelick indicated the remainder of the studies for both shoulders were unremarkable. Dr. Garelick diagnosed Petitioner with a bilateral shoulder sprain. The doctor felt there was no indication for surgical intervention or injections at that time. Dr. Garelick recommended Petitioner return to therapy and released him to full duty work. (Petitioner's Exhibit #2, pp. 159-161)

Petitioner returned to Dr. Garelick on June 27, 2016. Petitioner reported that his right shoulder was much better. He still reported slight pain on the lateral aspect of his left shoulder. Range of motion was relatively symmetrical with full rotator cuff strength. There was some residual pain noted with Neer and Hawkins testing on the left side. Dr. Garelick diagnosed resolved right shoulder pain contusion and left shoulder contusion with mild residual impingement syndrome. Dr. Garelick recommended no intervention for the right shoulder. Dr. Garelick recommended and completed an injection to the left shoulder. Petitioner was returned to work regular duty. Dr. Garelick also advised Petitioner to return in one month for follow up. (Petitioner's Exhibit #2, p. 192)

Petitioner testified that on July 22, 2016, he was working for Respondent. At approximately 9:30 p.m., he was cranking the "dolly legs" of a semi-tractor trailer when he felt a burning sensation in his lower back. Petitioner testified that the crank was not operating properly and, as a result, he was required to apply more force to the crank than was usually required. Petitioner reported his work injury to Respondent's operations manager Joe Spina and finished his work shift.

Petitioner was not scheduled to work on Saturday, July 23, 2016, or Sunday, July 24, 2016. Petitioner stated that because his lower back symptoms continued over the weekend, he returned to Concentra on Monday, July 25, 2016. Petitioner was examined by Ms. White. The history provided by Petitioner states, "Patient states he was cranking the damaged gear box when he started to feel pain in his lower back. Injury occurred at 10:00 p.m." The date of accident was recorded as "07/22/16". Petitioner reported bilateral low back pain described as burning in nature. Petitioner also reported radiating pain to the buttocks. Examination findings revealed tenderness in the lumbar spine. Petitioner exhibited a negative straight leg raise test. Petitioner also had some decreased extension of the lumbar spine with range of motion testing. Ms. White diagnosed Petitioner with back pain and a strain of the lumbar region and prescribed Cyclobenzaprine and Ibuprofen. Petitioner was also directed to treat his injury with ice 4 times a day. Petitioner was advised to begin physical therapy and given work restrictions of occasional lifting up to 20 pounds and pushing/pulling up to 20 pounds. Petitioner was also advised not drive a company vehicle due to functional limitations. (Petitioner's Exhibit #2, pp. 194-197)

That same day, July 25, 2016, Petitioner was also examined by Dr. Garelick for the final time. Petitioner reported that he believed his left shoulder was doing better post-injection. He still had some discomfort at night. Petitioner reported that although his right shoulder was "doing pretty good," both shoulders continued to bother him everyday. Examination findings revealed symmetric range of motion. Dr. Garelick noted no pain with resisted supraspinatus testing on the left shoulder. Petitioner exhibited a mildly positive Neer and Hawkins sign on the left. Dr. Garelick diagnosed resolving impingement syndrome, left still somewhat more marked than

right. Dr. Garelick placed Petitioner at maximum medical improvement and encouraged him to continue to work on his home exercises. Petitioner was released to return to work regular duty. (Petitioner's Exhibit #2, p. 207) Petitioner testified that although he was released full duty, he continued with shoulder symptoms, left worse than right.

On July 27, 2016, Petitioner was again examined by Ms. White for his lumbar spine. Petitioner reported that he was getting better. Petitioner requested that he be cleared to return to work regular duty. Petitioner was diagnosed with low back pain and a lumbar strain. Petitioner was released to return to work regular duty with the caveat of avoiding any cranking of broken dolly legs or opening corroded doors. Petitioner was also directed to participate in a physical therapy program 3 times per week for 2 weeks and to continue full duty work. (Petitioner's Exhibit #2, pp. 210-212)

Petitioner returned to Concentra again on August 3, 2016 and was examined by Ms. White. Petitioner's symptoms were improving. His pain levels were 3/10. Petitioner was directed to begin taking Naproxen and to continue full duty work. (Petitioner's Exhibit #2, pp. 217-219). Petitioner was last seen at Concentra for his lower back pain on August 11, 2016. Petitioner reported back stiffness but no pain. Petitioner denied any lower extremity symptoms. Petitioner reported his current level of pain as a 1 out of 10. The records noted that Petitioner was doing "overall well". Examination findings were normal. Petitioner was diagnosed with back pain and a lumbar strain. Petitioner was released from care and placed at maximum medical improvement for his back injury. (Petitioner's Exhibit #2, pp. 224-225)

Petitioner testified that he continued to work for Respondent. He stated that he continued to experience ongoing bilateral shoulder pain with greater symptoms on the left than the right. As a result of same, he elected to obtain a second opinion from Dr. Daniel Troy on September 16, 2016. Records submitted show Petitioner reported that he had been undergoing treatment since March 24, 2016 for bilateral shoulder pain. Petitioner reported that both of his shoulders were better but not 100%. He was still having difficulty with both. Also noted was that Petitioner had tried physical therapy and was performing a home exercise program. On examination, Petitioner had full flexion and abduction with pain in the left shoulder and slight pain in the right. Petitioner exhibited a positive Hawkins test and negative Neer on the left. Petitioner had no pain in the AC joint on the left. He had slight pain over his biceps tendon but no pain bilaterally. Petitioner had minimal symptoms in the right shoulder with mild to moderate Neer impingement. He also had minimal Hawkins. Bilateral shoulder x-rays were obtained revealing moderate degenerative changes of the bilateral AC joints. Dr. Troy reviewed the prior MRI studies of the left and right shoulder. Dr. Troy diagnosed bilateral shoulder impingement, left greater than right. Dr. Troy performed a repeat cortisone injection to Petitioner's left shoulder, this time with ultrasound guidance. After the injection, Dr. Troy prescribed Voltaren Gel, returned Petitioner to full duty work and directed him to return in 6 weeks. (Petitioner's Exhibit #4) Petitioner testified that he experienced relief of his left shoulder symptoms following the injection for approximately 2 weeks, and then the symptoms returned.

Petitioner testified that he continued to work for Respondent. He returned to see Dr. Troy on October 28, 2016. Petitioner reported that the injection to the left shoulder helped for about two weeks. Petitioner also reported symptoms in the right shoulder. Petitioner reported overall frustration. Petitioner complained of re-aggravation of his shoulder pain with truck driving. Dr. Troy noted that the examination findings were unchanged from the prior visit. The doctor noted that Petitioner continued with positive signs for bilateral impingement syndrome and bilateral positive Hawkins' sign. Dr. Troy diagnosed bilateral shoulder impingement, left greater than right and provided him with a right shoulder cortisone injection with ultrasound guidance. Dr. Troy directed Petitioner to continue full duty work and to return in 3 to 4 months. (Petitioner's Exhibit #4) Petitioner testified that he experienced relief of his right shoulder symptoms for approximately 2 weeks and then his symptoms returned.

Petitioner testified that he continued to work for Respondent while experiencing continual symptoms of soreness on the outside portion of both shoulders. On March 22, 2017, Petitioner returned to Dr. Troy. Petitioner continued to report difficulty with the left and right shoulder. Examination findings revealed positive impingement signs on the left greater than right. Dr. Troy again reviewed the prior MRI studies. Dr. Troy continued to diagnose bilateral shoulder impingement, left being more symptomatic than right. Dr. Troy recommended Petitioner proceed with diagnostic left shoulder arthroscopy and subacromial decompression. (Petitioner's Exhibit #4)

Petitioner testified that on May 12, 2017, he was working for Respondent in the truck depot parking area. As Petitioner was walking through the parking area, he stepped in a depression in a gravel surface, causing him to lose his balance. When Petitioner lost his balance, he struck his left shoulder on the chassis of a semi-tractor trailer. Petitioner stated he immediately felt severe pain on the outside of his left shoulder. Because of his symptoms of pain, Petitioner did not finish his work shift on May 12, 2017. Petitioner was not scheduled to work on Saturday, May 13, 2017, or Sunday, May 14, 2017. On Monday, May 15, 2017, Petitioner's symptoms remained. As a result, he reported his work injury to Joe Spina, the operations manager for Respondent.

On May 16, 2017, Petitioner retuned to Dr. Troy. Petitioner provided a history that states, "…he reports that Friday, 5/12/2017, at work he was walking and not paying attention. He subsequently ended up walking into a steel beam directly over the anterior aspect of his shoulder." Examination findings revealed ecchymosis over the anterior aspect of the left humerus. There was mild tenderness to palpation over the left AC joint. Petitioner had a positive Neer's and Hawkin's sign bilaterally. Petitioner had full strength in both arms. X-rays of the left shoulder demonstrated a mild amount of GH arthritis and a mild amount of arthritic changes in the AC joint. There were no other abnormalities seen on the imaging studies. Dr. Troy diagnosed bilateral shoulder pain and impingement syndrome. Dr. Troy prescribed Tramdol due to Petitioner's moderate to severe pain. Petitioner was advised that he should not operate a truck while taking the medications. Dr. Troy also restricted Petitioner to no lifting, carrying, pushing or pulling greater than 20 pounds. Dr. Troy continued to recommend a diagnostic left shoulder arthroscopy. (Petitioner's Exhibit #4)

Petitioner testified that after his May 16, 2017 appointment with Dr. Troy, he requested light duty work from Respondent's operations manager, Joe Spina. Petitioner stated that Respondent has not offered light duty work since May 16, 2017.

At the request of Respondent, Petitioner underwent a Section 12 examination with Dr. Joseph T. Monaco on May 23, 2017. In his report dated same, Dr. Monaco noted that he obtained a history of work incidents on March 24, 2016 and July 22, 2016. In addition to performing an examination, the doctor reviewed Petitioner's medical records and diagnostic studies. Upon examination, Dr. Monaco noted bruising over the anterolateral aspect of the left shoulder. O'Brien test was negative bilaterally. There was positive Hawkins' and Empty Can test bilaterally. Cross body abduction at +2 on the left and negative on the right. Dr. Monaco diagnosed 1.) resolved left and right shoulder strains; and 2.) degenerative changes of the acromioclavicular joints with impingement with both shoulders. Dr. Monaco opined that the bilateral shoulder strains suffered by Petitioner were related to his work accident on March 24, 2016, but that the strains resolved in a "couple of weeks." Dr. Monaco also opined that Petitioner suffered a temporary exacerbation of pre-existing impingement syndrome which returned to baseline within four (4) months after Petitioner's work injury on March 24, 2016. Dr. Monaco found that Petitioner had reached maximum medical improvement on July 25, 2016 when released by Dr. Garelick. He specifically opined the right shoulder condition had resolved by April 18, 2016 and the left had resolved by July 25, 2016. Dr. Monaco opined that Petitioner's conditions of ill-being at the time of his evaluation were unrelated to the work incident and any further treatment was not related to the March 26, 2016 accident. Dr. Monaco opined that as a result of his March 24, 2016 work injury, Petitioner was cable of returning to full duty work. Lastly, Dr. Monaco opined that treatment through the date of his evaluation was

reasonable and necessary. Dr. Monaco also performed an AMA Impairment Rating. (Respondent's Exhibit #2)

On June 13, 2017, Petitioner returned to Dr. Troy. Dr. Troy diagnoses remained the same and he continued his surgical recommendation. At this visit, Dr. Troy also took Petitioner off work (Petitioner's Exhibit #4). When Petitioner returned to Dr. Troy on June 30, 2017, the doctor noted Petitioner's continued complaints of pain in the left shoulder. Petitioner continued to exhibit positive results from Neer's and Hawkins' tests bilaterally. The doctor reviewed the report of Dr. Monaco dated May 23, 2017, noting Dr. Monaco felt Petitioner had achieved maximum medical improvement. Dr. Troy directed Petitioner to remain off work and to return in 4 to 6 weeks. (Petitioner's Exhibit #4) On August 16, 2017, Dr. Troy noted Petitioner continued to exhibit positive Neer's and positive Hawkins' tests for impingement. The doctor directed Petitioner to continue using Tramadol for his symptoms. On August 21, 2017, Dr. Troy completed a note confirming that Petitioner was to remain off work. (Petitioner's Exhibit #4)

At Respondent's request, Dr. Monaco authored an addendum report on September 21, 2017. In his report, Dr. Monaco noted he reviewed medical records for treatment received by Petitioner in 2009 as well as additional records from Dr. Troy since the doctor's last report in May of 2017. Dr. Monaco stated that his opinion remained the same, i.e., Petitioner sustained resolved bilateral shoulder strains as a result of the accident sustained on March 24, 2016. With respect to the May 12, 2017 accident, Dr. Monaco opined Petitioner sustained a contusion to the soft tissue of the left shoulder. The doctor opined that Petitioner's work injury on May 12, 2017 did not change his opinion regarding causation in any way. The doctor felt the May 2017 injury was nothing more than a minor soft tissue contusion of the left upper arm and shoulder area with no acute injury or internal derangement to the left shoulder joint. (Respondent's Exhibit #3)

Dr. Monaco opined that the degenerative changes of the AC joint of both shoulders pre-existed and were not caused by either work-related incident. Dr. Monaco stated the additional medical records show similar complaints and findings involving the left shoulder in 2009. He noted the diagnostic studies at that time showed findings similar to the MRI scans done in 2016. The doctor provided that Petitioner's symptoms in 2009 were consistent with temporary exacerbation of the pre-existing degenerative changes of the AC joint of the left shoulder with subsequent return to baseline. He opined that the work-related incidents of March 24, 2016 and May 12, 2017 resulted in temporary exacerbation of the pre-existing degenerative changes of the left shoulder AC joint. Dr. Monaco opined that Petitioner was at maximum medical improvement for both his March 24, 2016 accident and his May 12, 2017 accident. (Respondent's Exhibit #3)

Petitioner last saw Dr. Troy on October 14, 2017. The doctor noted Petitioner's examination remained unchanged, i.e., Petitioner exhibited positive Neer's and positive Hawkin's impingement tests, left "much more significant that right." Dr. Troy's diagnosis at that time was impingement syndrome of the left and right shoulder. The doctor repeated his recommendation that Petitioner proceed with diagnostic left shoulder arthroscopy. Dr. Troy also directed Petitioner to remain off work and advised Petitioner to return after obtaining approval for the proposed procedure. (Petitioner's Exhibit #4) Petitioner testified that he would like to proceed with the surgery recommended by Dr. Troy.

Petitioner testified that other than the work accidents on March 24, 2016 and May 12, 2017, he has not suffered any new injuries to his left or right shoulders. In addition, Petitioner has not suffered any injuries to his lower back since July 22, 2016.

Petitioner testified that prior to the March 24, 2016 accident, he sustained work-related injuries to his left shoulder and neck in February and March of 2009. Petitioner stated he was not an employee of Respondent at the time of his 2009 accidents. Petitioner testified that he received medical treatment at Parkview Orthopedics and Meridian Medical Associates. Petitioner testified that the symptoms he experienced following his 2009

accidents began in his neck and consisted of shooting pains down his arms. Petitioner testified that the shooting pains down his left arm were worse than his right arm. Petitioner testified that he did not receive any further medical treatment for his shoulders from 2010 up to the March 24, 2016 accident. Petitioner further testified that he did not lose any time from work subsequent to 2010 but before the March 24, 2016 accident. Petitioner denied any further injuries to his shoulders during that same time period.

Mr. Joseph Spina was called to testify by Respondent. Mr. Spina testified that he has worked for Respondent for approximately seven years as the safety director. Mr. Spina testified that he was in charge of Department of Transportation compliance as well as any workplace injuries. Mr. Spina testified that he would speak with the dispatchers, including Mr. Ibrahim, on a daily basis. Mr. Spina testified that he did not learn of Petitioner's first work accident of March 24, 2016 until April 8, 2016. Mr. Spina testified that Petitioner continued to work full duty up until the date he was placed on light duty. Mr. Spina testified that he was never made aware of any of Petitioner's ongoing problems while driving a truck or safety concerns that Petitioner testified to on direct examination. Mr. Spina stated that he could not recall if Petitioner requested light duty work. Mr. Spina also indicated that Respondent does not have light duty work for truck drivers.

Dr. Troy testified via deposition in this matter on December 4, 2017. (Petitioner's Exhibit #5) Dr. Troy testified that he first saw Petitioner on September 16, 2016. At that time Petitioner had bilateral shoulder pain complaints, left worse than right. Dr. Troy stated that Petitioner's rotation to his left was slightly diminished compared to the right. Both shoulders had positive impingement symptomatology. He had slight pain over the anterior aspect to the shoulder in the region of the biceps tendon. His right shoulder was symptomatic, but minimal. He had mild to moderate Neer impingement symptoms and minimal Hoffman's. Dr. Troy stated he assessed Petitioner with bilateral shoulder impingement, left greater than right. Dr. Troy recommended therapy, suggested and performed a second steroid injection to the left shoulder. The doctor testified that he later performed an injection to Petitioner's right shoulder. The doctor stated Petitioner only received short-term relief from both injections stating Petitioner kept having rebound symptomatology. (Petitioner's Exhibit #5, pp. 10-14)

Dr. Troy testified that he ultimately recommended surgical intervention of the left shoulder. Dr. Troy explained that Petitioner had been having symptoms since March of 2016. Dr. Troy stated, "…It's been a year. He's already did therapy. He's received two steroid injections. He's been using anti-inflammatories…So there is nothing further I can offer him except continue to live with the symptoms or to go in and surgically remove the inflamed bursa… which is part of the impingement process…" (Petitioner's Exhibit #5, pp. 15,16)

With respect to the May 12, 2017 incident, Dr. Troy testified that Petitioner sustained a left shoulder contusion. Dr. Troy did not believe that this second injury changed Petitioner's impingement diagnosis in any significant way. (Petitioner's Exhibit #5, p. 18)

Dr. Troy testified that he kept Petitioner off work following the June 30, 2017 visit. The doctor provided that Petitioner's symptoms were increasing and he reported being uncomfortable while driving. (Petitioner's Exhibit #5, p. 19) Dr. Troy testified that he continued to diagnose Petitioner with bilateral shoulder impingement syndrome left greater than right. Dr. Troy testified that Petitioner required a diagnostic left shoulder arthroscopy. (Petitioner's Exhibit #5, p. 20)

Dr. Troy offered an opinion on causal connection. Dr. Troy testified that he believed the impingement syndrome was related to the March 24, 2016 work accident. Dr. Troy based this opinion on Petitioner's reports that he became symptomatic in shoulders after the accident of March 24, 2016. Dr. Troy further based his opinions on Petitioner's reports of continuing shoulder symptoms post-March 24, 2016 accident. Dr. Troy believed that the May 12, 2017 accident represented a contusion that exacerbated Petitioner's pain in the left shoulder. Dr. Troy noted Petitioner was already symptomatic in the left shoulder before the May 12, 2017

incident and remained symptomatic thereafter. Dr. Troy did not believe that the May 12, 2017 incident changed the course of Petitioner's impingement syndrome. (Petitioner's Exhibit #5, pp. 21-23)

When asked what type of mechanism of injury would be required to cause impingement syndrome, Dr. Troy stated, "…the impingement syndrome is a constellation of rotator cuff tendinitis, associated bursitis of the shoulder and possible spurring. So any injury – a direct blow could. It's very atypical, but it could. A fall on an outstretched extremity also could. But one of those two things occurred when of course he fell off the truck." He testified that the fall off the truck could cause impingement syndrome. (Petitioner's Exhibit #5, p. 22) Dr. Troy testified that the diagnostic left shoulder arthroscopy appears to be causally related to the March 2016 event. The doctor explained that there was no evidence Petitioner was experiencing symptoms involving the left shoulder before the March 24, 2016 accident. He added that Petitioner remains symptomatic and has not returned to his pre-injury status. Dr. Troy testified that he was aware of the medical records regarding Petitioner's 2009 treatment and the prior left shoulder MRI from May 4, 2009. Dr. Troy testified that the records did not change his opinions. Dr. Troy noted that Petitioner had a series of approximately six (6) years of functioning well with no office visits or treatments to his left or right shoulder nor did he have any subjective statements that he was having symptoms to his left nor right shoulder during that time period. (Petitioner's Exhibit #5, pp. 25-26)

With respect to the right shoulder, Dr. Troy testified that Petitioner may or may not need right shoulder surgery. Dr. Troy was hopeful that the right shoulder symptoms would resolve on their own post-left shoulder surgery. Dr. Troy causally related Petitioner's right shoulder condition to the March 2016 incident. (Petitioner's Exhibit #5, p. 27)

Dr. Troy testified that he disagreed with the opinion of Dr. Monaco, Respondent's Section 12 examiner, that Petitioner merely sustained strains of the left and right shoulder. Dr. Troy stated, "If one suffered a strain, one would imply that he was returned back to his pre-work injury status, which based on his subjective statements of [Petitioner], he has not been…[T]hat would imply that the patient is now asymptomatic from the shoulder, which, based on his continued follow-up with myself, proves that he is not – that he did not have an exacerbation, which implies a temporary injury to his shoulder. He had more of an aggravation, and the proof of that is the patient's continued treatment of the left shoulder, and to a minimal degree, the right shoulder…" (Petitioner's Exhibit #5, pp.27-28) Dr. Troy believed that because of his ongoing symptoms, Petitioner was not at maximum medical improvement. (Petitioner's Exhibit #5, p. 29)

On cross-examination, Dr. Troy testified that he reviewed the records from Parkview Orthopedics relating to the 2009-2010 treatment. Dr. Troy testified that he did not review any of the medical records from Concentra or Dr. Garelick. Dr. Troy testified that it's possible his opinions on causation could change based upon review of the Concentra medical records. (Petitioner's Exhibit #5, pp. 31-32) Dr. Troy testified that the May 2009 MRI of the left shoulder revealed AC degenerative joint changes with bone spurring. Dr. Troy testified that those degenerative changes would progress over time. Dr. Troy testified that AC degeneration and bone spurs are one of the etiologies of impingement syndrome. Dr. Troy testified that a review of Petitioner's chart notes from July 6, 2009 appear to show Petitioner was having more problems in his neck than his shoulders with a possible left upper extremity radiculopathy and that any restrictions back then was related to the neck and not the shoulder. (Petitioner's Exhibit #5, pp. 34-36)

Dr. Troy testified that both the pre and post accident MRI studies of the left shoulder revealed AC joint arthropathy or bone spurring. Dr. Troy testified that that AC arthropathy or bone spurring was not caused by the March 24, 2016 work accident. Dr. Troy testified that AC arthropathy can cause pain in one shoulders. Dr. Troy also testified that arthropathy is one of the causes of shoulder impingement. Dr. Troy testified that these conditions will degenerative over time and not reverse course. (Pet. Ex. #5, 44 & 46). Dr. Troy testified that degenerative conditions can be exacerbated or aggravated. He believed Petitioner sustained a permanent

aggravation of his left shoulder condition as a result of the March 2016 work accident. The doctor added that although it was possible that the shoulder impingement and inflammation of the bursa was caused by the pre-existing bone spurring, it was not the absolute sole cause. The doctor stated that other causes are repetitive activity and traumatically induced rotator cuff tendinitis that fails to resolve and, "...we only have evidence of the traumatically induced trauma." (Petitioner's Exhibit #5, pp. 46-47) Dr. Troy testified that there was nothing on the May 16, 2016 MRI studies that were acutely caused by the March 24, 2016 accident. (Petitioner's Exhibit #5, p. 49)

Dr. Troy testified that the right shoulder MRI revealed mostly the same degenerative findings as the left shoulder study. Dr. Troy testified that it was likely that the findings on the right shoulder MRI in May of 2016 all pre-dated the March 24, 2016 work accident. (Petitioner's Exhibit #5, p. 51)

On redirect, Dr. Troy reviewed the final record of Dr. Garelick dated July 25, 2016. Dr. Troy testified that there was nothing in the record that was inconsistent with his findings when he examined Petitioner on September 16, 2016, outside of the fact Petitioner was more asymptomatic at the time of his September 2016 examination. The doctor provided that the report does not change his opinions on causation. The doctor stated, "I believe it does support the opinion...There's an event that caused a traumatically-induced inflammatory episode to his shoulder. It started the process of the inflamed bursal tissue, the rotator cuff tendinitis. He does have the spurring, but he has mild AC changes with palpation, but it started this impingement syndrome to his shoulder which has failed to resolve with conservative treatment." Dr. Troy added that it's a combination of both the degenerative condition and the trauma sustained. Dr. Troy stated, "...because degenerative changes could increase someone's risk for having impingement syndrome. So if one develops traumatically-induced bursitis to the shoulder, you're going to be at that much more risk for that to fail to resolve because you have preexisting degenerative changes of the AC joint and encroachment to the subacromial space. (Petitioner's Exhibit #5, pp. 55-58)

Dr. Joseph Monaco, Respondent's Section 12 examiner, was called to testify via evidence deposition on January 25, 2018. (Respondent's Ex. #1). Dr. Monaco testified that he examined Petitioner at the request of Respondent on May 23, 2017. Dr. Monaco testified that he reviewed Petitioner's medical records from Concentra as well as the records of Dr. Daniel Troy in preparation of his May 23, 2017 report. Dr. Monaco testified that he also reviewed the May 2016 MRI reports and films of Petitioner's bilateral shoulders. Dr. Monaco testified that he took a history of Petitioner's March 24, 2016 fall from a crosswalk approximately 3.5 feet above ground, landing on both of his upper extremities. Dr. Monaco testified that Petitioner also reported sustaining a second incident on May 16, 2017 resulting in a contusion to the left shoulder due to walking into a steel beam at work. (Respondent's Ex. #1, pp. 10-17)

Dr. Monaco testified that he reviewed the MRI films of Petitioner's left and right shoulders obtained in May of 2016. Dr. Monaco testified that his impression were that the findings were mostly age-related changes. Dr. Monaco testified that he believed there were degenerative changes of the AC joint with mild hypertrophy and mild marginal spurring with signs of impingement. (Respondent's Ex. #1, p.19) Dr. Monaco testified that those findings can be found on individuals who are asymptomatic. Dr. Monaco testified that there was no evidence of any acute injury on the films. (Respondent's Ex. #1, pp.19-20) Dr. Monaco testified that he compared the pre-accident MRI of Petitioner's shoulder to the post-accident studies. Dr. Monaco testified that the two studies were remarkably similar in regards to the changes due to age, with no evidence of acute injury. (Respondent's Ex. #1, pp. 21-22)

Dr. Monaco testified that he examined Petitioner. Dr. Monaco testified that the time of his first report, his opinion was that Petitioner sustained strains of left and right shoulders. Dr. Monaco opined that both strains had resolved. Dr. Monaco also diagnosed Petitioner with degenerative changes of the AC joint with impingement in both shoulders. Dr. Monaco opined that the strains of the left and right shoulder were a result of

the March 24, 2016 work accident. Dr. Monaco testified that the degenerative changes of the AC joint that were signs of impingement syndrome were a result of a temporary exacerbation of pre-existing condition. Dr. Monaco stated, "…[I]n this case there was no evidence of any acute injury as a result of the incident. He did have the preexisting degenerative changes…that are common, can be commonly found on asymptomatic individuals. So those degenerative changes can be involved in the provocation of bursitis, tendonitis and impingement of the shoulder, and that can happen as a result of an injury like a strain. But the absence of an acute injury the expectation would be this would return to baseline." Dr. Monaco testified that he based his opinion on the medical records he reviewed, most notably the findings of Dr. Garelick. (Respondent's Ex. #1, pp. 26-28) Dr. Monaco also explained that baseline is not the equivalent of being asymptomatic. Dr. Monaco explained that in cases of degenerative underlying osteoarthritis of the AC joint and signs of impingement, the expectation over time would be that the condition would worsen, "…so that you would not expect return to baseline to be returning to asymptomatic. You would expect it to return to where you expect it to be based upon the natural history of the condition you're dealing with." Dr. Monaco testified that he believed Petitioner was capable of working full duty without restrictions as it related to the March 2016 accident. Dr. Monaco again based his opinions on the findings and conclusions of Dr. Garelick. Dr. Monaco testified that he believed Petitioner reached MMI for both shoulder conditions at the time of the May 23, 2017 exam. (Respondent's Ex. #1, pp. 28-30)

Dr. Monaco testified that he also authored an addendum report which was dated September 21, 2017. Dr. Monaco testified that he reviewed additional medical records which included Petitioner's records from 2009 and updated records from Dr. Troy. (Respondent's Ex. #1, pp. 33-34) Dr. Monaco testified that he reviewed the 2009 MRI report of the left shoulder. Dr. Monaco testified that the findings were very similar on the pre-accident MRI versus the post-accident study. Dr. Monaco testified that Petitioner's present complaints and symptoms were very similar to his complaints and symptoms in 2009. Dr. Monaco noted that Petitioner claimed injuries in 2009 to both shoulders, with the right shoulder becoming less of an issue within weeks after the accident. Dr. Monaco found this to be similar to Petitioner's symptoms subsequent to the March 24, 2016 accident. Dr. Monaco also noted the similarities in Petitioner's treatment in 2009 versus post-March 24, 2016. (Respondent's Ex. #1, pp. 36-38) Dr. Monaco opined that the additional records revealed "… just almost a complete replay of the same course of action and complaints from 2009 to 2016." (Respondent's Ex. #1, pp. 39-40) Dr. Monaco testified that his prior IME opinions did not change after his review of the additional pre-accident medical records. Dr. Monaco testified that the pre-accident records confirmed his prior opinions. (Respondent's Ex. #1, pp. 42-43)

On cross-examination, Dr. Monaco testified that he generally agreed with the radiologists' findings with respect to the 2016 MRIs, with the exception of possible small tear of the labrum on the right. It was Dr. Monaco's opinion that the labrum was normal. (Respondent's Ex. #1, pp. 47-49) Dr. Monaco testified that he has performed the surgery proposed by Dr. Troy. Dr. Monaco stated that Petitioner's condition did not result from an acute injury and the surgery would not be related to the strain of the shoulders that Petitioner sustained with the fall onto his hands. He indicated the proposed surgery would address Petitioner's impingement syndrome. Dr. Monaco suggested that surgery would be a last option. Dr. Monaco opined that the surgery proposed by Dr. Troy was not inappropriate. Dr. Monaco had reservations about success. Dr. Monaco was concerned about the lack of objective findings on MRI studies and the ongoing subjective complaints of Petitioner. He felt Dr. Troy might be "backed into a corner and nothing else was helping." The doctor stated, "…if you take into account what happened in 2009, which is almost the same as what happened in 2016 as far as mechanism of injury and completely negative diagnostic findings and only positive findings, complaints of pain and the findings of provocative shoulder tests…and that went on for about a year and then I have no more records to review so I don't know what happened after that…So he had a significant problem with that left shoulder and also had some problem with his neck too, and you have to assume it eventually got better because he was back at work in 2016 and actually denying any problems with his shoulders prior to that. It's possible he

didn't recall it. It seems a little farfetched. Dr. Monaco testified that he did not disagree with Dr. Troy's treatment: but disagreed with the cause of Petitioner's problem. (Respondent's Ex. #1, pp. 54-60)

Dr. Monaco testified that impingement syndrome very often develops idiopathically. Dr. Monaco testified that oftentimes patient will come to him and not know the cause of shoulder problems other than the patient simply has pain. Dr. Monaco also stated there are instances when he's determine an individual has impingement syndrome after the person had an injury and subsequently complain of symptoms similar to Petitioner. The doctor stated he considered impingement syndrome to be more of a symptom conglomeration than an actual pathology. (Respondent's Ex. #1, pp. 61-63) Dr. Monaco testified that a fall from a height can aggravate a previously asymptomatic condition such as impingement syndrome and cause it to become symptomatic. Dr. Monaco testified that he believed that Petitioner temporarily aggravated his condition but returned to baseline. Dr. Monaco testified that Petitioner had a preexisting condition which was temporary exacerbated by the fall but got better when he reached MMI with Dr. Garelick. Dr. Monaco added, "…if there's underlying degenerative changes such as this which can cause impingement, then they can cause impingement without necessarily having another injury…So it doesn't mean that once –that just because he's saying he didn't have any pain before the fall and now he has pain that all pain in the shoulder after that is related to the fall…It appeared there wasn't any sign of any acute injury, so it's my feeling there was an exacerbation of this preexisting condition which got better, but it's not my opinion that it was all caused by the fall…So just because he has pain after the fall, a year and a half later…that temporal relationship is not felt to be a very good approach to determining causation, just because something happened and something happens following it. So I think that what happened following it because of the strain he had some pain which eventually got better, maybe not completely 100 percent as far as he's concerned but better and no further treatment was needed, and then it got worse." (Respondent's Ex. #1, pp. 66-69) Dr. Monaco agreed that Petitioner's treatment was reasonable, necessary and causally related up to the July 25, 2016 MMI date. Dr. Monaco agreed with the reasonableness of the shoulder treatment thereafter, but disagreed that it was related. (Respondent's Ex. #1, pp. 70-71)

Dr. Monaco testified that he was not provided with any medical treatment records between March 2010 and March of 2016. When asked "…what, if any conclusion can you draw from that fact," Dr. Monaco replied, "I can conclude that he has not sought medical care somewhere where the records would be available and that the shoulders got – that undergoing almost a year's worth of treatment before I had no more records he was still having some complaints but apparently would mean he got better." (Respondent's Ex. #1, p. 72) Dr. Monaco clarified his earlier statement that the mechanism of injury in 2009 and the mechanism of injury in March 2016 were similar. He admitted that the 2009 mechanism of injury involved Petitioner attempting to lower dollies on a truck and he was "pulling something." Dr. Monaco also admitted that majority of medical treatment noted in Petitioner's post-accident medical records after July 6, 2009 pertained to mainly cervical spine treatment. (Respondent's Ex. #1, pp. 72-76) Lastly, Dr. Monaco testified that Petitioner had preexisting impingement in his shoulders as opposed to impingement syndrome. The doctor stated that the concept of impingement syndrome requires symptoms. He indicated that Petitioner developed symptomatology consistent with impingement syndrome after the March 2016 accident. When asked "…[O]ther than the normal progression from aging has, in your opinion, [Petitioner's] baseline condition of his left shoulder changes since his work injury in March of 2016?," Dr. Monaco replied, " I think his symptoms have ebbed and flowed, but my thought, my feeling is he returned to baseline by July 2016." (Respondent's Ex. #1, pp. 78-79)

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

The Findings of Fact, as stated above, are adopted herein.

The Arbitrator adopts Petitioner's credible and uncontroverted testimony that he arrived for his work shift with Respondent in the evening on May 12, 2017. Petitioner testified that this was his usual start time for work with Respondent. Petitioner was working for Respondent in the truck depot parking area. As Petitioner was walking through the parking area, he stepped in a depression in the gravel surface, causing him to lose his balance. When Petitioner lost his balance, he struck his left shoulder on the chassis of a semi-tractor trailer. Immediately after the accident Petitioner felt severe pain on the outside of his left shoulder. Because of his symptoms of pain, Petitioner did not finish his work shift on May 12, 2017.

Petitioner was not scheduled to work on Saturday, May 13, 2017, or Sunday, May 14, 2017. On Monday, May 15, 2017, Petitioner's symptoms remained and he reported his work injury to Joe Spina, the operations manager for Respondent.

Petitioner's testimony regarding his work accident on May 12, 2017 is corroborated by the histories provided by Petitioner to the medical providers and the medical findings noted by the medical providers since his work accident. Specifically, on May 16, 2017, four days after his accident, the history recorded by Dr. Troy states, "[r]egarding the patient's left shoulder he reports that Friday, 5/12/2017, at work he was walking and not paying attention. He subsequently ended up walking into a steel beam directly over the anterior aspect of his shoulder." Upon examination of Petitioner's left shoulder, Dr. Troy noted a "3 inch in diameter area of ecchymosis directly over the anterior aspect of his humerus."

The Arbitrator also notes that the history recorded on May 23, 2017 by Respondent's Section 12 examiner, Dr. Monaco states, "[Petitioner] indicates that recently on May 16, 2017, he had an incident where he slammed his left arm area into a truck." Upon examination, Dr. Monaco noted that Petitioner exhibited a "significant sized bruise, 7 x 4 cm, on the lateral aspect of the left upper arm." The Arbitrator notes that Dr. Monaco has a different date than the date of injury claimed by Petitioner. Given the similar description of the incident in both histories, it is clear that both are describing the same event. The record is clear that Petitioner was examined by Dr. Troy on May 16, 2017, and the contusion was already evident on Petitioner's left shoulder. As such, the Arbitrator finds that the date contained in Dr. Troy's history is correct.

Based on the foregoing, the Arbitrator finds that Petitioner has proved, by a preponderance of the evidence, that he suffered an accident that arose out of and in the course of his employment by Respondent on May 12, 2017.

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

The Findings of Fact and Conclusions of Law, as stated above, are adopted herein.

Dr. Troy testified that Petitioner's injury was only a contusion and there was no change in the symptomology in his left shoulder following the May 12, 2017 injury. Dr. Troy attributed Petitioner's condition of ill-being as it relates to his left shoulder solely to Petitioner's work accident on March 24, 2016. The Arbitrator also notes that Respondent's Section 12 examiner, Dr. Monaco, opined that Petitioner merely suffered a contusion to his left shoulder as a result of his work accident in May of 2017 and that the existence of that incident did not change his opinion regarding casual connection whatsoever.

Based on the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being, as it relates to his left shoulder, is not related to his work injury on May 12, 2017.

19IWCC0217

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

The Findings of Fact and Conclusions of Law, as stated above, are adopted herein.

Based on the Arbitrator's findings regarding causal connection above, none of the medical treatment received by Petitioner is related to his work accident on May 12, 2017. Accordingly, Respondent has paid all appropriate charges for all reasonable and necessary medical services relating to this work injury.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Naughton,
Petitioner,

vs. No: 17 WC 13408

19IWCC0218

Michael's Cartage,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, medical expenses and 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 on June 14, 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

19IWCC0218

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 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: MAY 1 - 2019

Marc Parker

o-04/18/19
mp-sj
68

Deborah L. Simpson

Barbara N. Flores

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

NAUGHTON, JAMES
Employee/Petitioner

Case# **17WC013408**
17WC016570
18WC004024

MICHAEL'S CARTAGE
Employer/Respondent

19IWCC0218

On 6/14/2018, 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 2.07% 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:

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

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

19IWCC0218

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

James Naughton
Employee/Petitioner

v.

Michael's Cartage
Employer/Respondent

Case # **17** WC **13408**

Consolidated cases: **17 WC 16570 & 18 WC 4024**

An *Application for Adjustment 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 **April 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 ______

FINDINGS

19IWCC0218

On the date of accident, **March 24, 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 **$47,301.28**; the average weekly wage was **$909.64**.

On the date of accident, Petitioner was **44** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$0.00** 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 Petitioner temporary total disability benefits of **$606.43**/week for **48-3/7** weeks, commencing **May 16, 2017** through **April 19, 2018**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of **$5,164.00**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize the left shoulder glenohumeral arthroscopy and arthroscopic subacromial decompression surgery and any reasonable and necessary medical treatment incidental to that surgery, as recommended by Dr. Troy.

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

6/13/18
Date

ICArbDec19(b)

JUN 14 2018

FINDINGS OF FACT:

James Naughton (hereinafter "Petitioner") injured his bilateral shoulders and cervical spine on March 25, 2009. He received medical treatment from Meridian Medical Associates from March 25, 2009 through April 7, 2009. (Respondent's Exhibit #6). Petitioner then received medical treatment from Dr. Kevin W. Luke and Dr. Anis O. Mekhail at Parkview Orthopaedic Group, S.C. Dr. Luke provided Petitioner with a left shoulder injection on May 8, 2009 and specifically opined that he felt that Petitioner's symptoms were related to his neck. Dr. Mekhail treated Petitioner's cervical spine symptoms and referred Petitioner for cervical epidural steroid injections on July 29, 2009, August 12, 2009 and August 26, 2009. On January 21, 2010, Dr. Mekhail released Petitioner to return to full duty work and directed him to return as needed. (Respondent's Exhibit #4).

From 2010 through March 23, 2016, Petitioner did not have any injuries to either of his shoulders. In addition, Petitioner did not receive any medical treatment for either of his shoulders from early in 2010 through March 23, 2016. Lastly, Petitioner worked full duty as a truck driver and did not miss any time from work from early in 2010 through March 23, 2016. Petitioner had never injured his lower back prior to March 24, 2016 and had never received medical care of any kind for his lower back prior to March 24, 2016. In addition, Petitioner had never missed any time from work due to lower back problems prior to March 24, 2016.

Petitioner testified that he had worked for Michael's Cartage (hereinafter "Respondent") as a truck driver for four years. Petitioner testified that he is a regional truck driver and traveled between the tri-states. Petitioner testified that his hours varied between 8 to 14 hours depending on the work. Petitioner testified that he worked nights and usually began his routes between 2 pm and 6 pm. Petitioner testified that on March 24, 2016, he was working for Respondent when he fell off the catwalk of a semi-tractor trailer. Petitioner stated he fell approximately three (3) to four (4) feet, landing on the ground below with outstretched hands. Petitioner Petitioner testified that he immediately experienced pain and soreness in both of his palms, and his left and right shoulders. That same evening, Petitioner reported his work accident via telephone to his supervisor, Tawfic Ibrahim, who is the night dispatcher for Respondent. Petitioner stated he continued to work and finished his work shift for Respondent.

Petitioner testified that over the ensuing two weeks, he experienced gradual increase in the pain on the outside of his shoulders, left worse than right. The pain also began to affect his sleep pattern. Petitioner testified that his symptoms in 2009 and 2010 started in his neck and radiated into his arms. After his accident on March 24, 2016, his symptoms were located on the outside of his shoulders. Petitioner testified that he advised Mr. Ibrahim of his symptoms and that he was going to seek medical treatment. Petitioner indicated Mr. Ibrahim directed him to go to the company medical clinic, Concentra.

Records submitted show Petitioner presented at Concentra on April 8, 2016 and was first examined by Dr. Al-Saraf. The history provided by Petitioner states, "This is the result of a fall [and] from back of truck to ground, landed on hands, felt pain at lt shoulder, milder pain at rt shoulder and felt achy. Occurred while at work." (Petitioner's Exhibit #2, p.4) Dr. Abbas examined Petitioner's left shoulder and found tenderness in the AC joint, distal clavicle and deltoid and painful range of motion with forward flexion, extension abduction, internal rotation and external rotation. (Petitioner's Exhibit #2, p. 10) Dr. Abbas diagnosed Petitioner with a left shoulder strain, directed him to begin a physical therapy program, prescribed Ibuprofen, and directed him to return to modified work with occasional lifting limited to 10 pounds, occasional pushing and pulling limited to 20 pounds and no reaching above shoulder level with the left arm. (Petitioner's Exhibit #2, p. 11)

Petitioner began the physical therapy program that was recommended by Dr. Abbas at Concentra on April 8, 2016. (Petitioner's Exhibit #2, p. 12) In addition, Petitioner continued to work for Respondent after April 8, 2016. On April 11, 2016, Petitioner returned to Dr. Abbas. According to the records, Petitioner reported that his left shoulder was improving with better range of motion. Petitioner reported mild soreness in the right shoulder occasionally. According to the doctor, Petitioner was "not worried about it". The examination findings continued to reveal tenderness at the deltoid as well as painful range of motion with forward flexion, extension abduction, internal rotation and external rotation. The doctor diagnosed Petitioner with a left shoulder strain and directed him to continue his medication, physical therapy, and work restrictions. (Petitioner's Exhibit #2, pp. 23-25)

On April 18, 2016, Petitioner returned to Concentra and was examined by Nurse Practitioner, Jan Pitts. The records note that Petitioner's left shoulder was improving. Petitioner reported mild soreness in the right shoulder. Petitioner was again diagnosed with a left shoulder strain. Physical therapy and work restrictions were continued. (Petitioner's Exhibit #2, pp. 46-48)

Petitioner returned to Concetra on April 25, 2016, at which time he was examined by Dr. Eric Griffin. It was noted that Petitioner was still experiencing pain in his left shoulder at night and experienced painful range of motion with forward flexion, abduction, internal rotation and external rotation. Dr. Griffin diagnosed Petitioner with a left shoulder strain and directed him to continue his physical therapy program and medication. In addition, Dr. Griffin released Petitioner to return to modified work with frequent lifting limited to 20 pounds and frequent pushing/pulling limited to 40 pounds. (Petitioner's Exhibit #2, pp. 75-77) On May 2, 2016, Petitioner was examined by Laura K. White, Physician's Assistant at Concentra. Petitioner reported that although his symptoms were improving, he still experienced left shoulder pain. Petitioner described the symptoms as intermittent with pain levels at 5 out of 10. Aggravating factors were arm elevation, overhead use and lifting. Petitioner also reported right arm pain but the left was worse. Ms. White diagnosed shoulder strain, directed Petitioner to continue his physical therapy program and his modified work restrictions. Ms. White also prescribed Cyclobenzaprine and Naproxen. (Petitioner's Exhibit #2, pp. 97-99)

On May 9, 2016, Petitioner was again examined by Ms. White. Ms. White noted that Petitioner complained of pain in the anterior shoulders bilaterally and in the right lateral shoulder. Ms. White also noted that Petitioner experienced increased pain with heavy lifting and repeated activity. Ms. White diagnosed left and right shoulder strains. She directed him to continue his physical therapy program and medication. In addition, Ms. White recommended Petitioner obtain MRIs of his left and right shoulder and referred Petitioner to an orthopedic specialist. (Petitioner's Exhibit #2, pp. 120-123)

On May 16, 2016, Petitioner completed MRIs of his left and right shoulders at Accelerated Open MRI and Imaging. According to the radiologist's report, the right shoulder MRI revealed AC joint arthropathy with mild subacromial impingement of the rotator cuff. Small cystic changes were noted at the posterolateral aspect of the humeral head. There were also findings of supraspinatus tendinosis without evidence of tear. The remainder of the rotator cuff was normal. Lastly, there was a possible small tear at the anterior margin of the glenoid labrum. The MRI of the left shoulder was interpreted to reveal AC joint arthropathy causing mild subacromial impingement of the rotator cuff. There were small cystic changes of the posterolateral aspect of the humeral head. Supraspinatus tendinosis without evidence of tear was also indicated. The remainder of the rotator cuff was normal. (Petitioner's Exhibit #3)

Petitioner returned to Concentra on May 17, and was again examined by Ms. White. Petitioner reported bilateral shoulder pain, with the left should pain being worse. It was noted that he had constant residual pain but experienced increased pain with heavy lifting and repeated activity. Ms. White reviewed the MRIs of Petitioner's shoulders noting supraspinatus tendinosis and a mild anterior labral tear in Petitioner's right shoulder and supraspinatus tendinosis in Petitioner's left shoulder. Petitioner was diagnosed with right and left

shoulder strains and was directed to continue his physical therapy and to continue modified work. Additionally, Petitioner was directed to have his care assumed by a specialist. (Petitioner's Exhibit #2, pp. 140-142)

On May 23, 2016, Petitioner was examined by Dr. David Garelick. The doctor documented a history of accident at work. Petitioner complained of bilateral shoulder pain subsequent to a fall onto his outstretched hands. Petitioner reported that his right side was getting better in therapy but they both ached all the time. The notes indicate Petitioner was working regular duty and that Petitioner complained of fatigue at the end of the work week. Dr. Garelick examined both shoulders. The exam findings revealed more tenderness at the AC joint on the left than the right. Range of motion was noted to be symmetric. Petitioner had a positive Hawkins test on the left and equivocal on the right. In the supine position, there was some tenderness over the AC joint. Dr. Garelick reviewed both MRI studies. Dr. Garelick opined that Petitioner had a fair amount of degenerative changes in the AC joint on the left shoulder. Dr. Garelick indicated the remainder of the studies for both shoulders were unremarkable. Dr. Garelick diagnosed Petitioner with a bilateral shoulder sprain. The doctor felt there was no indication for surgical intervention or injections at that time. Dr. Garelick recommended Petitioner return to therapy and released him to full duty work. (Petitioner's Exhibit #2, pp. 159-161)

Petitioner returned to Dr. Garelick on June 27, 2016. Petitioner reported that his right shoulder was much better. He still reported slight pain on the lateral aspect of his left shoulder. Range of motion was relatively symmetrical with full rotator cuff strength. There was some residual pain noted with Neer and Hawkins testing on the left side. Dr. Garelick diagnosed resolved right shoulder pain contusion and left shoulder contusion with mild residual impingement syndrome. Dr. Garelick recommended no intervention for the right shoulder. Dr. Garelick recommended and completed an injection to the left shoulder. Petitioner was returned to work regular duty. Dr. Garelick also advised Petitioner to return in one month for follow up. (Petitioner's Exhibit #2, p. 192)

Petitioner testified that on July 22, 2016, he was working for Respondent. At approximately 9:30 p.m., he was cranking the "dolly legs" of a semi-tractor trailer when he felt a burning sensation in his lower back. Petitioner testified that the crank was not operating properly and, as a result, he was required to apply more force to the crank than was usually required. Petitioner reported his work injury to Respondent's operations manager Joe Spina and finished his work shift.

Petitioner was not scheduled to work on Saturday, July 23, 2016, or Sunday, July 24, 2016. Petitioner stated that because his lower back symptoms continued over the weekend, he returned to Concentra on Monday, July 25, 2016. Petitioner was examined by Ms. White. The history provided by Petitioner states, "Patient states he was cranking the damaged gear box when he started to feel pain in his lower back. Injury occurred at 10:00 p.m." The date of accident was recorded as "07/22/16". Petitioner reported bilateral low back pain described as burning in nature. Petitioner also reported radiating pain to the buttocks. Examination findings revealed tenderness in the lumbar spine. Petitioner exhibited a negative straight leg raise test. Petitioner also had some decreased extension of the lumbar spine with range of motion testing. Ms. White diagnosed Petitioner with back pain and a strain of the lumbar region and prescribed Cyclobenzaprine and Ibuprofen. Petitioner was also directed to treat his injury with ice 4 times a day. Petitioner was advised to begin physical therapy and given work restrictions of occasional lifting up to 20 pounds and pushing/pulling up to 20 pounds. Petitioner was also advised not drive a company vehicle due to functional limitations. (Petitioner's Exhibit #2, pp. 194-197)

That same day, July 25, 2016, Petitioner was also examined by Dr. Garelick for the final time. Petitioner reported that he believed his left shoulder was doing better post-injection. He still had some discomfort at night. Petitioner reported that although his right shoulder was "doing pretty good," both shoulders continued to bother him everyday. Examination findings revealed symmetric range of motion. Dr. Garelick noted no pain with resisted supraspinatus testing on the left shoulder. Petitioner exhibited a mildly positive Neer and Hawkins sign on the left. Dr. Garelick diagnosed resolving impingement syndrome, left still somewhat more marked than

right. Dr. Garelick placed Petitioner at maximum medical improvement and encouraged him to continue to work on his home exercises. Petitioner was released to return to work regular duty. (Petitioner's Exhibit #2, p. 207) Petitioner testified that although he was released full duty, he continued with shoulder symptoms, left worse than right.

On July 27, 2016, Petitioner was again examined by Ms. White for his lumbar spine. Petitioner reported that he was getting better. Petitioner requested that he be cleared to return to work regular duty. Petitioner was diagnosed with low back pain and a lumbar strain. Petitioner was released to return to work regular duty with the caveat of avoiding any cranking of broken dolly legs or opening corroded doors. Petitioner was also directed to participate in a physical therapy program 3 times per week for 2 weeks and to continue full duty work. (Petitioner's Exhibit #2, pp. 210-212)

Petitioner returned to Concentra again on August 3, 2016 and was examined by Ms. White. Petitioner's symptoms were improving. His pain levels were 3/10. Petitioner was directed to begin taking Naproxen and to continue full duty work. (Petitioner's Exhibit #2, pp. 217-219). Petitioner was last seen at Concentra for his lower back pain on August 11, 2016. Petitioner reported back stiffness but no pain. Petitioner denied any lower extremity symptoms. Petitioner reported his current level of pain as a 1 out of 10. The records noted that Petitioner was doing "overall well". Examination findings were normal. Petitioner was diagnosed with back pain and a lumbar strain. Petitioner was released from care and placed at maximum medical improvement for his back injury. (Petitioner's Exhibit #2, pp. 224-225)

Petitioner testified that he continued to work for Respondent. He stated that he continued to experience ongoing bilateral shoulder pain with greater symptoms on the left than the right. As a result of same, he elected to obtain a second opinion from Dr. Daniel Troy on September 16, 2016. Records submitted show Petitioner reported that he had been undergoing treatment since March 24, 2016 for bilateral shoulder pain. Petitioner reported that both of his shoulders were better but not 100%. He was still having difficulty with both. Also noted was that Petitioner had tried physical therapy and was performing a home exercise program. On examination, Petitioner had full flexion and abduction with pain in the left shoulder and slight pain in the right. Petitioner exhibited a positive Hawkins test and negative Neer on the left. Petitioner had no pain in the AC joint on the left. He had slight pain over his biceps tendon but no pain bilaterally. Petitioner had minimal symptoms in the right shoulder with mild to moderate Neer impingement. He also had minimal Hawkins. Bilateral shoulder x-rays were obtained revealing moderate degenerative changes of the bilateral AC joints. Dr. Troy reviewed the prior MRI studies of the left and right shoulder. Dr. Troy diagnosed bilateral shoulder impingement, left greater than right. Dr. Troy performed a repeat cortisone injection to Petitioner's left shoulder, this time with ultrasound guidance. After the injection, Dr. Troy prescribed Voltaren Gel, returned Petitioner to full duty work and directed him to return in 6 weeks. (Petitioner's Exhibit #4) Petitioner testified that he experienced relief of his left shoulder symptoms following the injection for approximately 2 weeks, and then the symptoms returned.

Petitioner testified that he continued to work for Respondent. He returned to see Dr. Troy on October 28, 2016. Petitioner reported that the injection to the left shoulder helped for about two weeks. Petitioner also reported symptoms in the right shoulder. Petitioner reported overall frustration. Petitioner complained of re-aggravation of his shoulder pain with truck driving. Dr. Troy noted that the examination findings were unchanged from the prior visit. The doctor noted that Petitioner continued with positive signs for bilateral impingement syndrome and bilateral positive Hawkins' sign. Dr. Troy diagnosed bilateral shoulder impingement, left greater than right and provided him with a right shoulder cortisone injection with ultrasound guidance. Dr. Troy directed Petitioner to continue full duty work and to return in 3 to 4 months. (Petitioner's Exhibit #4) Petitioner testified that he experienced relief of his right shoulder symptoms for approximately 2 weeks and then his symptoms returned.

Petitioner testified that he continued to work for Respondent while experiencing continual symptoms of soreness on the outside portion of both shoulders. On March 22, 2017, Petitioner returned to Dr. Troy. Petitioner continued to report difficulty with the left and right shoulder. Examination findings revealed positive impingement signs on the left greater than right. Dr. Troy again reviewed the prior MRI studies. Dr. Troy continued to diagnose bilateral shoulder impingement, left being more symptomatic than right. Dr. Troy recommended Petitioner proceed with diagnostic left shoulder arthroscopy and subacromial decompression. (Petitioner's Exhibit #4)

Petitioner testified that on May 12, 2017, he was working for Respondent in the truck depot parking area. As Petitioner was walking through the parking area, he stepped in a depression in a gravel surface, causing him to lose his balance. When Petitioner lost his balance, he struck his left shoulder on the chassis of a semi-tractor trailer. Petitioner stated he immediately felt severe pain on the outside of his left shoulder. Because of his symptoms of pain, Petitioner did not finish his work shift on May 12, 2017. Petitioner was not scheduled to work on Saturday, May 13, 2017, or Sunday, May 14, 2017. On Monday, May 15, 2017, Petitioner's symptoms remained. As a result, he reported his work injury to Joe Spina, the operations manager for Respondent.

On May 16, 2017, Petitioner retuned to Dr. Troy. Petitioner provided a history that states, "…he reports that Friday, 5/12/2017, at work he was walking and not paying attention. He subsequently ended up walking into a steel beam directly over the anterior aspect of his shoulder." Examination findings revealed ecchymosis over the anterior aspect of the left humerus. There was mild tenderness to palpation over the left AC joint. Petitioner had a positive Neer's and Hawkin's sign bilaterally. Petitioner had full strength in both arms. X-rays of the left shoulder demonstrated a mild amount of GH arthritis and a mild amount of arthritic changes in the AC joint. There were no other abnormalities seen on the imaging studies. Dr. Troy diagnosed bilateral shoulder pain and impingement syndrome. Dr. Troy prescribed Tramdol due to Petitioner's moderate to severe pain. Petitioner was advised that he should not operate a truck while taking the medications. Dr. Troy also restricted Petitioner to no lifting, carrying, pushing or pulling greater than 20 pounds. Dr. Troy continued to recommend a diagnostic left shoulder arthroscopy. (Petitioner's Exhibit #4)

Petitioner testified that after his May 16, 2017 appointment with Dr. Troy, he requested light duty work from Respondent's operations manager, Joe Spina. Petitioner stated that Respondent has not offered light duty work since May 16, 2017.

At the request of Respondent, Petitioner underwent a Section 12 examination with Dr. Joseph T. Monaco on May 23, 2017. In his report dated same, Dr. Monaco-noted-that he obtained a history of work incidents on March 24, 2016 and July 22, 2016. In addition to performing an examination, the doctor reviewed Petitioner's medical records and diagnostic studies. Upon examination, Dr. Monaco noted bruising over the anterolateral aspect of the left shoulder. O'Brien test was negative bilaterally. There was positive Hawkins' and Empty Can test bilaterally. Cross body abduction at +2 on the left and negative on the right. Dr. Monaco diagnosed 1.) resolved left and right shoulder strains; and 2.) degenerative changes of the acromioclavicular joints with impingement with both shoulders. Dr. Monaco opined that the bilateral shoulder strains suffered by Petitioner were related to his work accident on March 24, 2016, but that the strains resolved in a "couple of weeks." Dr. Monaco also opined that Petitioner suffered a temporary exacerbation of pre-existing impingement syndrome which returned to baseline within four (4) months after Petitioner's work injury on March 24, 2016. Dr. Monaco found that Petitioner had reached maximum medical improvement on July 25, 2016 when released by Dr. Garelick. He specifically opined the right shoulder condition had resolved by April 18, 2016 and the left had resolved by July 25, 2016. Dr. Monaco opined that Petitioner's conditions of ill-being at the time of his evaluation were unrelated to the work incident and any further treatment was not related to the March 26, 2016 accident. Dr. Monaco opined that as a result of his March 24, 2016 work injury, Petitioner was cable of returning to full duty work. Lastly, Dr. Monaco opined that treatment through the date of his evaluation was

reasonable and necessary. Dr. Monaco also performed an AMA Impairment Rating. (Respondent's Exhibit #2)

On June 13, 2017, Petitioner returned to Dr. Troy. Dr. Troy diagnoses remained the same and he continued his surgical recommendation. At this visit, Dr. Troy also took Petitioner off work (Petitioner's Exhibit #4). When Petitioner returned to Dr. Troy on June 30, 2017, the doctor noted Petitioner's continued complaints of pain in the left shoulder. Petitioner continued to exhibit positive results from Neer's and Hawkins' tests bilaterally. The doctor reviewed the report of Dr. Monaco dated May 23, 2017, noting Dr. Monaco felt Petitioner had achieved maximum medical improvement. Dr. Troy directed Petitioner to remain off work and to return in 4 to 6 weeks. (Petitioner's Exhibit #4) On August 16, 2017, Dr. Troy noted Petitioner continued to exhibit positive Neer's and positive Hawkins' tests for impingement. The doctor directed Petitioner to continue using Tramadol for his symptoms. On August 21, 2017, Dr. Troy completed a note confirming that Petitioner was to remain off work. (Petitioner's Exhibit #4)

At Respondent's request, Dr. Monaco authored an addendum report on September 21, 2017. In his report, Dr. Monaco noted he reviewed medical records for treatment received by Petitioner in 2009 as well as additional records from Dr. Troy since the doctor's last report in May of 2017. Dr. Monaco stated that his opinion remained the same, i.e., Petitioner sustained resolved bilateral shoulder strains as a result of the accident sustained on March 24, 2016. With respect to the May 12, 2017 accident, Dr. Monaco opined Petitioner sustained a contusion to the soft tissue of the left shoulder. The doctor opined that Petitioner's work injury on May 12, 2017 did not change his opinion regarding causation in any way. The doctor felt the May 2017 injury was nothing more than a minor soft tissue contusion of the left upper arm and shoulder area with no acute injury or internal derangement to the left shoulder joint. (Respondent's Exhibit #3)

Dr. Monaco opined that the degenerative changes of the AC joint of both shoulders pre-existed and were not caused by either work-related incident. Dr. Monaco stated the additional medical records show similar complaints and findings involving the left shoulder in 2009. He noted the diagnostic studies at that time showed findings similar to the MRI scans done in 2016. The doctor provided that Petitioner's symptoms in 2009 were consistent with temporary exacerbation of the pre-existing degenerative changes of the AC joint of the left shoulder with subsequent return to baseline. He opined that the work-related incidents of March 24, 2016 and May 12, 2017 resulted in temporary exacerbation of the pre-existing degenerative changes of the left shoulder AC joint. Dr. Monaco opined that Petitioner was at maximum medical improvement for both his March 24, 2016 accident and his May 12, 2017 accident. (Respondent's Exhibit #3)

Petitioner last saw Dr. Troy on October 14, 2017. The doctor noted Petitioner's examination remained unchanged, i.e., Petitioner exhibited positive Neer's and positive Hawkin's impingement tests, left "much more significant that right." Dr. Troy's diagnosis at that time was impingement syndrome of the left and right shoulder. The doctor repeated his recommendation that Petitioner proceed with diagnostic left shoulder arthroscopy. Dr. Troy also directed Petitioner to remain off work and advised Petitioner to return after obtaining approval for the proposed procedure. (Petitioner's Exhibit #4) Petitioner testified that he would like to proceed with the surgery recommended by Dr. Troy.

Petitioner testified that other than the work accidents on March 24, 2016 and May 12, 2017, he has not suffered any new injuries to his left or right shoulders. In addition, Petitioner has not suffered any injuries to his lower back since July 22, 2016.

Petitioner testified that prior to the March 24, 2016 accident, he sustained work-related injuries to his left shoulder and neck in February and March of 2009. Petitioner stated he was not an employee of Respondent at the time of his 2009 accidents. Petitioner testified that he received medical treatment at Parkview Orthopedics and Meridian Medical Associates. Petitioner testified that the symptoms he experienced following his 2009

accidents began in his neck and consisted of shooting pains down his arms. Petitioner testified that the shooting pains down his left arm were worse than his right arm. Petitioner testified that he did not receive any further medical treatment for his shoulders from 2010 up to the March 24, 2016 accident. Petitioner further testified that he did not lose any time from work subsequent to 2010 but before the March 24, 2016 accident. Petitioner denied any further injuries to his shoulders during that same time period.

Mr. Joseph Spina was called to testify by Respondent. Mr. Spina testified that he has worked for Respondent for approximately seven years as the safety director. Mr. Spina testified that he was in charge of Department of Transportation compliance as well as any workplace injuries. Mr. Spina testified that he would speak with the dispatchers, including Mr. Ibrahim, on a daily basis. Mr. Spina testified that he did not learn of Petitioner's first work accident of March 24, 2016 until April 8, 2016. Mr. Spina testified that Petitioner continued to work full duty up until the date he was placed on light duty. Mr. Spina testified that he was never made aware of any of Petitioner's ongoing problems while driving a truck or safety concerns that Petitioner testified to on direct examination. Mr. Spina stated that he could not recall if Petitioner requested light duty work. Mr. Spina also indicated that Respondent does not have light duty work for truck drivers.

Dr. Troy testified via deposition in this matter on December 4, 2017. (Petitioner's Exhibit #5) Dr. Troy testified that he first saw Petitioner on September 16, 2016. At that time Petitioner had bilateral shoulder pain complaints, left worse than right. Dr. Troy stated that Petitioner's rotation to his left was slightly diminished compared to the right. Both shoulders had positive impingement symptomatology. He had slight pain over the anterior aspect to the shoulder in the region of the biceps tendon. His right shoulder was symptomatic, but minimal. He had mild to moderate Neer impingement symptoms and minimal Hoffman's. Dr. Troy stated he assessed Petitioner with bilateral shoulder impingement, left greater than right. Dr. Troy recommended therapy, suggested and performed a second steroid injection to the left shoulder. The doctor testified that he later performed an injection to Petitioner's right shoulder. The doctor stated Petitioner only received short-term relief from both injections stating Petitioner kept having rebound symptomatology. (Petitioner's Exhibit #5, pp. 10-14)

Dr. Troy testified that he ultimately recommended surgical intervention of the left shoulder. Dr. Troy explained that Petitioner had been having symptoms since March of 2016. Dr. Troy stated, "…It's been a year. He's already did therapy. He's received two steroid injections. He's been using anti-inflammatories…So there is nothing further I can offer him except continue to live with the symptoms or to go in and surgically remove the inflamed bursa… which is part of the impingement process…" (Petitioner's Exhibit #5, pp. 15,16)

With respect to the May 12, 2017 incident, Dr. Troy testified that Petitioner sustained a left shoulder contusion. Dr. Troy did not believe that this second injury changed Petitioner's impingement diagnosis in any significant way. (Petitioner's Exhibit #5, p. 18)

Dr. Troy testified that he kept Petitioner off work following the June 30, 2017 visit. The doctor provided that Petitioner's symptoms were increasing and he reported being uncomfortable while driving. (Petitioner's Exhibit #5, p. 19) Dr. Troy testified that he continued to diagnose Petitioner with bilateral shoulder impingement syndrome left greater than right. Dr. Troy testified that Petitioner required a diagnostic left shoulder arthroscopy. (Petitioner's Exhibit #5, p. 20)

Dr. Troy offered an opinion on causal connection. Dr. Troy testified that he believed the impingement syndrome was related to the March 24, 2016 work accident. Dr. Troy based this opinion on Petitioner's reports that he became symptomatic in shoulders after the accident of March 24, 2016. Dr. Troy further based his opinions on Petitioner's reports of continuing shoulder symptoms post-March 24, 2016 accident. Dr. Troy believed that the May 12, 2017 accident represented a contusion that exacerbated Petitioner's pain in the left shoulder. Dr. Troy noted Petitioner was already symptomatic in the left shoulder before the May 12, 2017

incident and remained symptomatic thereafter. Dr. Troy did not believe that the May 12, 2017 incident changed the course of Petitioner's impingement syndrome. (Petitioner's Exhibit #5, pp. 21-23)

When asked what type of mechanism of injury would be required to cause impingement syndrome, Dr. Troy stated, "…the impingement syndrome is a constellation of rotator cuff tendinitis, associated bursitis of the shoulder and possible spurring. So any injury – a direct blow could. It's very atypical, but it could. A fall on an outstretched extremity also could. But one of those two things occurred when of course he fell off the truck." He testified that the fall off the truck could cause impingement syndrome. (Petitioner's Exhibit #5, p. 22) Dr. Troy testified that the diagnostic left shoulder arthroscopy appears to be causally related to the March 2016 event. The doctor explained that there was no evidence Petitioner was experiencing symptoms involving the left shoulder before the March 24, 2016 accident. He added that Petitioner remains symptomatic and has not returned to his pre-injury status. Dr. Troy testified that he was aware of the medical records regarding Petitioner's 2009 treatment and the prior left shoulder MRI from May 4, 2009. Dr. Troy testified that the records did not change his opinions. Dr. Troy noted that Petitioner had a series of approximately six (6) years of functioning well with no office visits or treatments to his left or right shoulder nor did he have any subjective statements that he was having symptoms to his left nor right shoulder during that time period. (Petitioner's Exhibit #5, pp. 25-26)

With respect to the right shoulder, Dr. Troy testified that Petitioner may or may not need right shoulder surgery. Dr. Troy was hopeful that the right shoulder symptoms would resolve on their own post-left shoulder surgery. Dr. Troy causally related Petitioner's right shoulder condition to the March 2016 incident. (Petitioner's Exhibit #5, p. 27)

Dr. Troy testified that he disagreed with the opinion of Dr. Monaco, Respondent's Section 12 examiner, that Petitioner merely sustained strains of the left and right shoulder. Dr. Troy stated, "If one suffered a strain, one would imply that he was returned back to his pre-work injury status, which based on his subjective statements of [Petitioner], he has not been…[T]hat would imply that the patient is now asymptomatic from the shoulder, which, based on his continued follow-up with myself, proves that he is not – that he did not have an exacerbation, which implies a temporary injury to his shoulder. He had more of an aggravation, and the proof of that is the patient's continued treatment of the left shoulder, and to a minimal degree, the right shoulder…" (Petitioner's Exhibit #5, pp.27-28) Dr. Troy believed that because of his ongoing symptoms, Petitioner was not at maximum medical improvement. (Petitioner's Exhibit #5, p. 29)

On cross-examination, Dr. Troy testified that he reviewed the records from Parkview Orthopedics relating to the 2009-2010 treatment. Dr. Troy testified that he did not review any of the medical records from Concentra or Dr. Garelick. Dr. Troy testified that it's possible his opinions on causation could change based upon review of the Concentra medical records. (Petitioner's Exhibit #5, pp. 31-32) Dr. Troy testified that the May 2009 MRI of the left shoulder revealed AC degenerative joint changes with bone spurring. Dr. Troy testified that those degenerative changes would progress over time. Dr. Troy testified that AC degeneration and bone spurs are one of the etiologies of impingement syndrome. Dr. Troy testified that a review of Petitioner's chart notes from July 6, 2009 appear to show Petitioner was having more problems in his neck than his shoulders with a possible left upper extremity radiculopathy and that any restrictions back then was related to the neck and not the shoulder. (Petitioner's Exhibit #5, pp. 34-36)

Dr. Troy testified that both the pre and post accident MRI studies of the left shoulder revealed AC joint arthropathy or bone spurring. Dr. Troy testified that that AC arthropathy or bone spurring was not caused by the March 24, 2016 work accident. Dr. Troy testified that AC arthropathy can cause pain in one shoulders. Dr. Troy also testified that arthropathy is one of the causes of shoulder impingement. Dr. Troy testified that these conditions will degenerative over time and not reverse course. (Pet. Ex. #5, 44 & 46). Dr. Troy testified that degenerative conditions can be exacerbated or aggravated. He believed Petitioner sustained a permanent

aggravation of his left shoulder condition as a result of the March 2016 work accident. The doctor added that although it was possible that the shoulder impingement and inflammation of the bursa was caused by the pre-existing bone spurring, it was not the absolute sole cause. The doctor stated that other causes are repetitive activity and traumatically induced rotator cuff tendinitis that fails to resolve and, "…we only have evidence of the traumatically induced trauma." (Petitioner's Exhibit #5, pp. 46-47) Dr. Troy testified that there was nothing on the May 16, 2016 MRI studies that were acutely caused by the March 24, 2016 accident. (Petitioner's Exhibit #5, p. 49)

Dr. Troy testified that the right shoulder MRI revealed mostly the same degenerative findings as the left shoulder study. Dr. Troy testified that it was likely that the findings on the right shoulder MRI in May of 2016 all pre-dated the March 24, 2016 work accident. (Petitioner's Exhibit #5, p. 51)

On redirect, Dr. Troy reviewed the final record of Dr. Garelick dated July 25, 2016. Dr. Troy testified that there was nothing in the record that was inconsistent with his findings when he examined Petitioner on September 16, 2016, outside of the fact Petitioner was more asymptomatic at the time of his September 2016 examination. The doctor provided that the report does not change his opinions on causation. The doctor stated, "I believe it does support the opinion…There's an event that caused a traumatically-induced inflammatory episode to his shoulder. It started the process of the inflamed bursal tissue, the rotator cuff tendinitis. He does have the spurring, but he has mild AC changes with palpation, but it started this impingement syndrome to his shoulder which has failed to resolve with conservative treatment." Dr. Troy added that it's a combination of both the degenerative condition and the trauma sustained. Dr. Troy stated, "…because degenerative changes could increase someone's risk for having impingement syndrome. So if one develops traumatically-induced bursitis to the shoulder, you're going to be at that much more risk for that to fail to resolve because you have preexisting degenerative changes of the AC joint and encroachment to the subacromial space. (Petitioner's Exhibit #5, pp. 55-58)

Dr. Joseph Monaco, Respondent's Section 12 examiner, was called to testify via evidence deposition on January 25, 2018. (Respondent's Ex. #1). Dr. Monaco testified that he examined Petitioner at the request of Respondent on May 23, 2017. Dr. Monaco testified that he reviewed Petitioner's medical records from Concentra as well as the records of Dr. Daniel Troy in preparation of his May 23, 2017 report. Dr. Monaco testified that he also reviewed the May 2016 MRI reports and films of Petitioner's bilateral shoulders. Dr. Monaco testified that he took a history of Petitioner's March 24, 2016 fall from a crosswalk approximately 3.5 feet above ground, landing on both of his upper extremities. Dr. Monaco testified that Petitioner also reported sustaining a second incident on May 16, 2017 resulting in a contusion to the left shoulder due to walking into a steel beam at work. (Respondent's Ex. #1, pp. 10-17)

Dr. Monaco testified that he reviewed the MRI films of Petitioner's left and right shoulders obtained in May of 2016. Dr. Monaco testified that his impression were that the findings were mostly age-related changes. Dr. Monaco testified that he believed there were degenerative changes of the AC joint with mild hypertrophy and mild marginal spurring with signs of impingement. (Respondent's Ex. #1, p.19) Dr. Monaco testified that those findings can be found on individuals who are asymptomatic. Dr. Monaco testified that there was no evidence of any acute injury on the films. (Respondent's Ex. #1, pp.19-20) Dr. Monaco testified that he compared the pre-accident MRI of Petitioner's shoulder to the post-accident studies. Dr. Monaco testified that the two studies were remarkably similar in regards to the changes due to age, with no evidence of acute injury. (Respondent's Ex. #1, pp. 21-22)

Dr. Monaco testified that he examined Petitioner. Dr. Monaco testified that the time of his first report, his opinion was that Petitioner sustained strains of left and right shoulders. Dr. Monaco opined that both strains had resolved. Dr. Monaco also diagnosed Petitioner with degenerative changes of the AC joint with impingement in both shoulders. Dr. Monaco opined that the strains of the left and right shoulder were a result of

the March 24, 2016 work accident. Dr. Monaco testified that the degenerative changes of the AC joint that were signs of impingement syndrome were a result of a temporary exacerbation of pre-existing condition. Dr. Monaco stated, "...[I]n this case there was no evidence of any acute injury as a result of the incident. He did have the preexisting degenerative changes...that are common, can be commonly found on asymptomatic individuals. So those degenerative changes can be involved in the provocation of bursitis, tendonitis and impingement of the shoulder, and that can happen as a result of an injury like a strain. But the absence of an acute injury the expectation would be this would return to baseline." Dr. Monaco testified that he based his opinion on the medical records he reviewed, most notably the findings of Dr. Garelick. (Respondent's Ex. #1, pp. 26-28) Dr. Monaco also explained that baseline is not the equivalent of being asymptomatic. Dr. Monaco explained that in cases of degenerative underlying osteoarthritis of the AC joint and signs of impingement, the expectation over time would be that the condition would worsen. "...so that you would not expect return to baseline to be returning to asymptomatic. You would expect it to return to where you expect it to be based upon the natural history of the condition you're dealing with." Dr. Monaco testified that he believed Petitioner was capable of working full duty without restrictions as it related to the March 2016 accident. Dr. Monaco again based his opinions on the findings and conclusions of Dr. Garelick. Dr. Monaco testified that he believed Petitioner reached MMI for both shoulder conditions at the time of the May 23, 2017 exam. (Respondent's Ex. #1, pp. 28-30)

Dr. Monaco testified that he also authored an addendum report which was dated September 21, 2017. Dr. Monaco testified that he reviewed additional medical records which included Petitioner's records from 2009 and updated records from Dr. Troy. (Respondent's Ex. #1, pp. 33-34) Dr. Monaco testified that he reviewed the 2009 MRI report of the left shoulder. Dr. Monaco testified that the findings were very similar on the pre-accident MRI versus the post-accident study. Dr. Monaco testified that Petitioner's present complaints and symptoms were very similar to his complaints and symptoms in 2009. Dr. Monaco noted that Petitioner claimed injuries in 2009 to both shoulders, with the right shoulder becoming less of an issue within weeks after the accident. Dr. Monaco found this to be similar to Petitioner's symptoms subsequent to the March 24, 2016 accident. Dr. Monaco also noted the similarities in Petitioner's treatment in 2009 versus post-March 24, 2016. (Respondent's Ex. #1, pp. 36-38) Dr. Monaco opined that the additional records revealed "... just almost a complete replay of the same course of action and complaints from 2009 to 2016." (Respondent's Ex. #1, pp. 39-40) Dr. Monaco testified that his prior IME opinions did not change after his review of the additional pre-accident medical records. Dr. Monaco testified that the pre-accident records confirmed his prior opinions. (Respondent's Ex. #1, pp. 42-43)

On cross-examination, Dr. Monaco testified that he generally agreed with the radiologists' findings with respect to the 2016 MRIs, with the exception of possible small tear of the labrum on the right. It was Dr. Monaco's opinion that the labrum was normal. (Respondent's Ex. #1, pp. 47-49) Dr. Monaco testified that he has performed the surgery proposed by Dr. Troy. Dr. Monaco stated that Petitioner's condition did not result from an acute injury and the surgery would not be related to the strain of the shoulders that Petitioner sustained with the fall onto his hands. He indicated the proposed surgery would address Petitioner's impingement syndrome. Dr. Monaco suggested that surgery would be a last option. Dr. Monaco opined that the surgery proposed by Dr. Troy was not inappropriate. Dr. Monaco had reservations about success. Dr. Monaco was concerned about the lack of objective findings on MRI studies and the ongoing subjective complaints of Petitioner. He felt Dr. Troy might be "backed into a corner and nothing else was helping." The doctor stated, "...if you take into account what happened in 2009, which is almost the same as what happened in 2016 as far as mechanism of injury and completely negative diagnostic findings and only positive findings, complaints of pain and the findings of provocative shoulder tests...and that went on for about a year and then I have no more records to review so I don't know what happened after that...So he had a significant problem with that left shoulder and also had some problem with his neck too, and you have to assume it eventually got better because he was back at work in 2016 and actually denying any problems with his shoulders prior to that. It's possible he

didn't recall it. It seems a little farfetched. Dr. Monaco testified that he did not disagree with Dr. Troy's treatment: but disagreed with the cause of Petitioner's problem. (Respondent's Ex. #1, pp. 54-60)

Dr. Monaco testified that impingement syndrome very often develops idiopathically. Dr. Monaco testified that oftentimes patient will come to him and not know the cause of shoulder problems other than the patient simply has pain. Dr. Monaco also stated there are instances when he's determine an individual has impingement syndrome, after the person had an injury and subsequently complain of symptoms similar to Petitioner. The doctor stated he considered impingement syndrome to be more of a symptom conglomeration than an actual pathology. (Respondent's Ex. #1, pp. 61-63) Dr. Monaco testified that a fall from a height can aggravate a previously asymptomatic condition such as impingement syndrome and cause it to become symptomatic. Dr. Monaco testified that he believed that Petitioner temporarily aggravated his condition but returned to baseline. Dr. Monaco testified that Petitioner had a preexisting condition which was temporary exacerbated by the fall but got better when he reached MMI with Dr. Garelick. Dr. Monaco added, "…if there's underlying degenerative changes such as this which can cause impingement, then they can cause impingement without necessarily having another injury…So it doesn't mean that once –that just because he's saying he didn't have any pain before the fall and now he has pain that all pain in the shoulder after that is related to the fall…It appeared there wasn't any sign of any acute injury, so it's my feeling there was an exacerbation of this preexisting condition which got better, but it's not my opinion that it was all caused by the fall…So just because he has pain after the fall, a year and a half later…that temporal relationship is not felt to be a very good approach to determining causation, just because something happened and something happens following it. So I think that what happened following it because of the strain he had some pain which eventually got better, maybe not completely 100 percent as far as he's concerned but better and no further treatment was needed, and then it got worse." (Respondent's Ex. #1, pp. 66-69) Dr. Monaco agreed that Petitioner's treatment was reasonable, necessary and causally related up to the July 25, 2016 MMI date. Dr. Monaco agreed with the reasonableness of the shoulder treatment thereafter, but disagreed that it was related. (Respondent's Ex. #1, pp. 70-71)

Dr. Monaco testified that he was not provided with any medical treatment records between March 2010 and March of 2016. When asked "…what, if any conclusion can you draw from that fact," Dr. Monaco replied, "I can conclude that he has not sought medical care somewhere where the records would be available and that the shoulders got – that undergoing almost a year's worth of treatment before I had no more records he was still having some complaints but apparently would mean he got better." (Respondent's Ex. #1, p. 72) Dr. Monaco clarified his earlier statement that the mechanism of injury in 2009 and the mechanism of injury in March 2016 were similar. He admitted that the 2009 mechanism of injury involved Petitioner attempting to lower dollies on a truck and he was "pulling something." Dr. Monaco also admitted that majority of medical treatment noted in Petitioner's post-accident medical records after July 6, 2009 pertained to mainly cervical spine treatment. (Respondent's Ex. #1, pp. 72-76) Lastly, Dr. Monaco testified that Petitioner had preexisting impingement in his shoulders as opposed to impingement syndrome. The doctor stated that the concept of impingement syndrome requires symptoms. He indicated that Petitioner developed symptomatology consistent with impingement syndrome after the March 2016 accident. When asked "…[O]ther than the normal progression from aging has, in your opinion, [Petitioner's] baseline condition of his left shoulder changes since his work injury in March of 2016?." Dr. Monaco replied, " I think his symptoms have ebbed and flowed, but my thought, my feeling is he returned to baseline by July 2016." (Respondent's Ex. #1, pp. 78-79)

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

The Findings of Fact, as stated above, are adopted herein.

The Arbitrator adopts Petitioner's credible and uncontroverted testimony that he arrived for his work shift with Respondent in the late afternoon or early evening on March 24, 2016. Petitioner testified that this was his usual start time for work with Respondent. At dusk, Petitioner was walking on the catwalk of a truck when he fell forward and landed on the ground below. The catwalk Petitioner was standing on was approximately 3' to 4' off the ground. When Petitioner fell, he landed on both of his outstretched hands at the same time. Immediately after the accident, Petitioner felt pain in both of his shoulders, both of his arms and both of his hands.

That same evening, Petitioner reported his work accident on the telephone to his supervisor, Mr. Tawfic Ibrahim, who is the night dispatcher for Respondent. Petitioner continued to work and finished his work shift for Respondent. Over the next two weeks, Petitioner began to experience a gradual increase in the pain on the outside of his shoulders. The pain in Petitioner's left shoulder was worse than the pain in Petitioner's right shoulder.

The Arbitrator notes that Petitioner's testimony regarding his work accident on March 24, 2016 is corroborated by the histories provided by Petitioner to the various medical providers he has seen since his work accident. Specifically, the injury date recorded by the company clinic, Concentra, during Petitioner's first medical appointment after his work accident states, "3/24/16." In addition, Petitioner's history of the accident states, "This is the result of a fall [and] from back of truck to ground, landed on hands, felt pain at lt shoulder, milder pain at rt shoulder and felt achy. Occurred while at work." The history recorded by the physical therapist who examined Petitioner on the same day, April 8, 2016, states, "Pt reports that he slipped and fell off the back of the truck falling straight onto his hands." The Arbitrator also notes that the history of Petitioner's injury that was recorded at Accelerated Open MRI & Imaging on May 16, 2016, states, "[f]all injury about 1.5 months ago. Patient stated he had both arm[s] outstretched in front of him to brace fall." In addition, the Arbitrator notes that the date of injury recorded by Dr. Troy on each of the Work Status Forms indicate "3-24-16." The detailed history taken by Respondent's Section 12 medical examiner, Dr. Monaco, on May 23, 2017, also supports Petitioner's testimony.

Respondent has not offered any persuasive evidence to dispute Petitioner's claim that he suffered an accident on March 24, 2016. Respondent called Joe Spina, Respondent's operations manager and safety director, to testify on behalf of Respondent. Mr. Spina testified that he did not learn of Petitioner's accident until April 8, 2016. As stated above, Petitioner testified that he reported his work injury to Mr. Ibrahim on the date of his work accident. Petitioner explained that Mr. Ibrahim was the night dispatcher for Respondent and Petitioner's direct supervisor. Petitioner also testified that he communicated with Mr. Ibrahim every work day and only communicated with Mr. Spina once every several weeks as part of his regular job. Mr. Spina did not dispute the fact that Petitioner reported his work injury to Mr. Ibrahim on March 24, 2016.

Based on the foregoing, the Arbitrator finds that Petitioner has proved, by a preponderance of the evidence that he suffered an accident that arose out of and in the course of his employment by Respondent on March 24, 2016.

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

The Findings of Fact and Conclusions of Law, as stated above, are adopted herein.

The Arbitrator relies on the testimony of Petitioner's treating orthopedic specialist, Dr. Daniel A. Troy. Dr. Troy testified that the impingement syndrome in Petitioner's left and right shoulders was causally related to Petitioner's work injury on March 24, 2016. Dr. Troy explained that a fall onto outstretched hands is the type of injury that would cause impingement syndrome in the shoulders. In addition, Dr. Troy specifically testified that

the diagnostic left shoulder arthroscopy he has recommended for Petitioner is causally related to Petitioner's work accident on March 24, 2016. Dr. Troy explained that his opinion was based on the fact that Petitioner did not have shoulder symptoms that predated his work injury on March 24, 2016. The Arbitrator notes that Dr. Troy explained that, although Petitioner clearly had degenerative changes in his shoulders that pre-existed his work accident on March 24, 2016, it was his opinion that the fall sustained by Petitioner caused a "traumatically-induced inflammatory episode" to Petitioner's shoulder that "started the process of the inflamed bursal tissue, the rotator cuff tendinitis." Dr. Troy was specifically asked about Petitioner's prior medical treatment on 2009 and 2010. The doctor explained that the existence of the prior medical treatment received by Petitioner did not change his causation opinion because Petitioner functioned for 6 years prior to March 24, 2016 without medical treatment for the left or right shoulder.

Respondent's Section 12 examiner, Dr. Monaco, admitted that a fall from height onto outstretched hands, such as the injury sustained by Petitioner, could aggravate a previously asymptomatic condition of impingement syndrome, causing it to become symptomatic. However, it was the opinion of Dr. Monaco that Petitioner merely suffered a temporary exacerbation of degenerative changes in the acromioclavicular joints of his shoulders. Dr. Monaco believed that Petitioner recovered from his work injury and returned to his pre-injury base line as of July 25, 2016. Dr. Troy does not agree with Dr. Monaco's opinion that Petitioner only suffered exacerbations of impingement syndrome in his shoulders on March 24, 2016. Dr. Troy explained that Petitioner's ongoing symptoms prove that his work accident on March 24, 2016 resulted in an aggravation of pre-existing impingement syndrome rather than a temporary exacerbation that returned to baseline as believed by Dr. Monaco.

It is well established that even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. Sisbro, Inc. v. Industrial Commission, 207 Ill. 2d 193, 205 (2003). In the instant case, the Arbitrator finds that, while it is clear that Petitioner had preexisting degenerative changes to his shoulders, it is equally clear that his work injury on March 24, 2016 was a causative factor in his increased shoulder symptoms, his inability to work, and his need for left shoulder surgery.

The Arbitrator finds that Dr. Troy's opinion of Petitioner's condition is supported by the medical evidence in the record. Specifically, the Arbitrator notes that Petitioner's shoulders were asymptomatic for 6 years prior to March 24, 2016 and, since that time, Petitioner has exhibited positive Hawkins' and Neer's testing which indicates the existence of impingement syndrome. By comparison, the Arbitrator notes that Dr. Monaco admits that Petitioner complained to Dr. Garelick on July 25, 2016 that both of his shoulders hurt every day. This is the date Dr. Monaco chose as the day Petitioner reached maximum medical improvement, because Petitioner had returned to his "baseline".

The Arbitrator finds that Petitioner's actual "baseline" for the 6 years prior to March 24, 2016 allowed him to work full duty pain free as a truck driver without any need for medical care. The medical records clearly indicate that Petitioner's shoulder condition changed after his work accident on March 24, 2016. The medical records are equally clear that Petitioner's shoulder condition has remained symptomatic since March 24, 2016.

Based on the foregoing, the Arbitrator finds that Petitioner has proved, by a preponderance of the evidence, that his current condition of ill-being, as it relates to his right and left shoulder, is causally related to his work accident on March 24, 2016.

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

The Findings of Fact and Conclusions of Law, as stated above, are adopted herein.

The Arbitrator adopts the opinion of Dr. Troy. The Arbitrator notes that Dr. Troy specifically testified that the medical care Petitioner received from Dr. Troy's office, Advanced Orthopedic and Spine Care, was reasonable and necessary. In addition, the Arbitrator notes that Respondent's Section 12 medical examiner, Dr. Monaco agrees with the medical treatment that Dr. Troy has provided to Petitioner. Specifically, Dr. Monaco testified, "...I can't disagree with the treatment Dr. Troy has given to the problem. I just disagree with the cause of the problem."

Petitioner has incurred medical expenses from Advanced Orthopedic and Spine care for services rendered from September 16, 2016 through October 14, 2017, in the amount of $5,164.00. (Petitioner's Exhibit #1)

Based on the foregoing, the Arbitrator finds that Petitioner has proved, by a preponderance of the evidence, that the medical services that were provided to Petitioner from Advanced Orthopedic and Spine Care were reasonable and necessary. The Arbitrator awards the medical charges contained in Petitioner's Exhibit #2, pursuant to Section 8.2 of the Act.

With respect to K.) Is Petitioner entitled to any prospective medical care, the Arbitrator finds as follows:

The Findings of Fact and Conclusions of Law, as stated above, are adopted herein.

On March 22, 2017, Dr. Troy recommended that Petitioner proceed with left shoulder arthroscopy and subacromial decompression surgery. Dr. Troy specifically testified that it is his opinion that the left shoulder surgery he has recommended for Petitioner is causally related to his work accident on March 24, 2016. Dr. Troy explained that because Petitioner continues to have symptoms of shoulder pain on a daily basis, and conservative treatment of his symptoms has not provided relief, the next medical option for Petitioner is the surgical procedure that has been recommended.

While Petitioner's symptoms have waxed and waned over the past two years, he has not presented to any medical provider since March 24, 2016 without complaints of pain to his left and right shoulders and positive Neer's and Hawkins' tests, both objective tests for signs of impingement.

Having found the requisite causal relationship, the Arbitrator finds that Respondent shall authorize the left shoulder glenohumeral arthroscopy and arthroscopic subacromial decompression surgery recommended by Dr. Troy. The Arbitrator notes that although Respondent's Section 12 examiner, Dr. Monaco, does not agree with causation, Dr. Monaco specifically testified that, "...what he is planning to do is not at all inappropriate."

With respect to the right shoulder, the Arbitrator notes that Dr. Troy does not recommend anything more than conservative care at this time. The doctor explained that, in his experience, there are occasions when a patient receives treatment for the more symptomatic shoulder and the symptoms in the opposite extremity improve or resolve on their own. Accordingly, the Arbitrator declines to award any prospective medical care, at this time, for Petitioner's right shoulder. However, this finding does not dilute the Arbitrator's finding above that the current condition of ill-being of Petitioner's right shoulder is related to his work accident on March 24, 2016.

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

The Findings of Fact and Conclusions of Law, as stated above, are adopted herein.

Petitioner was examined by Dr. Troy on May 16, 2017. On that date, Dr. Troy provided Petitioner with a light duty work restriction of limited lifting, carrying, pushing and pulling no greater than 20 pounds. Petitioner testified that he requested light duty work from Respondent's operations manager, Joe Spina. Respondent has not offered light duty work to Petitioner since May 16, 2017. The Arbitrator notes that Mr. Spina confirmed that Respondent does not have light duty work available for Petitioner.

On June 13, 2017, Dr. Troy directed Petitioner to remain off work. Dr. Troy also directed Petitioner to remain off work when he examined him on June 30, 2017, August 21, 2017, and the last time he examined Petitioner, October 14, 2017. Dr. Troy testified that he directed Petitioner to remain off work based upon the Petitioner's bilateral shoulder complaints and his concern for operating a commercial truck with his current complaints. Additionally, the Arbitrator notes that Petitioner cannot drive while taking Tramadol, as prescribed by Dr. Troy. Dr. Troy has not released Petitioner to return to any type of work since June 13, 2017.

Respondent's Section 12 examiner, Dr. Monaco, felt Petitioner could return to full duty work based on his opinion that Petitioner recovered from any ill effects of his March 24, 2016 work accident by July 25, 2016, the date Dr. Garelick released him from care. As noted above, the Arbitrator has found the causation opinions of Dr. Troy more persuasive.

Based on the foregoing, the Arbitrator finds that Petitioner has proved, by a preponderance of the evidence, that he is entitled to temporary total disability benefits from May 16, 2017 through April 19, 2018.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF KANE	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DEBORAH SOUVENIR,

Petitioner,

vs. NO: 17 WC 18956

19IWCC0219

DOVENMUEHLE MORTGAGE CO.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) of the Act having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of employee-employer relationship, accident, causal connection, medical expenses, prospective medical, temporary total disability (TTD) benefits and penalties and attorney's fees, and being advised of the facts and law, affirms and adopts the Arbitrator's Decision, which is attached hereto and made a part hereof.

The Commission only writes to clarify the correct finding of an employee-employer relationship. The Arbitrator incorrectly wrote that no relationship existed in the "Findings" section of her Decision, on page 3. However, the Arbitrator did find that an employee-employer relationship existed between Petitioner and Respondent, and indicated as such on pages 3 and 13-15 of her Decision. Therefore, the Commission writes to clarify that an employee-employer relationship existed between Petitioner and Respondent on May 8, 2017. The remainder of the Arbitrator's Decision is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on July 10, 2018, is hereby corrected as stated above, and otherwise affirmed and adopted.

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

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

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

DATED: MAY 1 - 2019

MEP/pm
O: 4-23-19
049

Maria E. Portela

Thomas J. Tyrrell

Deborah L. Simpson

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

SOUVENIR, DEBORAH
Employee/Petitioner

Case# **17WC018956**

DOVENMUEHLE MORTGAGE CO
Employer/Respondent

19IWCC0219

On 7/10/2018, 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 2.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5122 PORRO NIERMANN LAW GROUP LLC
KURT A NIERMANN
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AURORA, IL 60506

3227 HOLECEK & ASSOCIATES
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PO BOX 64093
ST PAUL, MN 55164-0093

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

DEBORAH SOUVENIR,
Employee/Petitioner

v.

DOVENMUEHLE MORTGAGE CO,
Employer/Respondent

Case # 17 WC 18956

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 Ketki Steffen, Arbitrator of the Commission, in the city of **Geneva, Illinois**, on **3/9/18 and 5/15/18**. 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. ☒ Is Petitioner entitled to any prospective medical care?

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other

FINDINGS

On the date of accident, **5/8/17**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

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

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

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

In the year preceding the injury, Petitioner earned $**640.00 per week**; the average weekly wage was $**640.00**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

Respondent shall be given a credit of **$0** for TTD, and $**853.34** in PPD, for a total credit of **$853.34**.

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

ORDER

On 5/8/17, an employee-employer relationship did exist between Petitioner and Respondent

On 5/8/17, Petitioner did not sustain an accident that arose out of and in the course of employment.

All other issues relating to causal connection, unpaid medical bills, TTD and prospective medical are moot as the accident did not arise from Petitioner's employment.

Respondent is not liable for any unpaid medical bills. TTD or propective medical care.

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

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

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

KSSteffen — Signature of Arbitrator

July 5, 2018 — Date

ICArbDec19(b)

JUL 10 2018

STATE OF ILLINOIS)
)
COUNTY OF KANE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION
OF THE STATE OF ILLINOIS

DEBORAH SOUVENIR,)
)
Petitioner,)
) Case: 17WC18956
)
DOVENMUEHLE MORTGAGE COMPANY,)
)
)
Respondent.)

FACTUAL HISTORY

Petitioner was 59 years old at the time of her accident. She was recruited and had just received an offer of employment by the Respondent. On 5/8/17 she arrived at the employee parking lot to report for work at 8 a.m. She parked in an open spot next to the curb shortly before 8 a.m. As she exited her car, she tripped and fell by the curb. Although multiple issues have been presented at Arbitration, the question of whether Petitioner was an employee and whether the accident arose out of and in the course of employment are the gatekeepers to Respondent's liability on the remainder matters.

Petitioner testified that she received a letter of employment and was instructed to park in the employee parking lot. She had previously filled out various paperwork and was directed to bring her driver's license and social security card to complete the tax forms with HR department.

Lisa Wilk was respondent's HR generalist and recruiter at the time of petitioner's accident. She sent an offer of employment letter to petitioner, instructing her to report for work on 5/8/17. She acknowledged that Petitioner bought her documents on 5/8/17

and filled out the paperwork at the end of her workday on 5/8/17. She also testified that employees had up to 3 days to complete this paperwork. If they failed to do so, they would be terminated. She acknowledges that employees could start work without filling out this paperwork and would remain employees until terminated (if they did not complete the paperwork by the third day)

Photographic evidence of the parking lot and the curb where the Petitioner fell was presented into evidence. (PX4) The pictures show a large parking lot with many open and unassigned spaces. The curb photographs show a normal (3-4 inch) raised curb which separated the parking spot from the grassy area inside the curb enclosure. There are walkways leading to the work entrances. There are zero visible cracks, defects, or abnormalities noted in the photographic evidence. The Petitioner agreed that the curb itself is not cracked or defective but stated that the inside grass appears to be the same height as the curb when, in fact, it is not.

Petitioner testified that she parked close to the curb, was unable to walk around the curb and stepped with her left foot out of her car and onto the median. The grassy area was much lower than the curb height and she did not expect it to be uneven. As she took steps towards the building, she tripped on the inside of the curb and fell onto the pavement of the parking lot. (T.169).

Petitioner stated that she told her employer (Mrs. Wilk/HR department) that she slipped and fell and injured her ankle and foot in the parking lot. She stated that she later also sent an email to Mrs. Wilk detailing her accident.

Respondent denied Petitioner's Worker's Compensation claim. George Acosta from Travelers (Respondent's insurance Company) testified that he first learned of the accident either the day of or the day after the accident from Ms. Wilk. He testified that

he spoke with the Petitioner a couple of days after the accident. He testified that the Petitioner stated she had got out of her car and fell after taking a couple of steps. He testified that after his investigation, including his conversation with the Petitioner, he denied the claim due to no defect or hazard present on the employer premises.

Petitioner testified that she was told her claim was denied (partly) because they deemed her accident to be caused by her own fault.

Mrs. Wilk testified that she was the human resource manager for the Respondent. She testified that PX9 was an offer letter conditional on certain requirements be met. Petitioner had to bring in at least two forms of ID to work. Id. She also had to sign a I-9 form, payroll form, and State and Federal tax forms to work for the company. If she did not bring or sign the documents required, she would not have been employed by the company. Mrs. Wilk stated that the accident occurred at around 7:55 a.m. and the Petitioner did not mention anything defective about the curb or pavement. She testified the Petitioner never told her about anything regarding uneven curb or grass at the time of the accident. She inspected the curb and did not find any defects. She testified that there were other open parking spaces. Mrs. Wilks testified that employees do not have to traverse any curbs to gain entrance into the company. She stated an employee could walk around the curb to gain entrance to the company. Ms. Wilk testified that there are two entrances from the parking lot to gain access to the building that are even with the parking lot.

Ms. Wilk also testified that RX4 is the Petitioner attendance records. She testified that according to the attendance records the Petitioner only worked 23 days. She stated the Petitioner missed 87 days of work. Id. Ms. Wilks testified that the Petitioner never presented her with any doctor's notes placing her off work or with any

work restrictions. The Petitioner testified she took off from work while being on a full duty release. She testified that she was only placed off work for two weeks in 2017. The Petitioner testified that she received her termination letter dated 10/9/17 and admitted that she did not work nine days prior to the letter. Id.

The Petitioner denied that she had any unexcused absences or that she had failed to provide medical off-work slips. Petitioner also testified that she felt that her work space did not allow her enough room to rest her ankle/foot to accommodate her medical restrictions.

MEDICAL

After her accident Petitioner went to work and continued to work her full duties until she went to Dreyer Medical Clinic on 5/16/17. (T.177-178; PX3) Petitioner testified that she worked through her pain and discomfort. Petitioner reported to the attending physician that she had an injury to the right foot and ankle one week earlier. (PX3 p.4) She reported experiencing difficulty bending the joint difficulty with walking, pain and swelling. (PX3 p.4) Her pain was severe and intermittent and worse with walking and standing. (PX3 p.4) The physician's examination identified petitioner limping favoring her injured extremity. (PX3 p.5) She had soft tissue swelling in the ankle, tenderness over the lateral malleolus, ankle joint effusion, and tenderness in the foot over the base of the fifth metatarsal. (PX3 p.5) X-rays of the ankle revealed mild soft tissue swelling about the lateral malleolus. (PX3 p.8) Dr. Hubbard diagnosed the condition as right foot and ankle sprain and advise petitioner to use Tylenol for pain, to use ice 15 minutes at a time until swelling and pain had resolved, and to keep the extremity elevated. (PX3 p.6) Petitioner next saw Dr. Paras at Castle Orthopedics on 5/25/17. (PX2 p.28) Petitioner reported her injury to the right ankle resulting from a fall. (PX2 p.28) Her

symptoms included ankle pain, swelling, decreased range of motion and difficulty bearing weight. (PX2 p.28) Her pain radiated to the right foot, pain which the patient described as burning. (PX2 p.28) Petitioner noted on the intake sheet that her pain was worse when she was not elevating her leg and with stepping. (PX2 p.29) Petitioner returned to Castle for a physical therapy evaluation on 6/15/17. (PX2 p.27) Her pain at that time was rated at five out of 10 on a visual analogue scale. Naproxen provided limited relief. Plantar flexion and walking increased her pain and elevating the leg decreased the pain. (PX2 p.27) Petitioner reported swelling in her foot as well as disruption of her sleep due to the pain. (PX2 p.27) She also experienced paresthesias when her legs were elevated or in a dependent position. (PX2 p.27) She also reported pain and difficulty with stair use. (PX2 p.27) The therapist's evaluation identified limitations in right dorsiflexion, plantarflexion, inversion, and eversion. (PX2 p.27) The right ankle strength was 2+/5 and she presented with an antalgic gate favoring the injured foot. (PX2 p.27) Petitioner returned to therapy on 6/26/17, reporting no real progression in her condition. (PX2 p.26) Her pain levels were now 6-7/10. (PX2 p.26) Standing and walking tolerance was only 10 to 15 minutes and she experienced throbbing pain after walking for more than 30 minutes. (PX2 p.26) The Naproxen was not really helping with the pain. (PX2 p.26) The therapist noted that petitioner's noticeable antalgic gait pattern caused her to have contralateral knee and ankle pain secondary to compensating for the injured limb. (PX2 p.26) Additional therapy was recommended. (PX2 p.26) Petitioner returned to see Dr. Paras on 6/27/17. (PX2 p.24) Petitioner reported persistent pain, with the majority of her symptoms localized to the distribution of the posterior tibialis tendon extending from its retromalleolar groove to its plantar insertion slip. (PX2 p.25) Her lateral ankle pain had improved significantly.

(PX2 p.25) Petitioner reported that therapy had been helpful but the medication was not working. (PX2 p.25) Dr. Paras also identified a gate alteration favoring the injured foot and he diagnosed the condition is chronic right ankle pain secondary to unresolved sprain and strain of the peroneal, posterior tibialis, and extensor tendons. (PX2 p.25) He recommended arch supports with all weight-bearing activities, a continuation of physical therapy, and he changed the medication to nab you Nabumatone and Tramadol. (PX2 p.25)

Dr. Paras also recommended that petitioner continue to remain off work for the next couple of weeks and then return to a sedentary position as tolerated. (PX2 p.25) Dr. Paras released her to work as tolerated on 7/27/17. (PX2 p.22) He also sent her to Dr. Watkins on to address the posterior tibialis dysfunction and her need for custom orthotics. (PX2 p.22) Petitioner saw Dr. Watkins on 7/31/17, opining that she would be good for sedentary work restrictions. (PX2 p.20)

Petitioner was restricted to sedentary duties for a couple of weeks. (T.178) She worked as customer service agent position. (T179) While petitioner worked the position, she experienced pain in the foot as she was not able to extend and elevate her foot while working. (T.179) She was instructed to work as tolerated. (T.180) She attended physical therapy. (T.181) She had a MRI and was released for full duty work by July. (T.181) She followed up with Castle Orthopedics and then with Hinsdale Orthopaedics. (T.183) None of the doctors said she would need surgery for the foot. (T.185) She saw Dr. Burgess at Hinsdale Orthopaedics on 10/12/17. (PX1 p.8) Dr. Burgess documented that the foot pain was sharp and stabbing, worse with activity, particularly using stairs and walking and standing. (PX1 p.8) Resting, elevation and icing improved the symptoms. (PX1 p.8) By the time of Burgess's visit, she had

swelling in both ankles and her left hip was starting to hurt. She had numbness in the right big toe, arch pain and pain to the lateral ankle. (PX1 p.8) Dr. Burgess found weakness in peroneal tendon strength on the right side and tenderness with palpation of the right peroneal tendons. (PX1 p.9) She also had pain along the plantar fascial ligament. (PX1 p.9) The 7/14/17 MRI confirmed focal bone edema at the anterior process of the calcaneus as well as a possible mild anterior talofibular ligament sprain without a full tear. (PX1 p.10) Dr. Burgess diagnosed the condition as peroneal and posterior tibialis tendinopathy of the right ankle with compensatory plantar fasciitis. (PX1 p.10) He sent her for a diagnostic ultrasound which was more accurate than an MRI for assessing peroneal tendon pathology around the foot and ankle. (PX1 p.10) Dr. Burgess restricted petitioner to sedentary work. (PX1 p.11)

The Petitioner was also treated at Castle Orthopedics by Dr. Watkins on 7/31/17. The Petitioner was a referral from Dr. Paras for evaluation of right posterior tibial tendinitis. PX2. He reported that she had fallen and injured her right ankle. Id. Dr. Watkins found the MRI only showed only a sprain. The Petitioner presented with ankle pain. Id. The symptoms were located in the right ankle. She was assessed with right tarsal tunnel syndrome and tendinitis. He recommended sedentary work, but she did not think that this type of job was available. Id. He reported that she wanted to be off work but he felt sedentary work was appropriate. PX2

On 10/31/17 he Petitioner underwent a CT scan which revealed no structural damage. PX1.

The Petitioner returned to Dr. Burgess on 11/9/17 to review the ultrasound results. PX1. She was assessed with chronic right foot ankle pain. PX1. Dr. Burgess noted no structural damage after reviewing the ultrasound. PX1. Dr Burgess diagnosed the

condition as a chronic right foot and ankle sprain. (PX1 p.14) He referred her to Dr. Kirincic for pain management (PX1 p.14) and released petitioner for full duties. (PX1 p.15) Petitioner saw Dr. Kirincic on 12/18/17 with pain in the right foot, both knees and low back. (PX1 p.17) Dr. Kirincic identified her presentation as right lower extremity pain, and compensatory pain in the low back, left foot and knees. (PX1 p.17) Petitioner reported that she was not interested in medications for treatment. (PX1 p.17) So Dr. Kirincic performed acupuncture, trigger point injections, as well as used a transcutaneous electronic nerve stimulator. (PX1 p.20) She also sent petitioner for therapy for postural retraining, myofascial releases as needed, range of motion and strengthening exercises. (PX1 p.23) During the follow up visit on 1/8/18, petitioner reported that injections and the TENS unit had been very helpful. (PX1 p.24) Petitioner asked for a repeat of those treatments as well as a home TENS unit. (PX1 p.24) Those treatments were performed and petitioner was given samples of Lorzone and Pennsaid. (PX1 p.27-28) At the next visit on 2/12/18, petitioner reported that her right foot pain had increased from moderate to severe level. (PX1 p.34) The medications helped a little. (PX1 p.34) She felt she was not able to work in her present condition and wanted a new evaluation. (PX1 p.34) Her prior scripts for therapy and the home TENS unit remained pending for approval by workers comp. (PX1 p.37) Dr. Kirincic repeated the acupuncture, stimulation and trigger point injections. (PX1 p.37) Dr. Kirincic renewed the therapy script and took petitioner off the medications. (PX1 p.38) She also recommended a FCE and sent petitioner to Dr. Ho, a foot specialist. (PX1 p.38) Dr. Kirincic removed petitioner from work pending the FCE. (PX1 p.38)

On 2/14/18 Petitioner saw Dr Ho. (PX1 p.44) Her pain levels were 6 out of 10 and treatment had consisted of casting as well as Dr. Kirincic's treatment which

provided some relief. (PX1 p.44) Dr. Ho's examination revealed tenderness over the proximal aspect of the plantar fascia and the heel, pain when squeezing the calcaneus, tenderness over the anterior ankle with some mild overlying swelling. (PX1 p.45) He recommended an additional MRI to rule out alternative diagnoses, such as an osteochondritis dessicans lesion and to rule out a stress fracture of the calcaneus. (PX1 p.46) He also thought she had plantar fasciitis and he removed her from work pending the MRI. (PX1 p.46) The MRI was done on 2/21/18, revealing mild tendinosis of the distal Achilles tendon with soft tissue edema superficial to the calcaneal insertion, mild edema of the interosseous ligaments in the sinus tarsi with reactive edema in the talus forming the roof of the sinustarsi, and possible ligament strain. (PX1 p.49). Petitioner returned to Dr. Ho on 2/23/18 with the same complaints. (PX1 p.50) Dr. Ho interpreted the MRI as showing no evidence of acute fracture or stress fracture. He saw edema in the sinus Tarsi with reactive bone edema of the talus consistent with a hindfoot sprain, as well as signal changes consistent with Achilles tendinosis. (PX1 p.52) She was given Achilles stretches to perform in the morning and after periods of immobilization, shoe inserts, a therapy script and Meloxicam. (PX1 p.52) He also continued her restriction from work. (PX1 p.53)

At the time of this hearing, Petitioner is no longer employed by Respondent and is seeking prospective medical treatment for her foot/ankle as well as TTD.

Findings/Analysis

B. In regards to disputed issue (B) on whether there was an employee-employer relationship, the Arbitrator finds the following:

The Arbitrator finds that the Petitioner was an employee of the Respondent on 5/8/17 when she slipped and fell in the employee parking lot upon exiting her motor vehicle on her first day of employment.

In determining whether or not an employee-employer relationship exist the courts looks at various factors that include whether the employer controlled the manner in which the person performs the work; whether the employer dictates the person's schedule; whether the employer pays the person hourly; whether the employer withholds income and social security taxes from compensation; whether the employer may discharge the person at will; and whether the employer supplies the person with materials and equipment. Additionally, courts may consider whether the employer's general business encompasses the person's work. Roberson v. Industrial Commission, 225 Ill. 2d 159 (2007).

Applying these factors to the case at bar, the Arbitrator finds that at the time of the accident the Petitioner was an employee of the Respondent. The Arbitrator notes that 5/8/17 was the first day of employment for the Petitioner. There is no contradictory evidence that Petitioner's work duties, hours and pay was directed by anyone other than the Respondent. In fact, Petitioner worked at Respondent's office site, was trained by Respondent, her hours were determined by the Respondent, no supplies or equipment was provided by the Petitioner and her duties were in line of Respondent's business. There is little doubt that Petitioner was a paid employee of Respondent. The question remains whether she was an employee at the time of her fall in the parking lot

on the first day of her employment in the few minutes before she entered the building. The Arbitrator finds that she was an employee at the time of her accident.

Petitioner testified that she received an offer of employment from the Respondent. Respondent's witness, Mrs. Wilk, the HR manager, testified that said offer was conditional on Petitioner providing her driver's license, social security car and filling out some additional tax forms. However, Mrs. Wilk also testified that Petitioner filled out the forms at the end of her work day and that employees had up to the first three days of work to complete this additional bookkeeping requirement. Mrs. Wilk acknowledged that a new hire became an employee and continued to be an employee until and uptil the third day. If the employee failed to fill out the paperwork and provide verification of their identity and ability to legally work (social security card); they would be terminated. This not just implies, but explicitly states, that the Respondent considered the Petitioner an employee as she arrived and reported for duty. In fact, Petitioner was welcomed to work that entire day and thereafter and filled out her tax related paperwork at the end of her first work day.

This evidence shows that the Petitioner objectively and rationally believed herself to be an employee and the Respondent considered the Petitioner an employee on the first day of her employment. The argument, that the employment was conditional, is factually accurate. However, by allowing employees to fill out the paperwork for up to three days and considering the fact that the Petitioner did meet this requirement is sufficient to show that Petitioner was Respondent's employee on the first day of work. Once the condition was met, Petitioner became an employee, nunc pro tunc, to the starting date of her employment. This is precisely what the Respondent intended and implemeted (policy wise).

As to the issue of whether Petitioner was an employee within the parking lot (at 7:55 a.m.) as opposed to becoming an employee when the entered the actual work facilities (at 8 a.m.), the Arbitrator finds that Petitioner was an employee at the time of her accident. The parking lot is an employee only lot, controlled and provided for by the Respondent. The Petitioner was directed to park in this lot by the Respondent and although she was not specifically directed to park in any particular assigned spot, said fact is immaterial to the Arbitrator's findings and evaluation on the issue of employer-employee relationship under this particular factual scenario.

The Arbitrator finds that the Petitioner was Respondent's employee at the time of her accident. As to the issue of how the Petitioner fell in the parking lot, the Petitioner's testimony is credible and amply supported by all of Respondent's witnesses. In fact, there is an immediate outcry by Petitioner, her foot and clothing have obvious signs of injury, and HR department examines the lot, the curb and Petitioner's car that is parked as Petitioner had indicated. Therefore, the Arbitrator finds that the Petitioner has proven that she fell on or near the curb of the employee parking lot on the first day of work. The Arbitrator further finds that the Petitioner was an employee of the Respondent on the date and time of her accident.

C. <u>In regards to disputed issue (C) on whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:</u>

After careful review of the evidence presented, the Arbitrator finds that the Petitioner failed to prove by a preponderance of the evidence that an accident arose out of and in the course of Petitioner's employment by Respondent.

Although much is addressed during the hearing relating to the Petitioner's credibility (based on her performance as an absentee employee); the essential facts of

whether Petitioner was within the scope and course of her employment are not in dispute. As discussed above, Petitioner was an employee who fell and was injured in the company's employee parking lot on the first day of work. Petitioner trips on a curb in the parking lot as she exited her parked car. Per her own testimony, the testimony of all other witnesses, as well as the photographic evidence, there are no cracks, defects or abnormalities in the slightly raised curb. The curb is akin to the other well maintained and probably, required safety curbs, that can demark, stop or limit the area between moving vehicles and the walkways or pathways that employee takes to go to work. Although there is no specific evidence presented of why there are curbs in Respondent's parking lot, the Arbitrator notes the common sense rational for curbs in parking lots. The slight rise of the curb prevents cars from rolling or driving upon the pathway and injuring pedestrians. As curb may also limit water, snow and ice accumulation (due to their raised architecture) and create a safe and delineated path that separated people from motor vehicle traffic. Often curbs may be enclosed areas with grass growing within the enclosure.

In Petitioner's case, there was such a curb. For some unknow reason, Petitioner was surprised when the grass within this curbed area compressed under the weight of her foot. She testified and argues that the curb was defective because the grass appeared to be the same height but becomes compressed and is lower in height when stepped on. She claims that the appearance of similar height between the grass and the curb is a defect. The Arbitrator has struggled greatly to understand the meaning and thrust of Petitioner's claim regarding this alleged irregularity or hazard. From every angle, in every picture, and per any reasonable analysis, there is simply no defect or surprise or damage in the nature of the parking garage, grass or the curb. Grass by it's

very nature will 'give' under our feet. Additionally, the height of the grass will vary due to growth or mowing and maintenance. To define this as unexpected or defective is to simply find any grassy curbed areas to be inherently defective. Petitioner simply slipped and fell on or near the curb as she did not expect the grass to be lower than the curb when pressed upon.

The Arbitrator emphasizes that such a conclusion is not meant to assign fault or negligence upon the Petitioner. The Arbitrator recognizes and supports our state's 'no fault' worker's compensation system. However, the Arbitrator also recognizes that not every fall by an employee gives rise to Respondent's liability for the same. To find a pavement or an area defective, there needs to be an objective and discernable defect. Otherwise, an Illinois employer, who is charged with the solemn task of providing a safe environment for their employees, is left with a liability problem that is unavoidable and unsolvable.

In support of her position, the Arbitrator notes Illinois Supreme Court case of Caterpillar Tractor Company v. Indus. Comm'n. Caterpillar Tractor Co. v. Indus. Comm'n, 129 Ill. 2d 52, 541 N.E.2d 665, 668–69 (1989) as being precisely on point. In *Caterpillar*, the injured worker was employed by the Caterpillar Tractor Company (Caterpillar) as a carton packer. Id. On July 7, 1979, after completing his shift, Price left the building through the door normally used by the employees, intending to go to his car, which was parked in the employee parking lot. Id. Immediately in front of the building was a sidewalk with a curb running along its edge. Id. Price walked along the sidewalk for about 30 feet and then stepped off the curb onto the blacktop driveway. Id. There was a slight cement slope, apparently for drainage, between the curb and the blacktop driveway. Id. As Price stepped off the curb, his right foot landed half on the

cement incline and half on the blacktop driveway and he twisted his ankle. Id. The driveway was part of the company premises and was used both by employees and by the general public to pick up employees. There is no evidence of holes, rocks or obstructions on the pavement. Caterpillar Tractor Co. v. Indus. Comm'n, 129 Ill. 2d 52, 56–57, 541 N.E.2d 665, 666 (1989).

The Court first determined that the employer's premises was not a contributing cause of the Claimant's injury. Id at 61. They found there was nothing in the record to indicate that the curb was either defective or hazardous. Id. Similarly, in the case at bar, the Arbitrator does not find anything defective about the curb. Mrs. Wilk testified she inspected the curb and did not find anything defective about the curb. TX 215. Mr. Acosta testified that the Petitioner said that the curb was normal. TX 106. The photographs do not reveal a defect. Further, the Petitioner did not present any objective evidence to show the curb was defective or hazardous at trial.

The Court in *Caterpillar* next considered whether the claimant was subjected to a greater degree of risk than the general public when he tripped over a curb. Id at 61. The Court found the claimant did not establish that he was exposed to a risk not common to the general public. Id. The object of comparing between the exposure of the particular employee to a risk and the exposure of the general public to the risk is to isolate and identify the distinctive characteristics of the employment. (See 1 A. Larson, The Law of Workmen's Compensation § 8.42 (1985).) Curbs, and the risks inherent in traversing them, confront all members of the public. Id. The claimant is no more liable to the employee twisting his ankle than he would have been had he been engaged in any other business. The Court found that while it true that he regularly crossed this curb to reach his car, there is nothing in the record to distinguish this curb from any other

curb. They held the mere fact that the duties take the employee to the place of the injury and that, but for the employment, he would not have been there, is not, of itself, sufficient to give rise to the right to compensation. (See State House Inn v. Industrial Comm'n (1965), 32 Ill.2d 160, 163, 204 N.E.2d 17; Schwartz v. Industrial Comm'n (1942), 379 Ill. 139, 145, 39 N.E.2d 980.) The claimant has the burden of establishing, by a preponderance of the evidence, some causal relation between the employment and the injury. Quality Wood Products Corp. v. Industrial Comm'n (1983), 97 Ill.2d 417, 423, 73 Ill.Dec. 571, 454 N.E.2d 668; Horath v. Industrial Comm'n (1983), 96 Ill.2d 349, 356, 70 Ill.Dec. 741, 449 N.E.2d 1345. Caterpillar Tractor Co. v. Indus. Comm'n, 129 Ill. 2d 52, 62–63, 541 N.E.2d 665, 669 (1989). They specifically noted, "this Court is not prepared to adopt the position that whenever an injury is suffered on work premises during work hours it is compensable, regardless of whether the conditions or nature of the employment increased or contributed to the risk which led to the injury." Caterpillar Tractor Co. v. Indus. Comm'n, 129 Ill. 2d 52, 64, 541 N.E.2d 665, 670 (1989).

Applying the law set forth in *Caterpillar* to the case at bar, the Arbitrator finds that the Petitioner was not exposed to a risk not common to the general public. Similarly, in this case, the Petitioner tripped over a curb. The Arbitrator notes that the curb in this case was not necessary to traverse to gain entrance to the employer while the curb in Caterpillar was customary to cross. The Arbitrator notes that there were other open parking spaces and the Petitioner could have walk around the curb to gain entrance to the company. Id. The Arbitrator also finds significant that there were several ways to get to the employer's entrance from the parking lot without having to transverse a curb. TX 176. Based on the foregoing, the Arbitrator finds that the Petitioner was not exposed to a risk greater than the general public and applies the principles set forth in

Caterpillar that the curb in this case, and the risks inherent in traversing them, confront all members of the public.

Although much of the trial testimony is devoted to how the Petitioner was a bad, undependable employee who worked only 23 days and missed about 87 days of work, the Arbitrator does not base her decision on this testimony. TX 223. Rather, the Arbitrator finds that there are few factual conflicts regarding Petitioner's fall or the condition of the parking lot. The issue of 'arising out of or in the course of employement' is largely a legal issue. The issues of whether Petitioner was an absentee employee or whether her current causal condition is related to her accident are moot based on above findings.

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

MARVIN A. BRUSTIN,

Petitioner,

vs. NO: 14 WC 23938

BRUSTIN & LUNDBLAD, LTD.,

19IWCC0220

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, permanent partial disability (PPD) benefits and the issue of special mission, and being advised of the facts and law, affirms and adopts the Arbitrator's Decision, which is attached hereto and made a part hereof.

The Commission only writes to clarify the correct date of injury. The Arbitrator incorrectly wrote that the accident of October 11, 2011 did not arise out of and in the course of Petitioner's employment with Respondent. (Arbitrator's Decision, pg. 2). However, the correct accident date was October 27, 2011, which the Arbitrator referenced repeatedly within the body of the Decision's Statement of Facts and Conclusions of Law. Therefore, the Commission writes to clarify that the accident of October 27, 2011 did not arise out of and in the course of Petitioner's employment with Respondent. The remainder of the Arbitrator's Decision is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on July 31, 2018, is hereby corrected as stated above, and otherwise affirmed and adopted.

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

19IWCC0220

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.

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

DATED: MAY 1 - 2019

MEP/pm
O: 4-23-19
049

Maria E. Portela

Thomas J. Tyrell

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRUSTIN, MARVIN A
Employee/Petitioner

Case# **14WC023938**

BRUSTIN & LUNDBLAD LTD
Employer/Respondent

19IWCC0220

On 7/31/2018, 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 2.16% 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:

0786 BRUSTIN & LUNDBLAD LTD
CHARLES E WEBSTER
TEN S DEARBORN ST SUITE 700
CHICAGO, IL 60602

0532 HOLECEK & ASSOCIATES
STUART PELLISH
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Marvin Brustin
Employee/Petitioner

v.

Brustin & Lundblad, Ltd.
Employer/Respondent

Case # **14** WC **023938**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Arbitrator Andros**, Arbitrator of the Commission, in the city of **Chicago**, on **April 17, 2018 and May 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. [ ] 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 **October 27, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did 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 **$60,320.00**; the average weekly wage was **$1,160.00**.

On the date of accident, Petitioner was **81** years of age, *married* with **0** dependent children.

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

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

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

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

ORDER

Because the Arbitrator has concluded the accident of October 11, 2011 did not arise out of and in the course of Petitioner's employment with Respondent, benefits are denied.

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

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

__#01_George J. Andros______
Signature of Arbitrator

July 32, 2018
Date

JUL 3 1 2018

Marvin Brustin vs. Brustin & Lundblad, Ltd.
Court No.: 14 WC 023938

19IWCC0220

Statement of Facts

Petitioner, Marvin Brustin, presently 81 years of age, is an attorney and president of Brustin & Lundblad Limited, a law practice with an emphasis on common-law actions but which also handles some Worker's Compensation claims. He is the firm's senior attorney. He supervises the office. He no longer handles day-to-day legal work. He continues to try jury cases, having tried one six months prior.

Mr. Brustin testified his working hours are 9:00 AM to 5:00 PM, Monday through Friday, and half a day on Saturday.

He currently seeks out business opportunities for the law firm and arranges financing for the firm. Mr. Brustin handles or oversights the firm's work on cases for major clients, those who are sources of business for the firm, as well as the firm's larger cases.

Brustin & Lundblad has an answering service which answers the phone in nonbusiness hours and emergencies. Mr. Brustin acknowledged the answering service was not involved in the call he received at home on October 27, 2011.

The answering service has Mr. Brustin's phone number and the office manager's number. They would call Mr. Brustin in an emergency or they would call the office manager, if Mr. Brustin could not be reached.

Mr. Brustin considers himself to be an on-call employee. If there is an emergency or something unusual or something that is delicate or important needing handling, he would be on call to solve the problem or participate in the solution.

On October 27, 2011, around 8:00 AM Mr. Brustin received a call from the firm's office manager. She was at the office. Mr. Brustin was informed Mr. Casey Boback had arrived early for their 10:00 AM scheduled meeting.

Mr. Boback is a business agent of a large laborers local. He is also a personal client of Mr. Brustin and of the law firm. Mr. Brustin has known Mr. Boback for many years. He describes Mr. Boback as being a very impatient man.

Mr. Brustin testified Mr. Boback is a very important person for the office. He is an enormous source of business for the law firm and a personal client, having recommended many, many people repeatedly to the law firm. He has recommended to members of the local, and to the president and the board of directors of the union's local to use Mr. Brustin for legal matters

Mr. Brustin represented Mr. Boback and his family on two high six-figure common-law cases which were settled by Mr. Brustin. He continues to represent Mr. Boback on a pending workers compensation claim.

Mr. Brustin has represented five or six of Mr. Boback's family. Mr. Brustin handles matters for members of other unions of whom Mr. Boback has made introductions. Mr. Boback's relatives are the president of the Polish Highlanders. Mr. Brustin has represented the president and wife of this organization along with other members of the Polish community.

Mr. Brustin testified the law firm has a rule that someone who is a big source of business, such as Mr. Boback, must be handled personally by Mr. Brustin or his partner, Mr. Lundblad.

Mr. Brustin testified he was concerned Mr. Boback would leave the office prior to his arrival at the office. He thought this might have had a deleterious effect upon the firm. Mr. Brustin acknowledged Mr. Boback still continues to act as a referral source for the law firm, referring cases of his family members and members of the laborers union. Mr. Brustin acknowledged, though he did not attend his appointment with Mr. Boback on October 27, there has been no diminishment in the firm's relationship with Mr. Boback.

After receiving the phone call from the firm's office manager, Mr. Brustin finished getting dressed, shaved and washed, preparing himself to go to the office.

Mr. Brustin lives in a high-rise building located at the corner of Bellevue and inner Lakeshore Drive in the City of Chicago. Mr. Brustin went out the front door of his building, which empties out onto inner Lakeshore Drive. He turned right, going from north to south, walking on the public sidewalk to the bus stop which was at the corner of Oak Street and the inner Lake Shore Drive. He chose to take a public bus to the office because it is direct and efficient.

Mr. Brustin testified the weather was nice and dry. There was no moisture on the sidewalk, no objects on the sidewalk and the path on the sidewalk was not blocked. There was nothing remarkable about the amount of vehicular or pedestrian traffic.

As he was walking at his normal pace on the public sidewalk, he tripped and fell forward onto the sidewalk. Mr. Brustin attributed the fall to an elevation issue with the sidewalk. He acknowledged he had filed a civil suit against the City of Chicago. The civil suit was dismissed on the City's motion for summary judgment. Affidavits supporting the motion for summary judgment indicated the sidewalk discrepancy in elevation was 1 1/8 inch to 1 7/8 inch.

After falling, Mr. Brustin got himself to his feet with assistance of others. He noticed pain in his left shoulder and arm, pain he had not experienced previously in the arm or shoulder.

Mr. Brustin sat near a building, composing himself. He chose not to have an ambulance called. He took a cab to Northwestern Hospital. He called the office manager while in the cab, informing her he could not make the appointment with Mr. Boback.

At Northwestern Hospital, Mr. Brustin complained of left arm pain, his non-dominant arm. X-rays taken at Northwestern Hospital noted he suffered an inferior dislocation of the humeral head. The left shoulder dislocation was reduced under sedation. He testified to not having suffered any prior or subsequent accidents to his left arm.

19IWCC0220

Mr. Brustin chose to have follow up care with Dr. Anthony Romeo of Rush University Medical Center. He was only seen once, on December 13, 2001. He complained of stiffness in his shoulder, pain at extremes of motion, along with some numbness in the forearm and a little bit of weakness in his left hand. Mr. Brustin acknowledged to Dr. Romeo the condition of his arm was slowly improving.

Dr. Romero prescribed anti-inflammatory medications and physical therapy. Mr. Brustin attended physical therapy at Accelerated Rehabilitation from December 19, 2011 until March 13, 2012, when he was discharged from therapy. He has not had any follow up orthopedic care since the one visit with Dr. Romeo.

Mr. Brustin acknowledged seeing Dr. Costas, his family physician over the last six years. He acknowledged he has not verbalized any complaints with the left shoulder to Dr. Costas during this period of time.

Over the last six years, Mr. Brustin has not taken any prescribed medications for his shoulder. He has not seen any doctors over the last six years for his shoulder complaints. He uses no appliances for care of his left shoulder. He testified he continues leading an active life.

Mr. Brustin testified of experiencing a loss of strength with overhead activities using his injured, non-dominant left shoulder Mr. Brustin acknowledged he has not had any diminishment in his earnings attributable to this incident of October 27th. He has not lost any time from work due to the incident of October 27, 2011.

Conclusions of Law

Did an accident occur arising out of and in the course of Petitioner's employment by Respondent:

The Workmen's Compensation Act was not intended to insure employees against all accidental injuries" but only those arising out of and occurring in the course of employment." (*Ace Pest Control, Inc. v. Industrial Com.* (1965), 32 Ill.2d 386, 388.) Normally, accidents which occur while an employee is traveling to or from employment are not compensable. This general rule is inapplicable in those cases in which the employment requires the employee to be traveling or away from the employer's regular premises. (*David Wexler & Co. v. Industrial Com.* (1972), 52 Ill.2d 506, 510; *U.S. Industries v. Industrial Com.* (1968), 40 Ill.2d 469, 474.) In cases of traveling employees, the determination of whether the injury is in the course of employment "depends upon the reasonableness of the specific conduct and whether it might normally be anticipated or foreseen by the employer." *U.S. Industries v. Industrial Com.* (1968), 40 Ill.2d 469, 475, *Ace Pest Control, Inc. v. Industrial Com.* (1965), 32 Ill.2d 386, 388-90.

The testimony of Mr. Brustin does not support a conclusion at the time of the October 27, 2011 incident, he was a traveling employee. He was traveling to his office, his fixed place of employment. He travels to the office daily. He was traveling using his ordinary means of travel, the public bus, transportation which he considers to be the most efficient of traveling to the office.

The coming and going rule means an employee cannot generally collect workers compensation benefits while commuting to or from work. (*Hindle v. Sjostrom v. Sproule* (1965), 33 Ill.2d 40, 43.) An exception to this rule occurs when the employer agrees to compensate the employee for time spent traveling to and from work. Commonwealth Edison v Industrial Commission 428 NE 2d 165(1981)

"When the employee is paid an identifiable amount as compensation for time spent in a going or coming trip, the trip is within the course of employment. This is a clear application of the underlying principle that a journey is compensable if the making of that journey is part of the service for which the employee is compensated. * * *
[A] demonstration that travel time was specifically paid for is one of the most reliable ways of making a case for the compensability of a going or coming trip, and is ordinarily sufficient in itself to support such a finding * * *." (1 A. Larson, Workmen's Compensation §16.20 (1978).)" Commonwealth Edison v Industrial Commission 428 NE 2d 165(1981)

Mr. Brustin testified his law firm provides a CTA bus card to its employees. While Illinois recognizes an employee who is compensated for this time traveling to work could give rise to a compensable accident, this is not the factual evidence in his case.

The record is devoid of any evidence to conclude Petitioner was paid for his travel time to the office. If the law firm provided to its employees a CTA pass to cover the cost of transportation, it merely demonstrates reimbursement for the expense of travel and is a form of additional compensation. It does bring the travel itself within the course of employment. Public Service Co v Industrial Commission (1938), 370 Ill.334.

The Arbitrator concludes as a matter of law the use of a public bus pass, provided by the employer to its employees, does not give rise to an exception to the general rule on coming and going.

Mr. Brustin proposes on October 27, 2011 he was on a special mission for the benefit of his law firm. Illinois law recognizes employees injured on a 'special mission' for their employer may give rise to a compensable accident. The Arbitrator concludes Mr. Brustin was not on a special mission at the time of slipping and falling on a public sidewalk.

After receiving the phone call from the firm's office manager, Mr. Brustin finished getting dressed, shaved and washed, preparing himself to go to the office. This is an activity which the Arbitrator can and does reasonably infer is part of his daily actions prior to going to his office.

Mr. Brustin testified to his normal working hours of 9:00 AM to 5:00 PM. Mr. Brustin testified his appointment with Mr. Boback was scheduled for 10:00 AM. The phone call he received from his office manager occurred around 8:00 AM.

Mr. Brustin's conduct on October 27th would be 'special' if it is extraordinary in relation to his routine duties. The special mission rule "is ordinarily held inapplicable when the only special component is the fact that employee began work earlier or quit work later than usual" (1 Larson, Workers Compensation Law, (1972) §16.12.

There is nothing exceptional or extraordinary about an attorney meeting with a client. It is one of the ordinary, routine duties performed by an attorney to keep his client informed of developments in the client's case.

Mr. Brustin on October 27th was not required to be away from his conventional place of employment. He was simply traveling to his office. At the time of his slip and fall, he was not engaged in the direct performance of his employment duties. He was simply going to his office.

Mr. Brustin was not required to make an extra trip to work on October 27th. He commuted by his ordinary means, taking the bus to his office on October 27th. While the phone call received by Mr. Brustin might have necessitated his arrival to his office earlier than planned, that alone does not make the trip to the office 'special'. Given the amount of time needed to finish getting dressed, shaved and washed, preparing himself to go to the office and traveling to his office via public transit, the call was simply notifying Mr. Brustin his 10:00 o'clock appointment had arrived early. The record is devoid of any testimony by Mr. Brustin of how long it would normally take to finish preparing to get ready to his office, walk to the bus stop, wait for the bus, travel on the bus and walk to his office. For a person who starts his work day at 9:00 AM, nothing done by Mr. Brustin demonstrates he was not engaged in his usual routine activities on the morning of October 27th.

The Arbitrator concludes on October 27, 2011 Mr. Brustin was not engaged in a special mission for the benefit of his law firm. This is so despite the admirable and palpable dedication to his clients and his craft as demonstrated and observed and heard in his very forthright, sincere testimony.

The Arbitrator, finding no factual basis to apply any of the exceptions to the general coming and going rule of non-compensability, denies all claims for benefits under the Workers Compensation 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 MADISON	)	☐ 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 WILBERT,

Petitioner,

19IWCC0221

vs.

NO: 16 WC 4045

SYNCREON HOLDINGS,

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner was injured on January 13, 2016, when he was struck by a forklift and pushed into pallets. The next day he went to an emergency department complaining of 4/10 pain and was diagnosed with myofascial lumbosacral strain and iliac-crest contusion. X-rays were normal. Naprosyn and Cyclobenzaprine were prescribed, and Petitioner was released with no cognitive or functional deficits. He came under the care of Dr. Gornet, who prescribed chiropractic treatment, prescribed medication, and ordered an MRI. The MRI taken on March 24, 2016 was interpreted as showing a disc bulge with small bilateral foraminal annular tear at L4-5 contributing to mild foraminal stenosis without significant spinal canal compromise. Thereafter, Dr. Gornet administered injections. Petitioner improved with injections and on June 20, 2016, Dr. Gornet released Petitioner to a trial of full-duty work.

On November 21, 2016, Dr. Gornet noted that Petitioner could continue to work at full duty, declared him at maximum medical improvement, and released him from care. However, on December 19, 2016 Petitioner returned to a hospital emergency department with left low back pain. There, he noted that he did a lot of twisting at work and believed he lifted and twisted simultaneously, which he believed exacerbated his back condition after being hit by the forklift. Petitioner returned to Dr. Gornet on August 26, 2017 complaining of radiating pain down the left leg. Dr. Gornet opined that he was tolerating his symptoms well, again declared him at maximum medical improvement, and again released him from treatment. However, Petitioner returned to Dr. Gornet on February 19, 2018, again complaining of radiating left-leg pain. Dr. Gornet ordered a new MRI to reassure Petitioner. The MRI was taken the same day and was interpreted as showing a broad-based protrusion at L4-5 extending to the foramina, particularly on the right where there was a small annual fissure with bilateral foraminal stenosis, small disc bulge at L3-4 with narrowing but no high-grade stenosis, and small disc bulge at L5-S1 with mild foraminal narrowing but no definite impingement. Dr. Gornet administered another injection and again declared him at maximum medical improvement as of June 11, 2018. That was the last time Petitioner saw Dr. Gornet.

The Arbitrator found that Petitioner proved that his work-related accident caused his condition of ill-being of the lumbar spine and awarded him 25 weeks of permanent partial disability benefits representing loss of the use of 5% of the person as a whole. We agree with the finding of causal connection and permanent partial disability award and affirm and adopt those portions of the Decision of the Arbitrator.

The Arbitrator also found that all medical treatment was reasonable and necessary to relieve the work-related condition of ill-being and awarded all medical expenses incurred. The Commission finds that Petitioner reached maximum medical improvement as of February 19, 2018, modifies the medical award, and vacates the award of all medical expenses for treatment rendered after that date. The Commission notes that even though Dr. Gornet declared Petitioner at maximum medical improvement twice before that date, Petitioner continued to complain of symptoms and even went to a hospital emergency department after the first time he was placed at maximum medical improvement. The Commission finds that because of Petitioner's continued complaints, Dr. Gornet's order of an MRI on February 19, 2018 was a reasonable diagnostic procedure at that time. However, the Commission concludes that the new MRI demonstrated that Petitioner's condition did not require any additional treatment at that time.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $297.74 per week for a period of 25 weeks, because the work-related injury caused the loss of the use of 5% of the person-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay medical expenses under §8(a) of the Act for treatment rendered on or before February 19, 2018.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical expenses incurred after February 19, 2018 is vacated.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,000.00. 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: MAY 2 - 2019

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
O-4/4/19
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0221

WILBERT, JOHN
Employee/Petitioner

Case# **16WC004045**

SYNCREON
Employer/Respondent

On 8/12/2018, 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:

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

2250 STEPHEN H LARSON LAW OFFICE
RHONDA KATTELMAN
940 WEST PORT PLAZA
ST LOUIS, MO 63146

19IWCC0221

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

JOHN WILBERT
Employee/Petitioner

v.

SYNCREON HOLDINGS, INC.
Employer/Respondent

Case # 16 WC 04045

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 **June 25, 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. [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 **January 13, 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 **$25,804.48**; the average weekly wage was **$496.24**.

On the date of accident, Petitioner was **46** years of age, *single* with **0** dependent child(ren).

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of **$52,733.70**, as provided in § 8(a) of the Act.

Respondent shall be given credit for medical benefits that have been paid through its group carrier, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in § 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$297.74/week for 25 weeks**, because the injuries sustained caused the **5%** loss of the **body as a whole**, as provided in § 8(d)2 of the Act.

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

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

Edward Lee

Signature of Arbitrator

8/12/18

Date

AUG 1 2 2018

FINDINGS OF FACT

On January 13, 2016, Petitioner was an employee for Respondent, Syncreon. His job was to scan cases of product and unload trucks. (T.9) On that date of injury, he was packing cases when an employee from another company brought a load out of the trailer with a forklift, and in so doing, he struck Petitioner and knocked him into some pallets. (T.9-10) A videotape of the accident produced by Petitioner corroborated his testimony. (PX12)

At the end of his shift, Petitioner went to the Gateway Medical Center Emergency Room, where the history was taken as follows:

> Presenting complaint: Patient states: "I was at work at [sic] a guy who wasn't paying attention bumped me with a forklift" [sic] Denies falling. States he was bumped into a pallet3 [sic]. Mechanism of Injury: No Mechanism of Injury. Patient's presenting complaint is a result of a work related injury. Company protocols verified and initiated. (PX3)

Petitioner presented with left flank pain rated 4 out of 10 on the pain scale. *Id.* X-rays were taken of his lumbar spine and were negative for fracture. *Id.* He was prescribed Naprosyn and cyclobenzaprine and instructed to follow up with Gateway Regional Occupational Health Services. *Id.* He presented there on January 15, 2016, where he saw the company physician, Dr. Knapp. (PX4, 1/5/16) The history there was taken as follows:

> . . . The patient works as a case packer, was scanning a product with his handheld scanning machine when a forklift was rounding a corner that he did not see and struck him in his lumbar region causing him to be thrown into some pallets . . . *Id.*

Petitioner admitted to having a prior history of low back pain approximately 3 years ago, which required therapy but no injections or surgery, and he made a good recovery. *Id.*

Dr. Knapp's examination showed marked tenderness with palpation to the bilateral lumbosacral region with palpable spasm. *Id.* Petitioner's range of motion was limited, and he was noted to have a slow gait. *Id.* Dr. Knapp's assessment was acute lumbar contusion with secondary strain. *Id.* Petitioner's medication regimen was updated with instructions to take Naprosyn as needed and change cyclobenzaprine to Skelaxin. *Id.* He was placed on modified duty until the 18th with no lifting over 10 pounds, no bending, stooping, or twisting, and advised to continue ice alternating with moist heat. *Id.* He followed up on January 18, 2016, with continued symptoms of back pain rated 7 out of 10 with sharp pain radiating into his buttock region. *Id.* He was continued on the same restrictions and referred for physical therapy. (PX4, 1/18/16) On the last page of the office visit, it was noted that physical therapy had been "order-waiting for approval." *Id.*

On January 19, 2016, Petitioner saw Dr. Matthew Gornet, whom he had seen before in 2015. (PX5, 1/19/16) Dr. Gornet noted that 3 years ago, Petitioner had been released to return to

work full duty with minimal complaints, no restrictions, and was doing well. *Id.* Dr. Gornet's examination demonstrated mild decrease in EHL function on the left at L4-5 with pain into Petitioner's low back, left buttock, left hip, and down his left leg to his calf. *Id.* Dr. Gornet believed that Petitioner had suffered an aggravation of his previous underlying low back condition and recommended 6 weeks of chiropractic care with Dr. Robert Fast, who assumed the office of the physician with whom Petitioner had previously treated for his old injury, Dr. Meinders. (PX5, 1/19/16; PX6) Dr. Gornet kept Petitioner on restrictions and recommended an MRI. (PX5, 1/19/16)

Petitioner began chiropractic treatment with Dr. Fast on January 25, 2016, and Dr. Fasts' examination showed left-sided flank and left lumbosacral pain. (PX6) Several orthopedic signs were also positive, and Petitioner was also noted to have limited range of motion. *Id.* Dr. Fast initiated conservative care, including chiropractic adjustments, traction, and use of a back brace. *Id.* Dr. Fast treated Petitioner only until February 26, 2016, as his symptoms did not improve, and referred him back to Dr. Gornet. *Id.* On February 23, 2016, Petitioner presented to Memorial Hospital's emergency room and indicated his pain was worsening. (PX7, 2/23/16) He reported no new injury. *Id.* It was noted that he had been hurting all day while at work. *Id.* As Petitioner continued to work, his symptoms worsened.

Petitioner returned to Dr. Gornet on March 24, 2016, and Dr. Gornet reviewed with him an MRI was taken the same day. (PX5, 3/24/16) The impression was disc bulge with small right and left foraminal annular tear at L4-5 contributing to mild foraminal stenosis bilaterally, but no significant central spinal canal compromise. *Id.* Dr. Gornet believed Petitioner had aggravated his previous L4-5 disc condition and foraminal stenosis and recommended a transforaminal steroid injection at L4-5. *Id.* He continued Petitioner on light duty with a 20 pound lifting limit and no repetitive bending. *Id.*

On April 5, 2016, Petitioner underwent the transforaminal steroid injection at L4-5. (PX7, 4/5/16) He continued to work, and because of increased complaints, presented again to the Belleville Memorial Hospital Emergency Room on April 26, 2016, where the history was given as follows:

> Pt notes left low back pain which began about 1 week ago. He states the pain shoots down his left leg. He states a few months ago he was injured by a forklift. He had an MRI at that time which displayed disc problems at L4/L5. He feels as though his back pain is from aggravating this old injury. He states he has to lift for work. He denies bowel or bladder incontinence, numbness, tingling, saddle anesthesia. Pt is ambulatory. He also notes left scrotal pain x 2 days. He denies swelling, penile discharge, N/V dysuria. He does not some [sic] urinary frequency. He denies any concerns or necessity to test for STIs. He is taking naproxen, meclizine, Flexeril at home for pain. *Id.*

Blood work was normal and an ultrasound showed no testicular or scrotal masses or fluid collection and no evidence of an acute inflammatory or infectious process. *Id.* The doctor at the emergency room noted:

> US shows no varicoceles and microlithiasis. No other findings. Suspect low back pain exacerbation with sciatica and believe this may be contributing to pain in testicular region. *Id.*

Petitioner was discharged and advised to follow up with Dr. Gornet. *Id.*

Petitioner returned to Dr. Gornet on June 20, 2016, and reported that he was feeling better and his symptoms were more tolerable after the injection. (PX5, 6/20/16) Dr. Gornet noted that Petitioner had a new job at an assembly line, which caused his symptoms to be much more tolerable, and recommended a trial of full duty with no restrictions. *Id.* Petitioner also brought with him a report from Dr. Donald DeGrange, Respondent's examiner. *Id.* While Dr. Gornet agreed with Dr. DeGrange's opinion that Petitioner sustained a work-related injury, he disagreed that Petitioner was at maximum medical improvement, as his condition has not yet plateaued. *Id.* Follow-up visits with Dr. Gornet showed that Petitioner continued to have problems, and Dr. Gornet repeated the transforaminal injection at L4-5. (PX5, 9/22/16, 10/4/16) On November 21, 2016, Petitioner returned to Dr. Gornet with improvement, but Dr. Gornet wanted to continue following Petitioner, as his back pain was still present. (PX5, 11/21/16)

Petitioner again went to Belleville Memorial Hospital Emergency Room on December 19, 2016, where the following history was noted:

> Patient presents with left lower back pain since Friday after work. Patient states that he does a lot of twisting for his job and believes he lifted and twisted simultaneously while at work which exacerbated his pain. Pt states it is intermittent in nature and worse when twisting to the left. Patient states he has a history of being hit by a forklift and injury to the back and states that his exacerbations [sic] feels similar to the current one. . . (PX7, 12/19/16)

Petitioner was given medication, and it was noted that he had back spasms. *Id.* The emergency room recommended continued heat and ice along with an over-the-counter pain patch. *Id.*

Petitioner returned to Dr. Gornet on August 26, 2017, with ongoing pain into his left leg. (PX5, 8/26/17) He noted that Petitioner had improved and was tolerating his symptoms. *Id.* Dr. Gornet recommended a trial of releasing Petitioner from care. *Id.* Petitioner returned to Dr. Gornet again on February 19, 2018, with continued symptoms into his left leg. (PX5, 2/19/18) To some extent, however, Petitioner felt his right leg symptoms were progressing. *Id.* Dr. Gornet recommended a new MRI scan. *Id.* This was done on February 19, 2018, and again showed an obvious right-sided annular tear and left-sided annular tear, but this time an annular fissuring was noted that could affect either L4 root. (PX8, 2/19/18) Dr. Gornet's recommendation was as follows:

> MRI scan from 2/19/18 is reviewed. This reveals an obvious right-sided annular tear and left-sided annular tear at L4-5. In the past, I have done injections on 4/5/16 on the left at L4-5 with a facet block. This was repeated on 10/4/16. Each time, he had fairly significant relief. He continues to have low back pain to both sides, both buttocks and both hips. Again, he has an annular tear on both sides at L4-5. The radiologist's report is consistent with our viewing, although he does not mention the disc pathology we have been treating on the left successfully for over a year.
>
> At this point, our recommendation would be to try a right-sided steroid injection. He has done very well with the left side. Again, our working diagnosis is disc injury L 4-5 with aggravation of some foraminal narrowing. He understands how a disc injury like this can progress over time. His pain is worse with mechanical loading. Exam is non-focal. *Id.*

Petitioner underwent an additional transforaminal steroid injection at L4-5 on the right and reported relief. (PX5, 5/22/18) Petitioner saw Dr. Gornet for the last time on June 11, 2018, and Dr. Gornet recommended that Petitioner follow-up as needed. (PX5, 6/11/18) He placed Petitioner at maximum medical improvement, but cautioned Petitioner that, given the fact that his symptoms were slowly returning as they had after each injection, he may require additional treatment in the future. *Id.*

Dr. Gornet testified by way of deposition. (PX11) He is a board certified orthopedic specialist focusing on neck and low back pain. *Id.* at 4. He has participated in over 40 FDA clinical trials and has authored numerous publications. *Id.* He sees 100 to 120 patients a week and performs anywhere from 5 to 10 surgeries in addition to lecturing around the world. *Id.* In addition to his own records, Dr. Gornet had records from Gateway Regional Medical Center, Dr. Fast, Belleville Memorial Hospital, and Dr. DeGrange's examination and deposition. *Id.* at 5-6. Dr. Gornet testified that he first saw Petitioner in 2014 for a work-related injury, and Petitioner had done well with injections, returning to work full-duty and seeing him last in June of 2015. *Id.* at 8. He had not seen Petitioner for approximately 7 months, until this injury while working for Respondent. *Id.*

Dr. Gornet testified to the findings in his office notes, and explained that Petitioner had aggravated his underlying condition. *Id.* at 8-10. He testified that he recommended the conservative care with Dr. Fast, a two-week course of oral steroids, and the transforaminal injections. *Id.* at 10-11. He also compared the MRI films that were taken after Petitioner's accident with Respondent to the previous MRI of 2015 and noted that there was a right-sided annular tear on both the January 28, 2015 and March 24, 2016 films; however there was a new left-sided annular tear that was not present on the earlier film. *Id.* at 12. His diagnosis was annular tear at L4-5 with aggravation of some preexisting foraminal stenosis bilaterally at the same level. *Id.* at 13. He believed that Petitioner's January 2016 injury caused the left-sided annular tear, which was not present on the January 28, 2015 film. *Id.* at 13-14. Dr. Gornet testified that he disagreed with Dr. DeGrange's opinion that Petitioner was at maximum medical improvement, and stated:

Q. Okay. Can you explain to the Arbitrator your comments on Dr. DeGrange's opinions?

A. Sure. I think I stated that for the most part, I agreed with Dr. DeGrange's opinions. I disagreed with him that the patient was at maximum medical improvement. His condition had not plateaued. The fact that he improved after the injection that we performed, which was at the objective pathology seen on MRI, is further evidence that his clinical condition had not plateaued and, therefore, by definition, he could not be at maximum medical improvement. So I think for the most part, Dr. DeGrange and I agree, but clearly the fact that he has sustained clinical improvement since the injection would be indicative that he had not yet reached maximum medical improvement as Dr. DeGrange had opined. *Id.* at 14.

As stated above, Respondent had Petitioner examined by Dr. Donald DeGrange, who was at the time of his examination a partner of Dr. Gornet. (RX1, p.19) Petitioner objected during the deposition as to whether this constituted a *Petrillo* violation. *Id.*

Dr. DeGrange acknowledged that Petitioner sustained a work-related injury on January 13, 2016. *Id.* at 23. Although he had the emergency room records, he did not have any of the records from Dr. Knapp, Respondent's occupational health physician, and did not know that Petitioner had pain radiating into his buttocks shortly after the accident. *Id.* at 26-27. When he authored his report on March 28, 2016, he believed that Petitioner had received thoughtful and appropriate diagnostic testing and conservative care related to his injury. *Id.* at 28. His examination that day, however, showed limited range of motion with low back and leg pain. *Id.* at 28-29. He also did not know that Petitioner was taking meloxicam and hydrocodone to relieve his pain. *Id.* at 30-32. He also reported that Petitioner denied any bowel or bladder issues, but acknowledged that Petitioner stated that he was on his intake form. *Id.* at 34. He testified that his report was not changed in any way by the company which hired him; however, he testified there were two different intake forms in this case with different information for which he had no explanation. *Id.* at 30-33.

Dr. DeGrange testified he had no records indicating that Petitioner had undergone any injections or that his condition was improved thereby. *Id.* at 37. He had not reviewed Petitioner's prior MRI scan. *Id.* at 38. After March of 2016, Respondent did not have Petitioner examined any further.

Petitioner candidly testified at arbitration that despite the improvement from treatment, he still has persistent pain that worsens with activity and standing for prolonged periods of time, which he notices particularly at the end of his work shifts. (T.14-16) He currently works for a company that packs boxes. (T.9) He asks for help with lifting activities at his job. (T.15) He regularly takes over-the-counter medication to manage his symptoms. (T.15) His hobbies of playing basketball and washing cars has been adversely affected. (T.16)

CONCLUSIONS OF LAW

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

Upon establishing causal connection 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, 229 Ill.Dec. 77 (Ill. 2000). This includes treatment required to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 758 N.E.2d 18 (1st Dist. 2001).

Respondent however, disputes liability for medical expenses, even while stipulating to causal connection, based on the independent medical evaluation report authored by Dr. DeGrange. However, the objective evidence, much of which Dr. DeGrange did not possess, leaves no room to dispute the reasonableness and necessity of Petitioner's care and treatment. It defies reason to rely on an expert's opinion regarding the reasonableness and necessity of treatment while not providing him all of Petitioner's medical records. Because of Respondent's inaction, Dr. DeGrange did not have the evidence needed to even attempt to give a credible opinion regarding Petitioner's care and treatment.

Dr. DeGrange agreed that Petitioner sustained a work-related injury, and he even admitted that Petitioner received thoughtful and appropriate diagnostic testing and conservative care up until his examination; however, he was completely unaware of the scope and severity of Petitioner's symptomatology and its response to conservative care. (RX1, p.28-29) He examination and report further reflect that Petitioner continued to be symptomatic with low back and leg pain resulting in limited range of motion. *Id.* at 28-29. He was unaware that Petitioner was taking meloxicam and other medications. *Id.* at 30-31. He had no records indicating that Petitioner had undergone any injections or that his condition was improved thereby. *Id.* at 37. He had not reviewed Petitioner's prior MRI scan to compare, as did Dr. Gornet, the difference between the two and appreciate the new left-sided annular tear which was not present on the original MRI. *Id.* at 38. Respondent's reliance on his inaccurate opinion is thus misplaced and intimates bad faith given that it withheld relevant records crucial to his determination.

The Arbitrator finds all of Petitioner's care and treatment, including Dr. Gornet's recommended course of conservative care, to be reasonable and necessary and well-founded on the objective medical evidence. Dr. Gornet not only had Petitioner's care and treatment records, he also had the benefit of being able to evaluate Petitioner before and after the work accident of January 13, 2016, and compare the objective diagnostic studies from both timeframes. (PX5; PX11) He credibly testified that the care he gave to Petitioner was reasonable and necessary to relieve the effects of Petitioner's injury, and the Arbitrator is persuaded by his testimony. The

Arbitrator therefore finds Petitioner has met his burden of proof in establishing his entitlement to medical care.

Respondent shall therefore pay the reasonable and necessary medical expenses contained in Petitioner's group exhibit. Respondent shall indemnify and hold Petitioner harmless from any claims arising from the expenses for which it claims credit.

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, are to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) 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).

(i) **Level of Impairment**: Neither Party submitted an AMA rating. The gives no weight to this factor.

(ii) **Occupation**: Petitioner returned to work full duty for a company, and his job is to pack boxes. (T.9) He is unable to perform his job without assistance and asks for help to perform lifting. (T.15) The Arbitrator places greater weight on this factor.

(iii) **Age**: Petitioner was 46 years old at the time of his injury. He is the same age as the claimant in *Jones v. Southwest Airlines*, 16 I.W.C.C. 0137 (2016), wherein the Commission concluded that greater weight should have been given to the fact that Petitioner was younger and would have to work with his disability for an extended period of time. The Arbitrator follows the same reasoning and gives greater weight to this factor.

(iv) **Earning Capacity**: There is no evidence of reduced earning capacity in the record. The Arbitrator gives no weight to this factor.

(v) **Disability**: As a result of his injury, Petitioner sustained a new left-sided annular tear. (PX5; PX8) Despite conservative care through injections and therapy, Petitioner continues to be symptomatic. Petitioner candidly testified at arbitration that despite the improvement from treatment, he still has persistent pain that worsens with activity and standing for prolonged periods of time, which he notices particularly at the end of his work shifts. (T.14-16) He currently works for a company that packs boxes. (T.9) He asks for help with lifting activities at his job. (T.15) He regularly takes over-the-counter medication to manage his symptoms. (T.15) His hobbies of playing basketball and washing cars has been adversely affected. (T.16) His complaints are supported by the record. (PX5, 6/11/18) When Dr. Gornet placed Petitioner at

maximum medical improvement on June 11, 2018, he noted that Petitioner's symptoms were slowly returning and advised Petitioner that he may require additional treatment in the future. *Id.*

Based upon the foregoing factors, the Arbitrator finds that Petitioner sustained serious and permanent injuries that resulted in the 5% loss of his body as a whole.

Respondent's lien rights under § 5(b) are also preserved.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BETTY A. STRAUBE,

19IWCC0222

Petitioner,

vs.

NO: 13 WC 8338

STATE OF ILLINOIS – DEPARTMENT OF TRANSPORTATION,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary total disability, and permanent partial disability and being advised of the facts and law, reverses the Decision of the Arbitrator, finds Petitioner sustained her burden of proving the stipulated work accident on February 28, 2013 caused a current condition of ill-being of her cervical spine, and awards benefits.

Findings of Fact & Conclusions of Law

1. Petitioner testified that she worked on-and-off for Respondent from 1998 to February 28, 2013 as a highway maintainer out of a union hall. She also worked some time from 2001 and 2003 for Kinney construction and for Pin Oak Township in similar positions, and from 1998 through 2001 she drove a truck for Madge Trucking and HB Hauling. She has not worked anywhere since her last day of work for Respondent. As highway maintainer she removed snow, trimmed brush/trees, cleaned debris/animals off the highway, repaired potholes, and directed traffic in addition to driving a truck. It was a physically demanding job.

2. On February 28, 2013, she was driving a "safety control truck to move traffic over." Her crew had stopped to repair a pothole. A semi was not moving out of the lane. She waived an orange flag from her truck, but the semi was not moving over. As she saw it wasn't going to move she "grabbed the steering wheel real hard" and put her "right foot on the brake real hard" and the semi hit her hard.

3. Petitioner agreed that her truck was hit "from the back and sort of sideswiped on the way up." Her mirror had been taken off by the accident and the crew had to use a paddle stop sign, so she could get out of the truck. Petitioner was "all shook up" and her neck, left arm, and left shoulder hurt. She was taken to an emergency department by ambulance. After she was released from the hospital, a co-worker brought her back to her car.

4. Petitioner acknowledged she had previous two-level cervical surgery in 2006 from a previous work injury. She continued to have pain after that surgery and her range of motion was limited, but she was able to perform her job, though she "usually went home in pain." Her doctor did not place any restrictions on her work. She did not take any prescription medication after her doctor released her and only took Advil occasionally. Prior to the instant accident, her pain was in her neck, arm, low back, and buttocks.

5. After her hospital visit, Petitioner followed up with her primary care physician, Dr. Alvarado. He referred her to Dr. Ungacta for treatment of her shoulder. He prescribed physical therapy and then administered an injection. He then referred Petitioner to Dr. Yazdi for treatment of her neck, whom she saw once. He recommended an injection or a dorsal column stimulator. At that time, she did not want either procedure. She had heard about possible infection from injections. She last saw Dr. Ungacta on August 27, 2013, when he advised her he could not do anything more for her.

6. Dr. Alvarado then referred her to Dr. Randle for pain management. He administered injections in May and June of 2014. Dr. Randle then referred her to Dr. Gornet. He referred her to Dr. Boutwell who administered one injection and then Dr. Gornet performed "revision surgery" on her neck on March 17, 2015.

7. Postop, Dr. Gornet referred her back to Dr. Boutwell, who administered another injection, and performed radiofrequency ablation. Dr. Gornet released her from treatment on March 17, 2016 with a permanent 20-pound restriction.

8. Petitioner recalled conversing with Dr. Alvarado on September 9, 2013 about her desire to return to work for which she needed to be able to lift 50 pounds. She thought that he provided her such a release. Petitioner was not sure she could work at that level, but "was going to give it a try." Respondent would not let her work with the restriction. Petitioner returned to Dr. Alvarado and wanted him to remove the restriction. Dr. Alvarado would not do it and she asked him about disability.

9. Petitioner was not sure she could perform her job without restrictions. She could not perform many of her activities of daily living with the 20-pound restriction, she had difficulty picking up milk, could not run her vacuum, and was bothered with bending and stooping. She did not believe she would perform the jobs of highway maintainer or truck driver because of the pain and restrictions. She needed her commercial driver's license ("CDL") in her job with Respondent. She thought that if she complained about her neck "to the practitioner" she would be in danger of losing her CDL.

10. Petitioner testified that currently her left arm bothers her all the time, she has pain in the back of her neck, down the back, and across her shoulder blades. She has "continuous pain," her muscles are "always tight and throbbing," and can't stand or lay down for extended periods of time. She has difficulty sleeping. Her symptoms worsen with activity. She has reduced range of motion in her neck. She had to stop twice to stretch in her two-hour + drive to the hearing. She did not have much strength in her left (dominant) arm. Her daughter and son-in-law do a lot of her housework when they have the time. Petitioner's condition was "way worse" than it was prior to the accident. Petitioner was 66 years old and received social security retirement income. She also received some disability benefits before.

11. On cross examination, Petitioner testified she did not know the time span between when she saw the semi and the time she was hit but agreed that she radioed in that she was going to be hit. She waived the rag out the window for "just seconds." The rag was beside her on the console. She testified that her truck was hit in the back, but then when shown the photograph agreed that it was hit "on the left side, the driver's side on the back of the attenuator." The semi then continued and sideswiped her truck. Petitioner was wearing her seat belt and the airbag did not deploy. She was able to drive her car home from the yard.

12. Petitioner agreed that she was a seasonal employee of Respondent during the winter. When she was brought in to work, she had a general understanding of when she would be laid off. The entire time of her employment with Respondent was this type of seasonal employment. She always worked with a crew of co-workers. There was usually a co-worker to help her lift heavy objects. She passed the physical to retain her CDL, but "it's not very demanding. You just go in and take a P test, and they look you over and check your heart, and that's about it."

13. Her restrictions included 20-pound lifting and no overhead work. She has no restriction on standing. Petitioner testified she had not engaged in any vocational rehabilitation, sought any additional training, or applied for any jobs. She had not had a functional capacity evaluation, to her knowledge. She last saw Dr. Gornet in March of 2017 and had no future appointments scheduled.

14. On redirect, Petitioner testified her CDL was valid and that her prescriptions had been taken over by her primary care physician.

15. Thomas Patrick Moore was called by Respondent, for which he worked as operations supervisor, and he had been in that position for 29 years. He was Petitioner's supervisor at the time of the accident and arrived at the scene about 20 minutes after the accident.

16. The truck that struck Respondent's truck had damage to the passenger side. On Respondent's truck, he noted some scrapes and the rear-view was damaged on the driver's side and there were scrapes on left rear side of the attenuator. The "actual structure" of the truck and attenuator were not altered in the accident. He asked if there were any injuries. Petitioner told him she "was fine. She was not injured. Approximately 10 minutes later she said that, yeah, maybe she does need to be looked at, evaluated from the ER."

17. He took her to her car after her release. Petitioner indicated she was sore but felt comfortable driving home. As a seasonal employee, Petitioner would begin working around December 1st and the employment would end in March or April. Her employment would have ended at that time with or without her accident. Seasonal employees have to reapply each year. After the accident, the truck was not taken out of service, but the attenuator was because "the integrity of the crash cushion was structurally not sound." An attenuator is always taken out of service after being in an accident.

18. On cross examination, Mr. Moore agreed that a witness report indicated Petitioner appeared to be "shaken up quite a bit." He did not test the attenuator and was not certified in accident construction. He had no knowledge whether Petitioner tried to seek employment with Respondent with restrictions.

19. The witness statement was dated March 4, 2013. In it, the witness indicated that a "semi tried to pull to the left lane cab missed TMA side of trailer from 5th wheel back hit the H-31 TMA & took out mirror on left side. Arrows were on on TMA. [Petitioner] was in truck & seemed shaken up quite a bit."

20. The medical records indicate that at the emergency department Petitioner reported "mild aching, frontal headache, posterior cervical spine pain, left shoulder pain, and low back pain." A CT scan showed no acute changes, and x-rays of the shoulder and lumbar spine were negative. Cervical strain, shoulder strain, and back pain were diagnosed.

21. Two days after her emergency department visit, Petitioner followed up with the physician's assistant to her primary care physician. She was prescribed medication. After she did not improve with the medication, she was referred to Dr. Ungacta to evaluate her shoulder.

22. A cervical MRI taken on June 18, 2013 showed "focus of spinal cord myelitis suspected posterior to C4 to the right of midline, no evidence of significant central canal or neural foraminal narrowing, and trachea diverticulum and aberrant origin of the right subclavian artery suspected, this appearance could be clarified by means of contrast enhanced CT of the chest if clinically indicated."

23. Dr. Ungacta treated Petitioner's shoulder with medication and physical therapy and later ordered an MRI. On August 19, 2013, Dr. Ungacta noted the MRI showed no evidence of a full-thickness rotator cuff tear but did show inflammation and some labral fraying. He believed most of her symptoms emanated from her cervical spine and referred her to Dr. Yazdi for treatment of her neck.

24. Petitioner returned to Dr. Alvarado on September 9, 2013 reporting that she thought she could return to work, even though had some neck pain and difficulty sleeping. She had to lift 50 pounds in her job but can ask for help if she had to lift such weight repeatedly. Dr. Alvarado believed she knew her limits and allowed her to return to work if she wanted.

25. On September 19, 2013, Petitioner presented to Dr. Yazdi and reported 7/10 pain in the neck, left shoulder, and triceps. The pain was attributable to a motor vehicle accident in which her truck was rear ended by a semi. Dr. Yazdi diagnosed left-sided cervical radiculopathy, which seemed to be the result of the accident. However, he did not see any structural issues from the MRI to account for her symptoms. He recommended either an epidural steroid injection or "DCS." Petitioner would let him know her choice.

26. On September 24, 2013, Petitioner reported to Dr. Alvarado that a neurosurgeon recommended injections, but she declined because of fear of contaminated steroids. She was supposed to return to work, but she continued "having neck pain with minimal work at home." She reported that she needed to lift more than 50 pounds and the employer would not accept restrictions. He did not believe unrestricted work was advisable because she already had a back injury. He recommended physical therapy. She wanted him to issue a disability letter, but he would not because she could possibly work in a different job. Dr. Alvarado referred Petitioner to Dr. Randle for pain management.

27. On April 29, 2014, Petitioner presented to Dr. Randle's office. It was noted that an MRI dated June 18, 2013 showed minimal central canal stenosis at C4-5 and C5-6. Epidural steroid injections at C5-6 were recommended. Petitioner was unsure and would contact the office when ready. Later, Dr. Randle administered bilateral epidural steroid injections on May 7, May 21, and June 4, of 2014 at C6-7, C4-5, and C5-6, respectively.

28. On December 19, 2014, Petitioner presented to Dr. Gornet on referral from Dr. Randle. In her pain diagram, Petitioner reported 8/10 pain from her head to her buttocks affecting every joint above the waist except the elbows. The worst pain was at the base of neck to middle of back, neck, shoulders.

29. Dr. Gornet noted that her current problem began when her truck was hit from behind and on the side by a semi. She had medication, physical therapy, and three injections. She readily admitted a prior neck condition in 2006, but she returned to full duty after fusion at C4-5 and C5-6 and continued to work in that capacity until the instant accident. Radiographic studies confirmed a failed fusion at C5-6. Dr. Gornet opined that Petitioner "aggravated the underlying structure of her spine, either causing a pseudoarthrosis or significantly aggravating it, making her symptomatic." He recommended an MRI and one more injection. If she did not improve they would consider revision fusion at C5-6. He placed a 10-pound restriction, with no overhead work, and alternate sitting/standing. A CT taken by Dr. Gornet showed lucency throughout the interbody bone graft compatible with nonfusion at C5-6. The C4-5 fusion was solid.

30. On February 12, 2015, Petitioner returned to Dr. Gornet who indicated she had a symptomatic failed fusion at C5-6. He recommended supplemental posterior fusion. He also noted there was a small possibility he would have to treat her C3-4 level as well. Petitioner wanted to proceed. Dr. Gornet retained the prior restrictions but added no repetitive bending.

31. Dr. Gornet took an MRI which showed instrumentation at C4-5 and C5-6 in satisfactory position with no evidence of canal or foraminal stenosis, facet arthropathy at C3-4, and C6-7, above and below the decompression, with no observed stenosis, and minimal disc bulge at C2-3 resulting in dural displacement but no significant stenosis.

32. On March 17, 2015, Dr. Gornet performed revision fusion with bone graft and instrumentation at C5-6 and exploration of the fusion for a failed fusion at that level.

33. When Petitioner was evaluated by physical therapy on July 7, 2015, she reported her current pain, which was also her best level of pain, was rated 8/10. At worst it was10/10. Her neck disability index was 70% (crippled perceived disability) and her McGill pain score was 59 (over 30 may indicate symptoms magnification).

34. On August 14, 2015, the therapist noted she reported constant 8/10 pain. Formal range of motion appeared inconsistent with functional motion in the clinic. She exhibited severely self-limiting behavior and moderate over guarding. Her prescription was completed, and discharge was recommended. Petitioner had no more physical therapy.

35. Dr. Mirkin testified by deposition on August 1, 2014. He conducted a Section 12 examination on Petitioner on May 30, 2014, reviewed records, and issued a report. Petitioner reported she was sitting in a dump truck when she was struck from behind by another truck. She never had problems with her musculoskeletal system prior to this date, but since has had pain from the top of her head all the way down both legs including her neck, her shoulders, her mid back, and low back.

36. She was treated by an orthopedist for her shoulder. She was told she had some arthritis and the orthopedist did not believe surgery was indicated. She had physical therapy. She was referred to a neurosurgeon, who also felt surgery would not be helpful and recommended injections. She reported not taking any pain medication but "she couldn't do anything." Dr. Mirkin summarized his examination and explained that he believed the limited range of motion in the shoulders was "volitional." "There's really reason no (*sic*) both shoulders should have the exact same limited range of motion." Dr. Mirkin also noted the positive Waddell signs of non-organic pain behaviors.

37. Dr. Mirkin opined that Petitioner sustained a strain of the cervical spine and temporary exacerbation of arthritis in her left shoulder. His examination and the imaging studies do not support Petitioner's complaints. Petitioner was at maximum medical improvement from her work accident, she did not need any additional testing or treatment, and she could return to work at full duty.

38. On cross examination, Dr. Mirkin testified he reviewed Petitioner's intake form during the examination. He did not go over it with Petitioner. He thought reasonable treatment included: initial evaluation at the hospital; evaluation of her neck and shoulder; and some physical therapy. She was off work for a long period of time, which he did not think was reasonable. He was unaware that Petitioner tried to return to work with a 50-pound restriction. He agreed that he did not see any other doctor opining Petitioner was magnifying her symptoms.

39. Petitioner continued to report neck pain and Dr. Gornet referred her to Dr. Boutwell. On January 12, 2015, she administered an epidural steroid injection at C5-6 for bilateral radiculopathy. On September 24, 2015. Dr. Boutwell administered a facet block at C3-4 for bilateral facet arthropathy. On October 10, 2015, Dr. Boutwell performed radiofrequency ablation at C3-4 for bilateral facet arthropathy.

40. Dr. Alvarado, an internist and Petitioner's primary care physician, testified by deposition on June 25, 2017. He believed her complaints were consistent with the type of injury she reported and he never got the impression that she was malingering or exaggerating her symptoms.

41. He agreed that in a January 2014 note, he indicated he had a feeling Petitioner wanted "to become disabled." He did not believe she told him that, but he "was trying to understand where she was coming from" at her age (61) and with her continuing problems. He did not believe she could return to work at her previous job, and with her age and background, finding a new job would be difficult.

42. Dr. Alvarado treated Petitioner's neck, lower back, and left shoulder. He opined that the accident Petitioner described aggravated her preexisting condition because she did not have the problems previously. He deferred to Dr. Gornet regarding her neck and concentrated on her other conditions. He did not release Petitioner to work, other than with the 50-pound restriction.

43. On November 27, 2017, Dr. Gornet testified by deposition. He first saw Petitioner on December 19, 2014 for problems with her neck. She had prior problems with her neck resulting in cervical fusion at C4-5 and C5-6. It was his understanding that after that surgery, Petitioner returned to work at full duty.

44. Petitioner reported that her truck was struck in the rear and back by a semi and she had essentially been off work since, which was about a year. Prior to her seeing him she had conservative treatment including, medication, physical therapy, and pain management.

45. Dr. Gornet opined that Petitioner aggravated a previously asymptomatic pseudoarthrosis at C5-6 from her previous surgery. He thought she might also have a disc protrusion at C3-4. A CT showed a failed fusion at C5-6, which was confirmed by a later MRI, which also showed the protrusion at C3-4.

46. Dr. Gornet performed revision fusion surgery on March 17, 2016. He last saw Petitioner on March 16, 2017. She still had left trapezius/shoulder pain, which was consistent with a nerve issue. He also thought she might have a "little subtle foraminal narrowing at T3-4" and that "she may have other conditions going on." He released her from care and placed a 20-pound restriction on her, which he thought would be permanent.

47. Dr. Gornet opined that the accident aggravated a previously asymptomatic pseudoarthrosis at C5-6 from her previous surgery, which is a well-documented phenomenon. He also believed it caused a subtle disc injury at C3-4 which aggravated facet arthritis. A motor vehicle accident does not have to involve a large impact to cause injury, especially "if you're not prepared for it and your head gets moved quickly, that, especially if you have some preexisting issues, easily could cause an injury, and we see this commonly."

48. Dr. Gornet also believed her rheumatoid arthritis played a role in her condition; it can also cause some facet arthropathy and make her more symptomatic. One cannot parse out what percentage of her condition was from the accident and from the rheumatoid arthritis.

49. Dr. Gornet believed Petitioner's subjective complaints corresponded with his diagnosis. He did not see any signs of magnification of symptoms. He believed her condition was permanent as were his restrictions.

50. On cross examination, Dr. Gornet testified all he knew about the accident was through the medical records and Petitioner's history. When he first saw her, she complained of neck pain, bilateral shoulder pain, pain between her shoulder blades, pain in her upper back, and tingling in her arms. Dr. Gornet described that "sort of structural neck pain or discogenic-type symptom." He did not recall Petitioner reporting any major complication from her first surgery. Regarding residual symptoms after that surgery, his impression was she wasn't perfect, but she was working full duty and doing relatively well.

51. Dr. Gornet noted that an accident described by Petitioner can disrupt a fibrous union making the patient symptomatic. Failed fusion was established because x-rays showed there was motion on flexion and extension, and the CT showed it clearly. The radiographic evidence of the failed fusion was "really quite striking and obvious." He believed the failed fusion had "probably been there for some time" but was aggravated by the accident.

52. Petitioner continued to have pain after the fusion became solid. Dr. Gornet believed that the facet joints were the pain generators. He agreed that the facet pathology could be age-related, "coupled with an adjacent fusion." She showed a little more facet pathology than he would have expected for her age. The fusion would not have helped her facets significantly. Petitioner's current pain was related to both her accident and her rheumatoid arthritis. Either "absolutely" could have caused her condition independently.

53. On redirect examination, Dr. Gornet testified that "there's no question" that the accident caused the need for the surgery. The rheumatoid arthritis did not cause the pseudoarthrosis symptoms.

In finding the Petitioner did not sustain her burden of proving causation, the Arbitrator concluded that Petitioner did not present "a valid causation opinion." He questioned the "veracity" of Dr. Alvarado because he was an internist treating her neck and shoulder and he gave opinions outside of the scope of his expertise.

The Arbitrator also discounted the opinion of Dr. Gornet because he did not know the specifics of the accident and even stressed that the accident could have caused the nonfusion because if Petitioner was unaware of the impending condition, she would be more likely to sustain whiplash-type injury. However, that supposition was directly contrary to Petitioner's testimony. In addition, Dr. Gornet acknowledged that the arthritis was also a cause of her condition.

On the contrary, the Arbitrator found the opinions of Dr. Mirkin persuasive. He stressed Petitioner's exaggerated reports of pain throughout her body which was not supported by the medical records. The Arbitrator also stressed that Petitioner's exaggeration of symptoms was found in the medical records.

On the issue of causation, the Commission assesses the relative persuasiveness of the opinion testimony of Dr. Gornet and Dr. Alvarado versus Dr. Mirkin differently than the Arbitrator given this record. The Arbitrator correctly pointed out that Dr. Alvarado is an internist and not an orthopedist and that he testified outside the field of his expertise. Nevertheless, he did treat Petitioner for many years and his opinions regarding her complaints pre-accident and post-accident are certainly relevant and worthy of consideration. Dr. Alvarado's observations are also corroborated by the fact that Petitioner was able to work at a physically demanding job until the accident.

In addition, we find persuasive Dr. Gornet's explanation that a relatively minor motor vehicle accident can disrupt a fibrous connection in the cervical spine making a failed fusion symptomatic. On the other hand, Dr. Mirkin interpreted Petitioner's symptoms magnification as an indication that she did not have any condition of ill-being. However, that interpretation appears to be incorrect. Rather, the imaging demonstrated that Petitioner had a failed cervical fusion. Finally, the witness report suggested the collision was not as benign as the Arbitrator determined and corroborated Petitioner's testimony that she was quite shaken by the accident.

Regarding the issue of medical expenses, Respondent has not argued that the medical treatment was either unnecessary or unreasonable. Therefore, the Commission awards all outstanding medical bills. Regarding the issue of temporary total disability, Respondent has not disputed Petitioner's assertion that it would not allow her to return to work with restrictions. No doctor has released Petitioner to full duty work. Therefore, the Commission awards the temporary total disability benefits Petitioner requests.

Regarding the issue of permanent partial disability, the Commission notes that no impairment rating under the AMA Guides was submitted. The Commission gives moderate weight to the fact that Petitioner has not been able to return to her previous physically demanding job. Regarding the issue of Petitioner's age and future earning capacity, the Commission notes that Petitioner has retired from employment. Therefore, her age and retirement is a factor that would tend to reduce a permanent partial disability award and the factor regarding future earning potential becomes irrelevant.

The most salient factor in this analysis is evidence of disability corroborated by the treating medical records. Petitioner testified to substantial continuing disability. However, her testimony was not corroborated by the treating medical records. In looking at the entire record before us, the Commission concludes that a permanent partial disability award of 75 weeks representing loss of the use of 15% of the person-as-a-whole is appropriate here.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $643.79 per week for an additional period of 98&6/7 weeks, that being the period of temporary total incapacity for work under §8(b).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay all outstanding medical expenses associated with treatment of Petitioner's work-related condition of ill-being for medical expenses under §8(a) of the Act, subject to the applicable medical fee schedule.

IT ISFURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $579.41 per week for a period of 75 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of the use of 15% 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.

DATED: MAY 2 - 2019

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
O-4/4/19
46

STATE OF ILLINOIS)		
) SS.	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
COUNTY OF DUPAGE)	☐ 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

Theophilus Phipps,

Petitioner,

vs. NO: 16 WC 15932

State of IL / IYC-St. Charles,

Respondent.

19IWCC0223

DECISION AND OPINION ON REVIEW

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

The Commission finds Petitioner sustained significant permanent disabilities as a result of the March 31, 2016, work accident. Petitioner, a Juvenile Justice Specialist, sustained a concussion after falling and hitting his head while trying to restrain an aggressive youth. Following the incident, Petitioner complained of intermittent headaches, dizziness, trouble sleeping, fatigue, sensitivity to light and sound, and nausea. His treating physician, Dr. Owens, prescribed extensive vestibular therapy to treat Petitioner's symptoms. In July 2016, after evaluating Petitioner's speech and cognition, Dr. Owens diagnosed Petitioner with cognitive and/or communication deficits characterized by recall deficits, higher level word reasoning/retrieval, and increased response time following a concussion. Dr. Owens prescribed a short course of speech therapy to address Petitioner's cognitive issues.

While Petitioner returned full duty to his normal job with Respondent in October 2016, he credibly testified that he still experiences headaches occasionally and has trouble communicating with others. Petitioner continues to use over the counter Advil approximately once a week when he has a headache. He testified that his comprehension is slower, and it sometimes takes a little extra time to pick up on things. Petitioner testified that he has difficulty formulating his thoughts at times and uses an over the counter supplement, melatonin, to help him sleep. He testified that before the work injury he used to exercise and was active with his sons. He testified that he has less energy and is no longer as active with his sons due to his residual complaints. The medical

records corroborate Petitioner's testimony regarding the chronic post-concussive symptoms he continues to experience. Petitioner remains in his original job and still occasionally needs to break up altercations and physically restrain aggressive youths at Respondent's facility.

The Commission finds Petitioner testified credibly regarding his treatment and his ongoing complaints. After considering the totality of the evidence, including Petitioner's testimony, the severity of Petitioner's injury, and Petitioner's chronic residual post-concussive symptoms including difficulty sleeping, headaches, and slightly delayed cognition, the Commission finds the Arbitrator's award of 7.5% loss of use of the whole person does not adequately account for the severity of Petitioner's permanent disability due to his work-related concussion. Instead, the Commission finds Petitioner sustained a 10% loss of use of the whole person due to the work injury.

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 11, 2018, is modified as stated herein.

IT IS FURTHER ORDERED that Respondent shall pay to Petitioner permanent partial disability benefits of $755.22 for 50 weeks, because Petitioner's injuries caused 10% loss of use of the whole person, as provided for in §8(d)2 of the Act.

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

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

DATED: MAY 7 - 2019

d: 4/23/19
TJT/jds
51

Thomas J. Tyrrell

Maria E. Portela

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PHIPPS, THEOPHILUS
Employee/Petitioner

Case# **16WC015932**

STATE OF ILLINOIS-IYC-ST CHARLES
Employer/Respondent

19IWCC0223

On 9/11/2018, 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 2.26% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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1350 CENTRAL MANAGEMENT SERVICES
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SPRINGFIELD, IL 62794-9208

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

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

SEP 11 2018

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Theophilus Phipps
Employee/Petitioner

Case # **16** WC **15932**

v.

Consolidated cases: **N/A**

State of Illinois-IYC-St. Charles
Employer/Respondent

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Wheaton**, on **August 7, 2018**. By stipulation, the parties agree:

On the date of accident, **March 31, 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 **$80,316.00**, and the average weekly wage was **$1,544.54**.

At the time of injury, Petitioner was **41** 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 **$31,332.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$31,332.00**.

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

Per the stipulation of the parties, the medical bills submitted as PX 1 either have been paid by Respondent or shall be paid directly to the providers by Respondent as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $1,029.69/week for 30 3/7 weeks, commencing April 1, 2016 through October 30, 2016, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $31,332.00 for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner the sum of $755.22/week for a further period of 37.5 weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **7.5% loss of the person as a whole.**

Respondent shall pay Petitioner compensation that has accrued from **March 31, 2016** through **August 7, 2018**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

September 7, 2018
Date

ICArbDecN&E p.2

SEP 11 2018

Statement of Facts

Petitioner Theophilus Phipps testified that he is employed by Respondent Illinois Youth Center-St. Charles as a Juvenile Justice Specialist. He has been so employed for 18 years. Prior to March 31, 2016, he had no history of prior head injury. He did have a prior MRI of his neck many years ago. He was on no restrictions at work.

On March 31, 2016, he was dealing with an aggressive youth. During the process of restraining him, Petitioner hit the ground and hit his head on the concrete surface. The Employer's First Report of Injury completed on the date of accident states that he hit his head when he fell to the ground. It notes the left side of his forehead is swollen (RX 2).

Petitioner sought initial treatment at Community Healthcare Emergency Department on April 2, 2016. The history stated that Petitioner was complaining of intermittent headaches that started after he hit the left frontal region of his head 4 days ago while breaking up a fight while working as a correctional officer. He describes it as a dull ache that became a sharp stabbing sensation this morning. He states he has no pain at this time. He denies any loss of consciousness. He is also complaining of nausea, generalized fatigue, intermittent blurred vision and dizziness since the incident. He denied any vomiting, double vision, or focal weakness/numbness. He had no neck pain, back pain, or any other extremity pain, no confusion or memory loss, no other associated symptoms or modifying factors at this time (PX 3). The physical examination found visual disturbance, nausea, dizziness and headaches. It was negative for syncope, weakness, numbness and confusion. The assessment was intermittent headache, dizziness, blurred vision since minor head injury 3-4 days ago, likely concussion, no red flags to suggest intracranial bleed or skull fracture. No CT scan is indicated. Petitioner was given concussion precautions, advised no work until cleared by MD and referred to the Concussion Clinic. He was prescribed hydrocodone, ibuprofen, and ondansetron for nausea (PX 3).

Petitioner returned to the clinic on April 6, 2016 with continued headaches, photophobia, and fatigue. A CT scan was ordered and read as normal. He was then referred to the Community Healthcare System Concussion Clinic to begin therapy (PX 4).

Petitioner's treatment thereafter was primarily with Dr. Michael Owens at Community Healthcare (PX 5). He was initially seen on April 20, 2016. Petitioner presented with complaints of headaches which can be present for hours at a time, nausea, impaired balance and dizziness, double vision, fatigue, light and sound sensitivity, mental fogginess and slowness, difficulty concentrating and remembering, irritability, drowsiness and trouble falling asleep. Symptoms worsen with physical or cognitive activity. Petitioner was diagnosed with a concussion. He was taken off work and ordered to begin vestibular therapy (PX 5).

Petitioner began therapy at Community Hospital's Dizziness, Balance and Neuro Rehabilitation Clinic on April 26, 2016, with symptoms of daily episodic headaches that lasted for hours in the left forehead or on the top of the head. Petitioner described the headaches as a stabbing pain. He reported sensitivity to light and noise, trouble reading and/or concentrating, blurred and double vision and bilateral ear ringing and occasional sharp pain in the left ear. While he denied any falls since the initial injury, he reported unsteadiness while walking or negotiating stairs (PX 3). The initial physical therapy vestibular examination was positive for blurred and double vision. Petitioner was only able to hold a gaze for a very brief period due to double vision with his right eye deviating outward. He ambulated with a slowed cadence and decreased stride. A dizziness handicap inventory revealed Petitioner to be in the moderate stage of function. The impression was uncompensated, post concussive vestibular dysfunction with an associated gaze/vestibule-ocular reflex, stabilization deficit and

visual preferred disequilibrium; post concussive headaches; potential labyrinthine concussion; potential cervical dysfunction/cervical vertigo component; cognitive dysfunction; will rule out any benign paroxysmal positional vertigo (BPPV) (PX 3).

Petitioner participated in vestibular therapy, cognitive therapy and physical therapy through October 25, 2016 (PX 3). Petitioner testified to the exercises. He testified the therapy helped his symptoms. Petitioner also followed up with Dr. Owens every two weeks through September 21, 2016. Dr. Owens' records documents Petitioner's improvement with reduction of symptoms over time. Petitioner increased his activity including driving. Petitioner noted increased symptoms when increasing his physical activity or with greater stimulation such as going out to dinner, taking care of a matter on the phone, or cognitive tasks. Dr. Owens ordered an MRI of the brain on June 15, 2016. He ordered a psychological evaluation to address increased irritability and nervousness due to stresses. Dr. Owens kept Petitioner off work (PX 5).

Petitioner attended a Section 12 examination with Dr. Andrew Zelby at Respondent's request on October 19, 2016 (RX 5). Petitioner gave a consistent history of the accident, stating he did not lose consciousness, but had a few minutes of amnesia. Petitioner noted improvement since his injury, but still complained of balance problems, intermittent dizziness, headaches and pain on the left side of his face. Sometimes he cannot think clearly. The neurological examination was normal. Dr. Zelby reviewed the normal April 6, 2016 CT scan report and the normal July 5, 2016 MRI. He reviewed Dr. Owens September 21, 2016 notes and the September 15, 2016 discharge summary from speech therapy. Dr. Zelby's impression was minimal cerebral concussion with mild post-concussion syndrome. He stated that the neurological examination was normal, and Petitioner's subjective complaints are inconsistent with the objective medical findings and inconsistent with the natural history of the medical condition. He opined that there is no medical basis to relate Petitioner's ongoing complaints to the injury. He found Petitioner's treatment was reasonable and necessary but found Petitioner at maximum medical improvement and in need of no further treatment or diagnostics. He opined that Petitioner could safely return to his regular job (RX 5).

Dr. Zelby testified by evidence deposition taken February 27, 2017 (RX 4). He testified to his history, records reviewed, physical examination and opinions as detailed in his report. He testified that Petitioner was neurologically normal. His CT scan and MRI showed no post-traumatic changes. He testified that the natural progression of the condition is that 90% of patients will get resolution within 4 months and the remaining 10% within 6 months. Dr. Zelby testified that Petitioner told him he was still experiencing symptoms. Dr. Zelby stated that based on the objective medical findings, these would be inconsistent with the condition (RX 4).

Petitioner testified that he returned to work for Respondent on October 30, 2016. Petitioner returned to Dr. Owens on January 25, 2017 for follow up (PX 3). He reported good days and bad days. Some days he feels normal and sometimes he has severe symptoms, typically at while at work. He has been working 32 hours per week. Dr. Owens allowed him to continue regular work, full days with breaks as needed for severe symptoms (PX 3). Petitioner saw Dr. Owens monthly through June 16, 2017. Petitioner reported feeling well. He is off medications. He has occasional brief headaches and occasional episodes of nausea. Work is going well, and he has been exercising some. The examination notes resolution of fatigue, ear tinnitus and neck pain, blurry vision, photophobia, cognitive issues and sleep disturbance. Petitioner's issues with activity change, headache, and dizziness were improved. He still reported mental hyperactivity and difficulty remembering. Petitioner was discharged to return as needed. He was cautioned to protect against repeat trauma and allowed to continue his job duties.

Petitioner testified he is still performing his job duties. He testified that periodically, if he gets overwhelmed, he has trouble with communication. When this happens, he will slow down, breathe and give himself a little time to get the words or thoughts together so that they come out clear. He gets headaches. The headaches occur if he gets frustrated or overwhelmed or things could be moving too fast. He will take a break and focus until his symptoms calm come down. He takes Advil. He testified that his comprehension is a little slower. It just takes longer and it is harder to formulate his thoughts. His energy level is not what is used to be. He takes an over-the-counter sleep aid. He has no driving restrictions.

Conclusions of Law

In support of the Arbitrator's decision with respect to 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 Juvenile Justice Specialist at the time of the accident and that he is able to return to work in his prior capacity as a result of said injury. The Arbitrator notes that Petitioner is performing the full duties of his job. The Arbitrator notes that his job may require him to react to unexpected situations and be involved in unplanned and uncontrolled physical activities such as subduing individuals or breaking up fights. Because of this, the Arbitrator therefore gives some weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 41 years old at the time of the accident. Petitioner would be considered a younger worker and is expected to remain in the workforce for an extended period of years. Because of this, 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 that Petitioner has been returned to his regular job and has presented no evidence of a diminution of earnings. Because of this, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner suffered an undisputed head trauma resulting in a concussion and post-concussion syndrome. The treating records document multiple conditions of ill-being resulting from the incident including headaches, nausea, impaired balance, dizziness, double vision, fatigue, light and sound sensitivity, mental fogginess and slowness, difficulty concentrating and remembering, irritability, drowsiness and trouble falling asleep. Petitioner underwent extensive therapy including vestibular therapy, cognitive therapy and physical therapy. Petitioner was able to return to his regular job and was discharged from care by Dr. Owens. He is on no prescription medications. Dr. Owens last office notes on June 16, 2017 document resolution of many of Petitioner's symptoms but continued complaints of headache, dizziness, mental hyperactivity and difficulty remembering. Petitioner testified to how he copes with the continued symptoms. 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 7.5% loss of use of the person as a whole pursuant to §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 WILLIAMSON)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tim Beasley,
Petitioner,

vs. NO: 17 WC 04093

State of Illinois,
Shawnee Correctional Center,
Respondent.

19IWCC0224

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, prospective medical 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 December 5, 2017 is hereby affirmed and adopted.

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 later of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

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

DATED: MAY 7 - 2019

Stephen Mathis

sm/wj
04-08-19
68

Deborah L. Simpson

Barbara N. Flores

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

BEASLEY, TIM
Employee/Petitioner

Case# **17WC004093**

SOI/SHAWNEE CORRECTIONAL CENTER
Employer/Respondent

19IWCC0224

On 12/5/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

DEC 5 - 2017

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

STATE OF ILLINOIS)

)SS.

COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

TIM BEASLEY
Employee/Petitioner

Case # 17 WC 4093

v.

Consolidated cases: ____

STATE OF ILLINOIS/SHAWNEE CORRRECTIONAL CENTER
Employer/Respondent

19IWCC0224

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **July 12, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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, **November 7, 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 $**87,648.00**; the average weekly wage was $**1,685.54**.

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

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

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

Respondent is entitled to a credit of $**ANY AND ALL** 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 November 7, 2016. Petitioner's current condition of ill-being with regard to his cervical spine is causally related to the accident. Petitioner has not reached maximum medical improvement for the accident.

Respondent shall pay reasonable and necessary medical services totaling $21,471.86, as set forth in Petitioner's Exhibit 1 and itemized in the Arbitration Decision, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act: Respondent shall receive credit for amounts paid, including those paid through its group medical plan, for which credit is allowed under Section 8(j) of the Act. Respondent shall hold Petitioner harmless from any claims by any providers for which Respondent is receiving credit under Section 8(j).

Respondent shall pay for prospective medical treatment related to Petitioner's cervical spine, including the proposed surgery, pursuant to Section 8(a) of the Act.

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

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

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

Signature of Arbitrator

December 1, 2017
Date

ICArbDec19(b)

DEC 5 - 2017

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

19IWCC0224

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

TIM BEASLEY
Employee/Petitioner

v. Case #: **17 WC 4093**

STATE OF ILLINOIS/SHAWNEE CORRECTIONAL CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On November 7, 2016, Petitioner was 48 years old, married, and had two dependent children. He was employed by Respondent as a Communications Equipment Technician II at the Shawnee Correctional Center. He works in the radio shop used for installing and maintaining radios in vehicles. He testified that next to his computer is a work bench where he does repair work for the portable hand-held radios for the prison.

Petitioner testified that on the date of accident he was sitting at his computer in a rolling chair on a concrete floor checking emails when a coworker, Mr. Walker, came in to speak with him. He testified that the computer chair had five rollers with casters made of hard plastic rather than the soft tread casters used for concrete flooring. Following the end of the conversation with Mr. Walker, Petitioner pushed away from his desk to get his feet from under his desk until his chair rollers hit a wire and jammed; he then pivoted to the left, clasped his hands behind his head and leaned back. When he did this, the chair back went farther than it normally did, and the chair rollers slid out from the concrete floor. Petitioner was flipped backwards over the chair and landed on his neck, left shoulder, and left elbow. When asked why the rollers jammed and the chair back went back further than it did in the past and caused the accident, he stated that was a combination of the fact that the chair was 21 years old with a broken tension mechanism, and that the chair rollers were caught on radio shop wire debris on the floor. He stated:

> [I]t was a combination of the chair back going back too far because the tension knob on the chair did not provide any level of tension. And I guess how I would describe it, I don't know if you're familiar with a tension knob, but when you turn it clockwise, the seat back will—it will be a lot harder for the seat back to go back whenever you have your—the tension knob tight versus if you loosen the tension knob, it will make the chair go back a lot easier with a lot less resistance.

> Well, in this specific chair that I am sitting in, that I was sitting in that day, for one thing, it was a chair that was 21 years old, it was—it's a wore out chair, and the tension knob does not—like I said, I can turn it full clockwise or full counterclockwise, and it does not provide any tension. It's very loose.
>
> So whenever I had my hands collapsed behind my head, leaned back on the concrete floor, the chair was slightly rolling, and there were—there was a 14 gauge wire—14 gauge automotive wire that the chair rolled onto, and that's what I feel caused the chair roller to jam.

Respondent's Employer's Form 45/First Report of Injury corroborates Petitioner's testimony and reads, "EE was sitting in a computer chair with rollers on cement floor. EE leaned back and the chair kicked out from underneath him. EE states he landed on his back, hit his elbow and hurt his back, L shoulder, neck." RX1. Petitioner signed an incident report the same day indicating that "the chair kicked out on me sending me backwards on floor." RX2. Respondent's Supervisor's Report of Injury noted in the section for "unsafe acts or conditions which contribute[d] to the accident/incident" that the "[c]hair allowed him to lean back beyond tip threshold." RX3. This again corroborates his testimony. Pictures of the chair in question were admitted into evidence by both Petitioner and Respondent. PX10, RX8, RX9.

Respondent's Assistant Warden of Operations, Mr. Brett Campbell, testified that he had the chair inspected, and that it was reported to him that the chair was in full working order. He acknowledged that although he took pictures of the chair in question he did not, however, sit in the chair himself. He also testified that it was reasonably foreseeable that gauge wires and conduit wires could fall onto the floor while radios were being worked on. Mr. Campbell testified that he was not aware of whether the chair had been altered or worked on between the time of accident and the time he took his pictures 5 months after the accident. He was not aware whether the chair had been altered with spacers in the interim.

Following the accident, Petitioner had contusions and bruises including a large bruise on his elbow. He continued working, as evidenced by the Supervisor's Report of Injury and further corroborated by the Employee's Notice of Injury wherein Petitioner stated "I thought I was going to be okay" in the field for explanation of the reporting delay when injuries are not reported on the same day. These forms further reflect that Petitioner began having increasing symptoms of pain and paresthesia in his neck and left upper extremity. (RX1, RX2, RX3)

On November 28, 2016, Petitioner presented to Work Care and was examined by Nurse Practitioner Deborah Sullivan. He reported he was sitting in an office chair that had rollers, he leaned back in the chair and the chair "kicked out" and he fell backward and landed on his upper trapezius/left scapular area, neck and left elbow. He reported he had continued to work full time since the injury. He complained of continued pain in the neck, left trapezius, left scapular area and left elbow pain. He did not report any left shoulder pain. He indicated he has not seen anyone since the incident happened. He indicated that he reported the accident on November 21, 2016, when he saw the company nurse, and filled out an Incident form on November 22, 2016. A report was not made the day of the accident. Petitioner reported the accident was not witnessed but that co-workers heard the fall and came in to find him on the floor. He denied any

prior neck injury, but it was noted he had a prior dislocated left elbow in the second grade, with no problems with his left arm since that distant injury. He denied any prior injury to the left scapula. It was noted that Petitioner was left hand dominant. PX3.

Upon examination, Petitioner showed tenderness over the trapezius area, scapula, and left lower cervical spine, pain with forward flexion of the neck, and limited range of motion with pain. Petitioner's bruising and swelling had abated by this time. With regard to medical causation, NP Sullivan stated, "The objective findings are consistent with the history of a work-related etiology." Her diagnosis was cervicalgia, pain in elbow, and muscle spasm. She recommended alternating ice and heat along with physical therapy and continuation of regular duty since Petitioner had mainly a desk job. PX3.

Petitioner participated in physical therapy at Herrin Hospital, which did not improve his cervical symptoms and radiculopathy. PX4. On December 16, 2016, Petitioner returned to Work Care and was seen by Dr. Mark Smith and reported continued neck pain. Dr. Smith ordered continued physical therapy as well as a cervical MRI. PX3. The MRI took place at Cedar Court Imaging on January 4, 2017. The radiologist's impressions were as follows: (1) C6-7 severe neural foraminal narrowing bilaterally, due to a combination of a disc osteophyte complex with a predominant disc component and degenerative changes; C4-5 and C5-6 moderate neural foraminal narrowing bilaterally; (2) C6-7 mild spinal canal narrowing; (3) cervical spine straightening suggested muscle spasm, to be correlated clinically; degenerative changes likely contributed; (4) red marrow reconversion indicated a hypoxic state of the body with etiology considerations including smoking, exercise, obesity, and anemia; (5) marrow lesion within the C6 vertebral body on the left measuring slightly over 1 cm in diameter most likely representing a lipid poor hemangioma. PX5.

Petitioner was then seen by Dr. Matthew Gornet on February 28, 2017, and reported a consistent history of the accident and his treatment to date. Dr. Gornet noted that physical therapy had not improved Petitioner's condition, and further noted that Petitioner was still working despite his worsening symptoms. Examination showed decreased left biceps and decreased left triceps, along with hyperreflexia of the brachioradialis in the triceps. There was also some decreased sensation at C6 and C7 on the left. Dr. Gornet reviewed the MRI, but believed it to be of moderate-to-poor quality. He agreed with the radiologist that there was a disc herniation centrally at C5-6 and an annular tear at the same level. In addition, there was a left sided fragment at C6-7. Dr. Gornet recommended a new MRI with foraminal views, which was completed the same day. It showed fairly large central herniations at C5-6 and C6-7, along with a free fragment coming off the disc at C6-7. The foraminal views also revealed the large free fragment at C6-7. Dr. Gornet recommended epidural steroid injections and allowed Petitioner to continue working. PX6, PX7.

On March 30, 2017, Petitioner presented to Dr. Kaylea Boutwell, upon referral by Dr. Gornet. He underwent a left C6-7 epidural steroid injection at that time. On April 13, 2017, he underwent a left C5-6 epidural steroid injection. PX8.

On May 2, 2017, Petitioner was evaluated by Dr. David Robson at Respondent's request, pursuant to Section 12. In addition to examining Petitioner, Dr. Robson reviewed all of

Petitioner's medical records and all of his diagnostic studies. He noted that Petitioner continued to work, despite his symptoms. On examination, there was decreased response to stimulation in the left, middle, and index finger; decreased left biceps; decreased left brachial radialis reflex; and some diminished left triceps reflex. Dr. Robson's assessment was central disc bulge at C5-6 and left disc herniation at C6-7. He recommended surgery, to consist of anterior cervical discectomy and fusion at C5-6, C6-7. With regard to causal connection, Dr. Robson stated, *"I believe there is a causal relationship between the patient's current objective findings and the reported incident. The patient had no prior history of neck pain prior to the November 7, 2016, injury. I believe the fall off of the chair caused the disc bulge at C5-6 and disc herniation at C6-7 on the left."* RX7.

Petitioner returned to Dr. Gornet on May 4, 2017, and reported that the previous injections gave only temporary relief. On exam, Petitioner continued to show radicular symptoms with decreased strength in the triceps and biceps and decreased sensation at C6-7 on the left. Dr. Gornet recommended a CT myelogram, followed by disc replacement at C5-6 and C6-7. He noted Petitioner could continue to work full duty. PX6. The Arbitrator notes this is the final treatment record from Dr. Gornet.

Petitioner credibly testified at hearing as to the facts surrounding the accident. He was presented with Petitioner's Exhibit 10, a series of photographs. He identified some of them as pictures of the room he works in, the chair that he was sitting in, and the kind of screws and wires he works with and which sometimes end up on the floor. Petitioner gave a consistent history of the accident to his employer and all his treating physicians. His symptoms remained the same throughout treatment, and they have not improved. He testified he would like to have the surgery recommended by Dr. Gornet.

On cross-examination, Petitioner testified he took the photographs in Petitioner's Exhibit 10 with a cell phone camera. He did not recall the date he took the pictures, but noted it was not on the date of the accident. He testified that picture number one showed items sitting on a desk, rather than on a floor, and acknowledged that those were simply items that may be on the floor at different times. Petitioner acknowledged that when completing injury reports, the employee is supposed to be as thorough as possible about what happened to cause the injury. He admitted that if he believed there was a defect or problem with a piece of equipment, he was to report that or tell someone; he further admitted he did not do so with regard to the chair in question.

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 agreed that all issues flowed from the issue of accident. 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 Worker's 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).

There is no dispute that Petitioner's accident occurred in the course of his employment. Rather, the dispute is whether it arose out of his employment.

An injury arises out of one's employment if its origin is in a risk connected with or incidental to the employment so that there is a causal relationship between the employment and the accidental injury. In order to meet this burden, a claimant must prove that the risk of injury is peculiar to the work or that he or she is exposed to the risk of injury to a greater degree than the general public. *Orsini v. Indus. Comm'n*, 117 N.E.2d 38, 45 (1987). Specifically, the Court has acknowledged the existence of three categories of risk: (1) risks distinctly associated with employment; (2) personal risks; and (3) neutral risks which have no particular employment or personal characteristics. *Springfield Urban League v. Illinois Workers' Comp. Comm'n*, 2013 IL App (4th) 120219WC, 990 N.E.2d 284, 290 (4th Dist. 2013).

Injuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public. *Id.* This increased risk may be qualitative, such as some aspect of employment that contributes to risk, or quantitative, such as the number of times they are required to encounter the risk. *Id.* Liability is also generally imposed where an injury occurs as a direct result of a hazardous condition on the employer's premises. *USF Holland, Inc. v. Industrial Commission*, 357 Ill.App.3d 798, 804 (1st Dist. 2005). When injury to an employee takes place in an area that is a part of the employer's premises that is attendant with a special risk or hazard, the hazard becomes part of the employment and satisfies the "arising out of" requirement of the Act. *Springfield Urban League v. Illinois Workers' Comp. Comm'n*, 990 N.E.2d 284, 291 (4th Dist. 2013), citing *Litchfield Healthcare Ctr. v. Industrial Comm'n*, 349 Ill.App.3d 486, 491(5th Dist. 2004).

Although Respondent disputes that the chair in question was defective, the Arbitrator does not find the evidence in support of that position to be compelling. Respondent's pictures (RX8, RX9) purportedly showing that the chair was in good repair were not taken contemporaneous with the accident, but rather some 5 months later, and it could not be verified that no changes or repairs had been made to the chair in the interim. Further, the Arbitrator notes that the pictures actually show that the chair had quite a bit of wear and tear. More compelling, however, are Petitioner's pictures of the chair. Specifically, pictures 16 and 22 clearly show that the chair back is in more of a reclining position, rather than a straight up and down position, which is not normal. Pictures from both Petitioner and Respondent clearly depict that the chair is worn in various places, including on the arms and on the seat. In addition, several of Petitioner's pictures show that spacers or washers of some kind have been added underneath the seat. While it is not clear the purpose of these washers or when they were added, it is obvious that they are not original to the chair. In addition, Petitioner's picture 19 shows that the chair was manufactured in 1996, 20 years prior to Petitioner's accident on November 7, 2016. All of

these factors lead to the conclusion that the chair in question was, at a minimum, in a state of disrepair. The Arbitrator finds that such disrepair increased Petitioner's risk of injury from both a qualitative and a quantitative standpoint. Given his testimony and consistent history that the chair tipped over or came out from under him as he leaned back, the Arbitrator finds that Petitioner's accident arose out of his employment.

Arguendo, and irrespective of any disrepair or defect in the chair, while the Commission has on some occasions found that injuries caused by rolling chairs constitute a work-related risk in some instances (*See Calloway v. Cook County Dept. of Corrections*, 13 I.W.C.C. 0159; *Bacheldor v. Wal-Mart*, 14 I.W.C.C. 0176; *Burcham v. Governor's State University*, 14 I.W.C.C. 0795; *Muriel Minter-Mell v. Verizon Wireless*, 07 I.W.C.C. 1632), and non-compensable neutral risks in others (*See Elliot Daymon v. Vienna Corr. Ctr.*, 15 I.W.C.C. 0369), in the majority of cases, the Commission has found the injuries compensable either as a work-related risk or neutral risk to which the claimant was exposed to a greater degree than the generally public, particularly in cases that involved rolling chairs on slick surfaces.

In *Burcham*, the Commission reversed the Arbitrator's denial of benefits to a claimant who was working in her office and injured when she tried to sit on a swiveling chair. The Arbitrator found that Petitioner's accident of standing and reaching for a folder and then sitting back down on a rolling chair that moved when she hit it with her buttocks was not an accident. The Arbitrator held that the risk of injury must be particular to that employment and that the Petitioner failed to prove that she was exposed to a risk to a greater degree than the general public. The Commission, however, disagreed, and stated that since the claimant was performing acts the Respondent might reasonably have expected her to perform in regard to her assigned duties; she sustained accidental injuries arising out of and in the course of her employment with Respondent. *Burcham v. Governor's State University*, 14 I.W.C.C. 0795.

In *Calloway*, the Commission found that rolling chairs are "tools" of a trade when used regularly in the course of employment, and that they present an increased risk of injury compared to fixed, four-legged chairs. The conclusion of law noted that, "Stated another way, a wheeled chair tends to dodge the buttocks more readily than a conventional one." The claimant even testified that if the chair had been a non-rolling chair, the incident would not have occurred. *Calloway v. Cook County Dept. of Corrections*, 13 I.W.C.C. 0159.

The Commission in *Bacheldor* affirmed that rolling chairs on smooth surfaces represent a risk of injury to which the public is not equally exposed. In that case, the claimant sustained injuries when her rolling chair went out from under her, causing her to fall and injure her right shoulder. Significantly, the chair had no defects. The Commission found that the claimant was exposed to an increased risk of injury to a greater degree that the general public when she attempted to sit in an armless chair on rollers on a concrete floor with a vinyl floor covering while she was in the process of observing how to load paper into a machine. (Based on precedent subsequently to be considered herein, the fact that the chair was armless is not dispositive of whether Petitioner was exposed to an increased risk of injury). *Bacheldor v. Wal-Mart, 14 I.W.C.C. 0176.* In finding that the claimant was exposed to risk of injury to a greater degree than the general public, the Commission relied on *Poole v. Cook County Medical Examiner*, 12 I.W.C.C. 0866. In *Poole*, the Commission noted that rolling chairs are less stable

than most chairs and cited several Commission cases as precedent, including *Marcus Max v. Schaumburg Police Department*, 09 I.W.C.C. 0636; *Muriel Minter-Mell v. Verizon Wireless*, 07 I.W.C.C. 1632; and *Revere v. Chicago Public Library*, 02 I.I.C. 0934.

In *Marcus Max*, the claimant sustained compensable injuries when, while attempting to sit down on a chair to print up a report, the chair "shot out from underneath him" causing injury to his back. In finding that the claimant sustained a compensable injury, the Arbitrator and Commission held that "Petitioner's use of a wheeled office chair, in combination with the plastic mats placed over the carpet to make the chairs move more easily, created an increased risk of harm, in that the chair might roll away when the employee attempts to sit down." Simply stated, using a rolling chair on a slick surface represented an increased risk to which the general public was not equally exposed. *Marcus Max v. Schaumburg Police Department*, 09 I.W.C.C. 0636.

In *Revere*, the claimant simply reached up and across the table to pick up an item when the chair slid out from under her, causing her to fall. The Commission again found that the claimant's injuries arose out of and in the course of her employment. *Revere v. Chicago Public Library*, 02 I.I.C. 0934.

In *Muriel Minter-Mell*, the claimant also sustained injuries as a result of falling out of a "standard" rolling chair. Notably, the employer's floor was carpeted and there is no indication that the chair was armless. When the claimant performed an overhead stretch by extending both arms over her head while seated in her chair, the chair went out from underneath the claimant. Both the claimant and her supervisor testified that neither the chair nor the floor was defective. In holding that the claimant's injuries arose out of her employment, the Commission noted that because workers' compensation is a no-fault system, the claimant was not required to prove that her chair was defective in order to be entitled to benefits. "That incident also 'arose out of' her work as she was performing acts she could reasonably be expected to perform, using equipment provided by Respondent, when a piece of that equipment, her chair, slid out from under her and she fell to the floor." The Commission in *Minter-Mell* noted that the stretching activity the claimant was performing at the time of the accident and the manner in which the claimant was performing the activity was anticipated by the employer. *Muriel Minter-Mell v. Verizon Wireless, 07 I.W.C.C. 1632 (2007).*

Similarly, the Arbitrator notes that Petitioner in this case was leaning back in his chair when it flipped on him. Although Petitioner need not establish that the chair was defective, there is sufficient evidence in the record for a reasonable person to conclude that the chair was indeed defective, or at least that Petitioner was subject to a heightened risk of injury by virtue of debris left on the floor. It is unrebutted, though, that Petitioner was using a wheeled chair on a slick surface, and was in the course of his employment at the time of his injury. The combination of the wheeled chair and the slick concrete floor created a risk that most members of the general public would not face at home or at the workplace. It is also unrebutted that Petitioner was injured by flipping out of the chair, and his account is substantiated by all historical accounts in the record. Consequently, the Arbitrator finds that Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent.

In support of the Arbitrator's decision relating to issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

A claimant has the burden of proving by a preponderance of the credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. *Parro v. Industrial Commission*, 260 Ill.App.3d 551, 553 (1st Dist. 1994).

The parties stipulated that all disputed issues stemmed from the issue of accident. However, the Arbitrator notes that the record in its entirety supports the conclusion that Petitioner's current condition of ill-being is causally related to his injury of November 7, 2016. Respondent's examining physician agreed with Petitioner's treating physician that Petitioner's current condition of ill-being was causally related to his accident, and that he was in need of surgical treatment. As such, the Arbitrator finds that Petitioner met his burden of proof on the issue of causal connection.

In support of the Arbitrator's decision relating to issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury. *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill.App.3d 463, 470 (4th Dist. 2011).

In light of the Arbitrator's findings with respect to 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 November 7, 2016. Respondent is liable for the following medical bills as set forth in Petitioner's Exhibit 1, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for any prior payments, including those made pursuant to Section 8(j), for which a credit is allowed.

	Provider	Amount
1.	Work Care Occupational Health/Dr. Smith/NP Sullivan	$ 454.00
2.	Cape Radiology	$ 133.00
3.	Southern Illinois Healthcare	$ 5,218.04
4.	Cedar Court Imaging	$ 1,694.00
5.	Dr. Matthew Gornet/The Orthopedic Center of St. Louis	$ 3,534.00
6.	MRI Partners of Chesterfield	$ 2,700.00
7.	Dr. Kaylea Boutwell	$ 3,262.00
8.	Orthopedic Ambulatory Surgery Center of Chesterfield	$ 4,476.82
	TOTAL	**$21,471.86**

The Arbitrator declines to award charges billed by Dr. Gornet for CPT code 99080, Special Report. A provider may not charge a fee for writing a standard report that is generated in the normal course of treatment. Although a provider may charge an additional fee for a special

report that is unusual or outside the standard reporting form, the Arbitrator finds that none of the medical reports admitted into evidence meet this standard. As such, charges for such reports are not reasonable and the Arbitrator finds that Respondent is not liable for them. Specifically, the following charges are not reasonable and Dr. Gornet is not entitled to payment: (1) 2/28/17, $33.00; and (2) 5/4/17, $33.00.

In support of the Arbitrator's decision relating to issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

Upon establishing causal connection and the reasonableness and necessity of recommended medical treatment, employers are responsible for necessary medical care required by their employees. Specific medical procedures or treatment that have been prescribed by a medical service provider have been "incurred" within the meaning of the statute, even if they have not yet been paid for. *Plantation Mfg. Co. v. Industrial Commission*, 294 Ill.App.3d 705, 710 (2nd Dist. 1997).

In light of the Arbitrator's findings with respect to issue (F), the Arbitrator finds that Petitioner is not currently at maximum medical improvement for the injuries sustained in his accident of November 7, 2016. Dr. Gornet and Respondent's examining physician, Dr. Robson, both opined that Petitioner was in need of surgery.

The Arbitrator finds Respondent is liable for prospective medical care for Petitioner's cervical injury, including the surgery recommended by Dr. Gornet.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Blaine Huls,
Petitioner,

vs. NO: 16 WC 35101

19IWCC0225

North American Beverages/Pepsi.
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that, other than as stated above, the Decision of the Arbitrator filed September 6, 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 Petitioner on account of said accidental injury.

19IWCC0225

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 7 - 2019

Marc Parker

o-04/18/19
mp-wj
68

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HULS, BLAINE
Employee/Petitioner

Case# **16WC035101**

NORTH AMERICAN BEVERAGES-PEPSI
Employer/Respondent

19IWCC0225

On 9/6/2018, 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 2.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1551 STOKES LAW OFFICES
JACOB R JACKSON
200 N GILBERT ST
DANVILLE, IL 61832

5001 GAIDO & FINTZEN
JASON P ALLAIN
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

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 $558.91/week for a further period of 6.15 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused **3% loss of use of the right hand.**

Respondent shall pay Petitioner compensation that has accrued from **April 27, 2017** through **July 11, 2018**, 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 31, 2018
Date

SEP 6 - 2018

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
NATURE AND EXTENT ONLY

BLAINE HULS
Employee/Petitioner

v.

NORTHA AMERICAN BEVERAGES-PEPSI
Employer/Respondent

Case # **16** WC **35101**

Consolidated cases: _____

19IWCC0225

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 **Urbana**, on **July 11, 2018**. By stipulation, the parties agree:

On the date of accident, **August 11, 2015**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**48,439.26**, and the average weekly wage was $**931.52**.

At the time of injury, Petitioner was **33** years of age, *single* with **0** 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**.

STATE OF ILLINOIS)
) SS
COUNTY OF CHAMPAIGN)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT

BLAINE HULS
Employee/Petitioner

v.

Case #: **16 WC 35101**

NORTHA AMERICAN BEVERAGES-PEPSI
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The Arbitrator notes at the outset that Petitioner had three cases which were heard at the same time, but which were not consolidated. The cases are 16 WC 35486 (low back, date of accident 12/28/15); 18 WC 10103 (low back, date of accident 5/23/16); and 16 WC 35101(right wrist, date of accident 8/11/15). Exhibits were kept separate for each accident; however, there was only one trial transcript which covers all three cases. The Arbitrator will issue separate Decisions on each case.

The parties stipulated that on August 11, 2015, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent, resulting in injury to his right wrist. The parties further stipulated that the only issue in dispute is the nature and extent of Petitioner's permanent partial disability.

On the date of accident, Petitioner was 33 years old, single, and had no dependent children. He was employed by Respondent as a Delivery Driver. He testified that his duties required him to deliver, unload, stack, and rotate beverage products of various shapes, sizes, and weights. The job involved a great deal of lifting, bending, and twisting. Petitioner testified that he used a hand cart in the performance of his duties and that the hand cart rested on his right hand and wrist when he delivered products.

Petitioner testified that on August 11, 2015, he had a lot of pain and swelling in his right wrist. He sought treatment at Carle Clinic and ultimately had an MRI. He did not have any therapy or injections. He believed he missed about a half day of work due to his injury.

Petitioner testified that he no longer works for Respondent and currently works for Republic Services as a garbage truck driver. His duties include driving the truck, picking up trash

cans and containers, and picking up bulk trash such as dressers, couches, and mattresses. On an average day he picks up approximately 60 trash cans ranging in weight from 30 to 100 pounds. He does work overtime and is currently earning a little bit more money working for Republic than he did working for Respondent.

On cross-examination, Petitioner acknowledged that he had the MRI on November 18, 2015, and then did not return to the doctor for his wrist until April 2017, about a year and a half later. He acknowledged that he told the doctor at that time that he had only minimal pain in his wrist. He has not sought medical treatment since then and is not currently taking any prescription medication for his wrist. He admitted that he continues to play pool on occasion.

Following the accident, Petitioner presented to Carle Clinic on August 12, 2015, and was seen by Dr. James Desalvio. He reported that he had noticed discomfort and swelling on the dorsal surface of his right wrist the day before. It was noted there was "no fall and no direct trauma". On examination there was diffuse swelling at the dorsal aspect of the distal radius and ulna. It was noted, "On palpation it almost has the consistency of a lipoma." There was no pain with compression of the carpal bones and no pain with gripping. Grip strength was equal to that on the left and range of motion was full. Wrist x-rays showed nonspecific dorsal soft tissue swelling of the wrist, centered about the distal radius and ulna, but no fractures or dislocations. Assessment was tenosynovitis of the right wrist/distal forearm. Dr. Desalvio noted, "The patient states that when he uses his hand truck the crossbar of the hand truck does tend to rest on this side of the wrist. I suspect that perhaps he has developed some swelling in this area due to repetitive trauma." He recommended conservative observation. No work restrictions were issued. PX1A, PX2A.

Petitioner followed up with Dr. Desalvio on August 26, 2015, and reported that the swelling had gone down but the area was now slightly tender. On examination, there was swelling on the dorsum of the distal aspect of the right forearm. The area was slightly tender on palpation, with some radiation up the dorsal aspect of the forearm. Dr. Desalvio noted this was consistent with inflammation of the tendon and tendon sheaths. Grip strength was normal and there was no significant pain with compression of the carpal bones. Assessment was tenosynovitis, extensor side of right forearm. Dr. Desalvio continued to recommend conservative observation. Petitioner advised that they had changed the type of cart he used at work, so he was no longer resting the handle of the cart on the affected area. It was noted that if the problem had not resolved by the next appointment, a referral to orthopedics may be necessary. PX1A.

On October 8, 2015, Petitioner returned to Dr. Desalvio and noted that over time the area had become irritated. He had been able to perform his normal work duties, but it did bother him from time to time. On examination, there continued to be puffy swelling of the distal aspect of the dorsal surface of the right forearm, just proximal to the wrist. Dr. Desalvio again noted that the consistency was that of a lipoma, but that clinically that diagnosis seemed unlikely. The area of swelling was 7-10 cm in length, began at the proximal wrist, and extended up the forearm. There was normal movement of the fingers and wrist movement was full in all planes. Impression was "soft tissue swelling on the dorsum of the right distal forearm of questionable etiology". Petitioner was referred to Orthopedics Hand and was allowed to continue working his regular job without any restrictions. He was to return to Dr. Desalvio following the orthopedic evaluation. PX1A.

On October 22, 2015, Petitioner presented to the Hand Surgery Division of Orthopedics at Carle Clinic and was evaluated by Physician's Assistant James Berkes. He reported continued swelling, which was noted on the x-rays in August. On examination, there was "general boggy swelling" to the dorsal aspect of the right forearm. All extensor tendons and flexor tendons were functionally normally, and neurologically he was intact. PA Berkes opined that there could be a mass present or it could be synovitis. Since Petitioner did not have much pain, however, he was not sure that it would be tendinitis. Due to the continued "rather large" swelling, he recommended an MRI. Petitioner was allowed to continue working without restrictions. PX3A.

On November 18, 2015, Petitioner underwent an MRI of the right forearm. It showed nonspecific dorsal subcuticular soft tissue edema with no well-defined masses. It was noted that the edema was nonspecific, and considerations included post-traumatic change, inflammation, or infection. PX4A.

The next medical record is April 27, 2017, nearly 18 months later. Petitioner returned to PA Berkes, who noted that he had not returned for follow up after the MRI "for various reasons". The MRI results were discussed. Petitioner reported that his forearm still hurt occasionally, and he was concerned that it looked different than his left arm. On examination, there was a little mild swelling in the dorsal aspect of the forearm but it was noted that it did not look as remarkable as when he was last examined. He had minimal pain on examination. PA Berkes opined that there was "nothing there that poses any real concern" and noted that he expected it would eventually fade away. He did not believe there was much that could be done about it. Petitioner was released from care at that time. PX3A.

Petitioner testified that following his release from medical care, his right wrist continued to be a little stiff but not too bad, and he continued to have some swelling.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. The only issue in dispute at the time of trial was the nature and extent of permanent partial disability. With regard to the nature and extent of disability, for accidents occurring on or after September 1, 2011, pursuant to Section8.1b 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 Petitioner was employed as a Delivery Driver at the time of the injury, missed no time from work due to the injury, and was able to return to work in that capacity without any restrictions. He testified that he subsequently left his employment with Respondent and now drives a garbage truck. His duties include driving the truck, picking up trash cans and containers, and picking up

bulk trash such as dressers, couches, and mattresses. On an average day he picks up approximately 60 trash cans ranging in weight from 30 to 100 pounds. 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 33 years old at the time of the accident. He is a young man and has many work years ahead of him, during which he must deal with his disability. Over time, his condition could improve, stay the same, or get worse. No direct evidence was presented as to how his age impacts his disability. The Arbitrator places greater 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 the treating medical records**, the Arbitrator notes that Petitioner sustained soft tissue swelling on the dorsum of the right distal forearm. The etiology was not specifically identified, but was generally attributed to Petitioner's use of the hand truck during his work duties. He underwent conservative treatment of monitoring only, with no injections, physical therapy, or medications. X-rays and an MRI both confirmed soft tissue swelling, but neither identified an etiology. Petitioner testified that he continues to have ongoing right wrist swelling with some pain and stiffness, which is consistent with the treating medical records. 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 3% loss of use of the right hand (6.15 weeks) pursuant to Section 8(e) of the Act. The parties stipulated that Petitioner's average weekly wage was $931.52. The Arbitrator finds his permanent partial disability rate is $558.91.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Blaine Huls,
Petitioner,

vs. NO: 16 WC 35486

19IWCC0226

North American Beverages/Pepsi.
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that, other than as stated above, the Decision of the Arbitrator filed September 6, 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 Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 7 - 2019

Marc Parker

o-04/18/19
mp-wj
68

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HULS, BLAINE
Employee/Petitioner

Case# **16WC035486**

NORTH AMERICAN BEVERAGES-PEPSI
Employer/Respondent

19IWCC0226

On 9/6/2018, 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 2.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1551 STOKES LAW OFFICES
JACOB R JACKSON
200 N GILBERT ST
DANVILLE, IL 61832

5001 GAIDO & FINTZEN
JASON P ALLAIN
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

BLAINE HULS
Employee/Petitioner

v.

NORTH AMERICAN BEVERAGES-PEPSI
Employer/Respondent

Case # 16 WC 35486

Consolidated cases: ______

19IWCC0226

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 **Urbana**, on **July 11, 2018**. By stipulation, the parties agree:

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

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**47,703.66**, and the average weekly wage was $**917.38**.

At the time of injury, Petitioner was **34** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner the sum of $**550.43**/week for a further period of **10 weeks** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **2% loss of use of the body as a whole.**

Respondent shall pay Petitioner compensation that has accrued from **February 26, 2016** through **July 11, 2018**, 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 31, 2018
Date

SEP 6 - 2018

STATE OF ILLINOIS)
) SS
COUNTY OF CHAMPAIGN)

19IWCC0228

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT

BLAINE HULS
Employee/Petitioner

v. Case #: **16 WC 35486**

NORTH AMERICAN BEVERAGES-PEPSI
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The Arbitrator notes at the outset that Petitioner had three cases which were heard at the same time, but which were not consolidated. The cases are 16 WC 35486 (low back, date of accident 12/28/15); 18 WC 10103 (low back, date of accident 5/23/16); and 16 WC 35101(right wrist, date of accident 8/11/15). Exhibits were kept separate for each accident; however, there was only one trial transcript which covers all three cases. The Arbitrator will issue separate Decisions on each case.

The parties stipulated that on December 28, 2015, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent, resulting in injury to his low back. The parties further stipulated that the only issue in dispute is the nature and extent of Petitioner's permanent partial disability.

On the date of accident, Petitioner was 34 years old, single, and had no dependent children. He was employed by Respondent as a Delivery Driver. He testified that his duties required him to deliver, unload, stack, and rotate beverage products of various shapes, sizes, and weights. The job involved a great deal of lifting, bending, and twisting.

Petitioner testified that on December 28, 2015, he was on a delivery and was lifting and stacking product. It was raining and, as he was removing cases of two-liter bottles of beverage product from the top shelf of the truck, he slipped down and twisted sideways. He sought treatment at Carle Clinic and was referred to physical therapy. He treated until February 2016, at which time he was released. He missed only a day or two of work, was on light duty for a time, and subsequently returned to full duty work.

Petitioner testified that he currently works for Republic Services as a garbage truck driver. His duties include driving the truck, picking up trash cans and containers, and picking up bulk trash such as dressers, couches, and mattresses. On an average day he picks up approximately 60

trash cans ranging in weight from 30 to 100 pounds. He does work overtime and is currently earning a little bit more money working for Republic than he did working for Respondent.

Petitioner testified that his back "hurts all the time", including when he is working. He noted that the suspension in his work truck is not very good and he gets bounced around a lot. He takes Flexeril and Naproxen when necessary and uses ice and heat about once a week. He continues to do the stretches learned in physical therapy on a daily basis. Prior to the accident his hobbies included hiking, going to amusement parks, and playing pool. He currently has trouble doing any of these activities due to his low back pain. He occasionally plays a couple games of pool but can no longer participate in all-day tournaments.

On cross-examination, Petitioner testified that after he returned to work in February 2016 he was able to work full duty until he sustained another work accident in May 2016. He did not see a doctor during the period between February and May 2016 and was not taking any prescription medication during that time.

Following the accident, Petitioner presented to Carle Clinic on December 28, 2015, and was evaluated by Nurse Practitioner Virginia Brown. He reported low back pain, worse on the right, with no radiation to his legs. He rated the pain at 5/10. On examination, there was tenderness to palpation on both sides, more on the right. Straight leg raise was negative. Assessment was low back strain. Petitioner was allowed to return to work with restrictions of no lifting, pushing, or pulling over 10 pounds. He was to avoid bending and twisting at the waist, bent-over positions, climbing ladders or stairs, and kneeling and squatting. PX1B

On January 5, 2016, Petitioner returned to NP Brown and reported continued pain that did not radiate into his legs but did wrap around into his groin. He noted the pain was not as severe and no longer constant or sharp, but was now more dull and intermittent. He continued to rate it at 5/10. On examination, there was tenderness to palpation to the right lumbosacral musculature and straight leg raise was negative. Assessment was low back strain. Petitioner continued with the same work restrictions and was allowed to drive the truck but not do any lifting. PX1B.

On January 19, 2016, Petitioner returned to NP Brown. She noted, "He states that he had been doing significantly better up until January 13, 2016, when he had to take a trailer for a distance. He left it, but then when he came back, the truck was bouncing quite significantly and it seemed to aggravate his back pain again." He continued to have pain primarily on the right side of his low back, which he rated at 6/10, but he continued to deny radiation of pain or paresthesias down the legs. On examination, there was tenderness to palpation and Petitioner was noted to grimace when changing positions. He was instructed to continue with work restrictions and begin physical therapy. PX1B.

Petitioner presented to Carle Clinic Physical Therapy on January 21, 2016, for an initial evaluation. He underwent therapy on January 21, 27, 29, and February 2 and 4. PX2B.

On February 5, 2016, Petitioner returned to NP Brown and reported that his pain was much improved and was down to 2/10. He noted that physical therapy had been very helpful. On examination, he was able to get on and off the table without difficulty. Straight leg raise was negative, and there was no tenderness to palpation. He had good extension and forward flexion. He was to continue physical therapy and continue work restrictions. PX1B.

Petitioner underwent physical therapy on February 9, 11, 16, 18, and 23, 2016. At his final session he advised the therapist that if he could work into his normal job that week, he believed he would be able to do all his job duties the following week. He rated his pain at 0/10. PX2B.

On February 19, 2016, Petitioner returned to NP Brown, who noted that he was "definitely improved" since his last visit. He continued to have dull, achy back pain but no radiation of pain or paresthesias to the legs. He was instructed to transition back into work with no lifting, pushing, or pulling over 25 pounds. PX1B.

On February 26, 2016, Petitioner returned to Carle and was seen by Dr. James Desalvio. He reported he had gradually been doing more at work and was doing fairly well. He continued to have some low-grade discomfort in the low back, which he rated at 2/10, but stated he was ready to try his normal job duties. On examination, he was able to arise from a seated position without difficulty, gait was normal, and he could heel and toe walk without difficulty. He had relatively full forward bending without significant pain. Reflexes and strength were good. There were no specific points of tenderness on palpation. Impression was lumbar strain, improved. Petitioner was released to return to full duty as of February 29 and was advised that if he had a flare-up he would probably be referred to work conditioning. He was to return to Dr. Desalvio on March 26. The Arbitrator notes, however, that this was the final treatment record. PX3B.

Petitioner testified that he returned to work full duty for Respondent on February 29, 2016, as instructed by Dr. Desalvio. He also testified that this was the last time he was examined by a treating physician for this work accident.

On April 20, 2018, Petitioner was evaluated by Dr. Jesse Butler of Spine Consultants, Respondent's Section 12 and AMA examiner. Dr. Butler reviewed treating records and conducted a physical examination, which was normal. He noted there were no objective findings and that subjective complaints were low-level back pain. Assessment was resolved lumbar strain. Dr. Butler opined that treatment to date had been reasonable and necessary, and that Petitioner had reached maximum medical improvement with no need for additional treatment. He further opined that Petitioner's AMA disability rating was 1% whole person impairment. The Arbitrator notes that Dr. Butler did not specify which edition of the AMA Guides he used in arriving at his rating, nor did he explain the grade modifier adjustments assigned for the functional history, physical examination, or clinical studies. RX1B.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. The only issue in dispute at the time of trial was the nature and extent of permanent partial disability. With regard to the nature and extent of disability, for accidents occurring on or after September 1, 2011, pursuant to Section8.1b 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)**, the Arbitrator notes that Respondent submitted an impairment rating performed by Dr. Butler who found a 1% impairment of the whole person. However, Dr. Butler did not specify which edition

of the AMA Guides he used in arriving at his rating. Further, he did not explain the grade modifier adjustments assigned for the functional history, physical examination, or clinical studies. As such, the Arbitrator places little weight on this factor.

In regard to factor **(ii) the occupation of the injured employee**, the record reveals Petitioner was employed as a Delivery Driver at the time of the injury and was ultimately able to return to work in that capacity without any restrictions as a result of said injuries. He testified that he subsequently left his employment with Respondent and now drives a garbage truck. His duties include driving the truck, picking up trash cans and containers, and picking up bulk trash such as dressers, couches, and mattresses. On an average day he picks up approximately 60 trash cans ranging in weight from 30 to 100 pounds. 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 34 years old at the time of the accident. He is a young man and has many work years ahead of him, during which he must deal with his disability. Over time, his condition could improve, stay the same, or get worse. No direct evidence was presented as to how his age impacts his disability. The Arbitrator places greater 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 the treating medical records**, the Arbitrator notes that Petitioner sustained a low back strain which was treated conservatively with rest, modified activity, medications, and physical therapy. The treating records show a progression towards decreased symptoms, decreased pain levels, and increased physical capabilities. Dr. Desalvio noted in his final treatment record of February 26, 2016 that Petitioner continued to have some low-grade discomfort in the low back, which he rated at 2/10. His physical examination that day was normal and there were no specific points of tenderness on palpation. Petitioner testified that his back "hurts all the time", including when he is working. He indicated that he gets bounced around a lot in his garbage truck; however, the Arbitrator notes that he no longer works for Respondent. He indicated that he takes Flexeril and Naproxen when necessary and uses ice and heat about once a week. His hobbies of hiking, going to amusement parks, and playing pool have been negatively impacted.

The Arbitrator notes there is some difference between Petitioner's testimony and what is recorded in the final treating medical records, which goes to the assessment of his disability. 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 2% loss of use of the body as a whole (10 weeks) pursuant to Section 8(d)2 of the Act. The parties stipulated that Petitioner's average weekly wage was $917.38. The Arbitrator finds his permanent partial disability rate is $550.43.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Blaine Huls,
Petitioner,

vs. NO: 18 WC 10103

North American Beverages/Pepsi.
Respondent.

19IWCC0227

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that, other than as stated above, the Decision of the Arbitrator filed September 6, 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 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 $14,000.00. 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: MAY 7 - 2019

Marc Parker

o-04/18/19
mp-wj
68

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HULS, BLAINE
Employee/Petitioner

Case# **18WC010103**

NORTH AMERICAN BEVERAGES-PEPSI
Employer/Respondent

19IWCC0227

On 9/6/2018, 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 2.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1551 STOKES LAW OFFICES
JACOB R JACKSON
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STATE OF ILLINOIS)
)SS.
COUNTY OF **CHAMPAIGN**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

BLAINE HULS
Employee/Petitioner

v.

NORTH AMERICAN BEVERAGES-PEPSI
Employer/Respondent

Case # **18** WC **10103**

Consolidated cases: _____

19IWCC0227

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 **Urbana**, on **July 11, 2018**. By stipulation, the parties agree:

On the date of accident, **May 23, 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 $**47,996.99**, and the average weekly wage was $**923.00**.

At the time of injury, Petitioner was **34** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner the sum of **$553.80**/week for a further period of **25** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **5% loss of use of the body as a whole**.

Respondent shall pay Petitioner compensation that has accrued from **September 20, 2016**, through **July 11, 2018**, 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]
Signature of Arbitrator

August 31, 2018
Date

SEP 6 - 2018

STATE OF ILLINOIS)
) ss
COUNTY OF CHAMPAIGN)

19IWCC0227

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT

BLAINE HULS
Employee/Petitioner

v.

Case #: **18 WC 10103**

NORTH AMERIAN BEVERAGES-PEPSI
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The Arbitrator notes at the outset that Petitioner had three cases which were heard at the same time, but which were not consolidated. The cases are 16 WC 35486 (low back, date of accident 12/28/15); 18 WC 10103 (low back, date of accident 5/23/16); and 16 WC 35101(right wrist, date of accident 8/11/15). Exhibits were kept separate for each accident; however, there was only one trial transcript which covers all three cases. The Arbitrator will issue separate Decisions on each case.

The parties stipulated that on May 23, 2016, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent, resulting in injury to his low back. The parties further stipulated that the only issue in dispute is the nature and extent of Petitioner's permanent partial disability.

On the date of accident, Petitioner was 34 years old, single, and had no dependent children. He was employed by Respondent as a Delivery Driver. He testified that his duties required him to deliver, unload, stack, and rotate beverage products of various shapes, sizes, and weights. The job involved a great deal of lifting, bending, and twisting.

Petitioner testified that on May 23, 2016, he was on a delivery and was running products to the cooler. He explained this involved lifting and stacking product and filling and rotating the shelves. As he was doing so he experienced a lot of pain in his back that went all the way down into his right foot and a little into his left foot. He noted this was different than the pain he had with his first accident, as he did not have pain down his legs with that accident. He sought treatment at Carle Clinic and was referred to physical therapy and work conditioning. He testified that he missed almost nine weeks of work and was paid benefits while he was off. He was eventually released from care, but he did not return to work for Respondent, as he was let go.

Petitioner testified that he currently works for Republic Services as a garbage truck driver. His duties include driving the truck, picking up trash cans and containers, and picking up bulk trash such as dressers, couches, and mattresses. On an average day he picks up approximately 60 trash cans ranging in weight from 30 to 100 pounds. He does work overtime and is currently earning a little bit more money working for Republic than he did working for Respondent.

Petitioner testified that his back "hurts all the time", including when he is working. He noted that the suspension in his work truck is not very good and he gets bounced around a lot. He takes Flexeril and Naproxen when necessary and uses ice and heat about once a week. He continues to do the stretches learned in physical therapy on a daily basis. Prior to the accident his hobbies included hiking, going to amusement parks, and playing pool. He currently has trouble doing any of these activities due to his low back pain. He occasionally plays a couple games of pool but can no longer participate in all-day tournaments.

On cross-examination, Petitioner testified that since his full duty release from Carle, he has not gone back to any doctor for treatment of his low back. The only prescription medication he is presently taking is Flexeril on occasion. His exercise routine consists of stretching for approximately ten minutes per day.

Following the accident, Petitioner presented to Carle Clinic on May 24, 2016, and was evaluated by Physician's Assistant Steve Jacobs. He reported back pain of 10/10, with right leg numbness and tingling. PA Jacobs noted that Petitioner had a previous low back injury, with the last visit being February 26, 2016, and that he had no leg symptoms with that injury. He further noted that it was felt at that time that if he had a recurrence of symptoms he may need some work conditioning. Examination was fairly normal, though straight leg raise did cause back pain without radicular symptoms on the right. Assessment was back strain with sciatic type symptoms in the right leg. Petitioner was given restrictions of no lifting, pulling, or pushing over ten pounds, no bending or twisting, and no chronic bent posture. He was given an injection of Toradol and was instructed to take Flexeril and Ibuprofen or Naprosyn as needed. PA Jacobs noted that the goal was to calm down the symptoms to baseline and then probably get Petitioner into therapy and then work conditioning. PX1C.

On May 31, 2016, Petitioner returned to PA Jacobs and reported his pain was down to 3/10. It was noted that his sciatic symptoms seemed to have calmed down considerably. On examination, Petitioner was able to move with more ease, thought he did still have discomfort in the low back. There were no spasms and there was no evidence of nerve root irritation. Assessment was back strain with improved sciatic symptoms. Work restrictions were modified from ten pounds to fifteen pounds and Petitioner was referred to physical therapy. He was to continue with the same medication. PX1C.

On June 2, 2016, Petitioner presented to Carle Physical Therapy for an initial evaluation. He underwent therapy on June 2, 8, 10, 14, 16, and 20, 2016. PX2C.

Petitioner followed up with PA Jacobs on June 21, 2016 and reported he was improving but still had back pain and off-and-on numbness to the right leg. He expressed that he believed he

may have been released too quickly following his previous back injury and immediately went from minimal lifting to heavy lifting. On examination, there was no inflammation to the back and he could forward flex and touch his toes. Straight leg raise caused some back pain but no radicular symptoms. Assessment was unchanged and work restrictions remained the same. He was to continue therapy, stretching at home, and Ibuprofen as needed. PX1C.

Petitioner underwent physical therapy on June 23, 28, and 30. He was discharged from therapy on July 12, 2016. PX2C.

Petitioner returned to PA Jacobs on July 12, 2016, and reported he was doing well, with pain at best at 2/10. On examination, he had full range of motion, no swelling, no tenderness to palpation, and negative straight leg raise. Assessment was resolved back strain and Petitioner was released to return to work without restrictions. PX1C.

Petitioner testified that he returned to work for approximately one and a half days before returning for treatment. He presented to Carle on July 19, 2016, and was seen by Dr. William Scott. He reported that he had returned to work for less than a week and his symptoms returned with increased pain in his low back. On July 19 he had broken down product and moved cases of soda when he developed acute low back pain again. He rated the pain at 7/10 but noted that it did not radiate into his legs. Pain was aggravated by bending, squatting, or prolonged standing. On examination, range of motion of the lumbosacral spine was very guarded and he had difficulty bending forward. Palpation was not particularly tender. It was noted that he got up slowly and was guarded in movement. Straight leg raise was negative. Petitioner was given an injection of Toradol and instructed to follow up with Naprosyn. He was restricted to only light activities for a week and was referred to work conditioning. PX3C.

On July 26, 2016, Petitioner followed up with PA Jacobs and reported continued low back pain that was localized in the lower lumbar paraspinal area without radiation. PA Jacobs agreed with Dr. Scott that work conditioning was warranted. On examination, Petitioner was able to forward flex but stated it was painful. There was no evidence of radicular symptoms with straight leg raise and no evidence of nerve root impingement. Lumbar x-rays were done, which showed minimal L5-S1 degenerative disc disease. Petitioner was given a 20-pound weight restriction and was to avoid bending and twisting of the back. PX1C, PX4C.

On August 1, 2016, Petitioner presented to Carle for a Work Conditioning initial evaluation. He attended work conditioning on August 1, 3, 5, and 8, 2016. PX5C.

Petitioner returned to PA Jacobs on August 9, 2016, and reported low back pain that was localized. He noted he had been attending work conditioning, which he believed to be beneficial, but he was not yet lifting anything too heavy. Examination was essentially normal. Work restrictions remained the same. PX1C.

Petitioner regularly attended work conditioning on August 10, 12, 15, 17, 19, 24, 26, and 29, 2016. PX5C.

On August 30, 2016, Petitioner returned to PA Jacobs, who noted that work conditioning had been helpful and that Petitioner had gotten up to 40 pounds. He agreed with the therapist, who recommended an additional three weeks of conditioning. Petitioner's work restrictions were increased to the 40 pounds attained with therapy. PX1C.

Petitioner regularly attended work conditioning on August 31, September 12, 14, 16, and 19, 2016. PX5C.

On September 20, 2016, Petitioner followed up with PA Jacobs, who reviewed the work conditioning records and noted he was up to 50 pounds or better without any issues. PA Jacobs went through Petitioner's history of his two work injuries and intermittent flare-ups, which he attributed somewhat to a deconditioned state. Petitioner reported his back pain at its worst was now 2/10, but at the time of the visit it was 0/10. He noted that he had no leg symptomatology and that his back was just "achy". Examination was essentially normal. PA Jacobs believed Petitioner could return to work full duty, though wanted him to complete the final two weeks of work conditioning. He was instructed to continue with his exercise program at home and to "work smart". He was released from care at that time. PX1C.

Petitioner attended work conditioning on September 21 and 26 and was discharged on October 13, 2016. PX5C.

On September 23, 2016, Petitioner was evaluated by Dr. Jesse Butler, Respondent's Section 12 examiner. He reported a work injury of May 23, 2016, that resulted in lower back pain with radiation into the right and left legs. Dr. Butler reviewed the treating records and performed a physical examination, which was essentially normal. His assessment was lumbar strain. He noted that Petitioner did not exhibit signs of symptom magnification. He recommended Petitioner complete his final two weeks of work conditioning and then return to work full duty. He opined Petitioner would reach maximum medical improvement in two weeks. RX1C.

On April 20, 2018, Petitioner returned to Dr. Butler for purposes of a re-examination and an AMA impairment rating. Dr. Butler reviewed treating records and conducted a physical examination, which was normal. He noted there were no objective findings and that subjective complaints were low-level back pain. Assessment was resolved lumbar strain. Dr. Butler opined that treatment to date had been reasonable and necessary, and that Petitioner had reached maximum medical improvement with no need for additional treatment. He further opined that Petitioner's AMA disability rating was 1% whole person impairment. The Arbitrator notes that Dr. Butler did not specify which edition of the AMA Guides he used in arriving at his rating, nor did he explain the grade modifier adjustments assigned for the functional history, physical examination, or clinical studies. RX2C.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. The only issue in dispute at the time of trial was the nature and extent of permanent partial disability. With regard to the nature and extent of disability, for accidents occurring on or after September 1, 2011,

pursuant to Section8.1b 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)**, the Arbitrator notes that Respondent submitted an impairment rating performed by Dr. Butler who found a 1% impairment of the whole person. However, Dr. Butler did not specify which edition of the AMA Guides he used in arriving at his rating. Further, he did not explain the grade modifier adjustments assigned for the functional history, physical examination, or clinical studies. As such, the Arbitrator places little weight on this factor.

In regard to factor **(ii) the occupation of the injured employee**, the record reveals Petitioner was employed as a Delivery Driver at the time of the injury and was ultimately able to return to work in that capacity without any restrictions as a result of said injuries. He testified that he subsequently left his employment with Respondent and now drives a garbage truck. His duties include driving the truck, picking up trash cans and containers, and picking up bulk trash such as dressers, couches, and mattresses. On an average day he picks up approximately 60 trash cans ranging in weight from 30 to 100 pounds. 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 34 years old at the time of the accident. He is a young man and has many work years ahead of him, during which he must deal with his disability. Over time, his condition could improve, stay the same, or get worse. No direct evidence was presented as to how his age impacts his disability. The Arbitrator places greater 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 the treating medical records**, the Arbitrator notes that Petitioner sustained a low back strain with sciatic symptoms in the right leg. It was well-documented that Petitioner continued to have symptoms throughout his four months of treatment. He was treated conservatively with rest, modified activity, injections, medications, and physical therapy. He attempted to return to work and after less than two weeks had a flare-up of symptoms. It was noted on multiple occasions that he would likely need work conditioning to get back into the heavy lifting required on his job and, in fact, he was ultimately referred for that. He participated in work hardening for two months and was able to progress to the point of a successful return to full duty work. PA Jacobs noted in his final treatment record of September 20, 2016, that Petitioner had had two low back work injuries and intermittent flare-ups, and that he had needed work conditioning to get him to the point of being able to return to regular duties. He noted that Petitioner reported his back pain was 2/10 at its worst, that he no longer had leg symptoms, and that his back continued to be "achy". Examination at that time was normal. Petitioner was to continue with his exercise program and to "work smart".

Petitioner testified that his back "hurts all the time", including when he is working. He indicated that he gets bounced around a lot in his garbage truck; however, the Arbitrator notes that he no longer works for Respondent. He indicated that he takes Flexeril and Naproxen when

necessary and uses ice and heat about once a week. His hobbies of hiking, going to amusement parks, and playing pool have been negatively impacted.

The Arbitrator notes that Petitioner's testimony is generally consistent with his treating medical records. 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 5% loss of use of the body as a whole (25 weeks) pursuant to Section 8(d)2 of the Act. The parties stipulated that Petitioner's average weekly wage was $923.00. The Arbitrator finds his permanent partial disability rate is $553.80.

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

Matthew Buckner,

Petitioner,

vs.

NO: 14 WC 24572

19IWCC0228

State of Illinois Department
of Human Services,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 25, 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.

DATED: MAY 9 - 2019
DDM:yl
o 5/1/19
52

D. Douglas McCarthy

Stephen J. Mathis

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUCKNER, MATTHEW
Employee/Petitioner

Case# **14WC024572**

SOI/DEPT OF HUMAN SERVICES
Employer/Respondent

19IWCC0228

On 7/25/2018, 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 2.14% 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:

0320 LANNON LANNON & BARR LTD
MICHAEL S ROLENC
200 N LASALLE ST SUITE 2820
CHICAGO, IL 60601

5875 ASSISTANT ATTORNEY GENERAL
STEPHANIE KEVIL
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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

JUL 25 2018

STATE OF ILLINOIS)

)SS.

COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Matthew Buckner
Employee/Petitioner

Case # 14 WC 24572

v.

Consolidated cases: ____

State of Illinois/Department of Human Servies
Employer/Respondent

19IWCC0228

An *Application for Adjustment 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 **05-10-18**. 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. [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 4, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**16,038.36**; the average weekly wage was $**308.43**.

On the date of accident, Petitioner was **40** 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 $**51,779.42** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**51,779.42**.

Respondent is entitled to a credit of $ **221,030.22** under Section 8(j) of the Act.

ORDER

Respondent is responsible for all medical treatment rendered to the Petitioner for his lumbar condition and shall hold the Petitioner harmless for the same. Respondent is entitled to receive proper billing information from the treatment providers including, but not limited to CPT codes, dates of service, description of services rendered, and billing history. No balance billing is allowed under the Act.

Respondent shall pay Petitioner temporary total disability benefits of $253.00/week for 165 weeks, commencing June 5, 2014 through August 2, 2017, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of $501.34/week for life, commencing August 3, 2017, as provided in Section 8(f) of the Act.

Commencing on the second July 15 after the entry of this award, Petitioner may be eligible for costs of living adjustments, paid by the Rate Adjustment Fund, as provided in Section 8(g) of the Act.

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

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

Signature of Arbitrator

07-24-18
Date

JUL 25 2018

FINDINGS OF FACT

This matter was previously tried as a 19(b) on June 11, 2015 following which a decision was rendered on August 28, 2015. That decision has now become the law of the case.

Petitioner testified that following that hearing, he continued treating with his primary care physician at Family Health Clinic. He was seen there on July 14, 2015 with complaints of constant back pain (PX. #1).

On July 24, 2015, Petitioner was seen at the University of Illinois Medical Center by Dr. Khalid Malik with complaints of chronic low back pain following his lumbar surgery on August 27, 2014 and April 20, 2015. A left L5-S1 tranforaminal ESI was recommended. Petitioner was advised to remain on his Tramadol and GB (Gabapentin) PX. #2).

Petitioner testified he returned to Family Health Clinic on August 13, 2015. The record reflects Petitioner was seen at the pain clinic where it was recommended he consider a spinal cord stimulator and epidural steroid injections.

On September 17, 2015, Petitioner returned to Dr. Malik who attempted a TF epidural which had to be aborted due to pain (PX. #2).

On November 19, 2015, Petitioner testified he was seen at the Blue Island Family Health Center by Dr. Solomon Okai. Petitioner had complaints of chronic neck and back pains (PX. #1).

Petitioner testified he underwent a trial spinal cord stimulator placement at the U of I Medical Center on January 4, 2016. He testified that was due to his failed back surgery syndrome. Petitioner then underwent implantation of the spinal cord stimulator on January 20, 2016 (PX. #2).

Following the surgery, Petitioner testified he saw Dr. Malik on January 28, 2016. He had one other appointment with Dr. Malik which was on August 4, 2016. Dr. Malik opined that Petitioner was having good results from the spinal cord stimulator although there was some pain noted. He advised Petitioner to continue with his current medications of GB (Gabapentin), Elavil and Norco (PX. #2).

Petitioner testified he continued seeing Dr. Okai on a monthly basis until September 13, 2016 when he came under the care of a new primary care physician, Dr. Prabhakar. Dr. Prabhakar was also with Blue Island Family Health Center (PX. #1).

Petitioner testified, and the records reflect that Dr. Prabhakar took over Petitioner's refills on his pain medication. Petitioner testified he last saw Dr. Prabhakar about a month ago.

Petitioner also testified that at his attorney's request, he saw Dr. Charles Slack on August 2, 2017. At the request of the Respondent, he saw Dr. Michael Kornblatt on December 4, 2017. Both examinations were for evaluation purposes only.

Petitioner was asked on cross-examination about anxiety problems and he testified that he does have some issues with anxiety. He testified he has been seeing a therapist by the name of Norma on regular intervals for this condition.

Petitioner also testified that he has never treated for any hip condition. Petitioner further testified that he does have arthritis, diabetes and hypoglycemia. Petitioner testified he can drive a car but not for long distances.

On re-direct examination, Petitioner testified that he has had anxiety issues for several years prior to his accident in 2014. Notwithstanding those anxiety issues, Petitioner testified he was able to work for the State of Illinois as a personal care giver.

Petitioner testified he is receiving $695.00 on Social Security disability and has been receiving that amount since August 2017.

Presently, Petitioner testified that he is barely able to stand. He had difficulty sleeping. He testified he sleeps elevated otherwise, he has spasms. Petitioner testified he sleep on his left side and is in daily pain in his low back, buttocks and legs. He described the pain as burning, throbbing type of pain. He testified he must keep his leg elevated due to blood clots.

Petitioner also testified that he has a high school diploma but no medical background. He does not believe he would be able to return to any type of work such as a telemarketer, cashier or clerk as he cannot stand and sit without difficulty.

The Arbitrator finds Petitioner's testimony to be credible.

CONCLUSIONS OF LAW

In support of the Arbitrator's decision as to whether Respondent has paid all appropriate charges for all reasonable and necessary medical services (J), the Arbitrator finds as follows:

Petitioner placed into evidence medical bills from the University of Illinois in the amount of $1,045.00 and a lien from the Department of Health & Family Services in the amount of $4,415.80. The two bills from the University of Illinois Medical Center were for dates of service June 11, 2014 and July 23, 2014. Medical records corresponding to those dates were placed into evidence at the end of the 19(b) hearing.

The Arbitrator notes that Respondent placed into evidence as Respondent's Exhibit #1, a payment listing for Petitioner. Included in this printout is a list of the medical bills paid by the Respondent. The Arbitrator notes that the two bills placed into evidence by Petitioner for services rendered on June 11, 2014 and July 23, 2014 are not on Respondent's list. Respondent offered no evidence to suggest that they paid these two bills.

The Arbitrator, therefore, finds that Respondent is liable pursuant to the Fee Schedule of the Act for these two medical bills, if they are related to Petitioner's lumbar spine condition. No balance billing is allowed.

Petitioner also placed into evidence a letter from the Illinois Department of Healthcare & Family Services reflecting a lien amount of $4,415.80. The itemization contained in the attachment reflects that all of the bills paid by HFS were for treatment or medication Petitioner received for his back injury. Although there are no medical records for some of the providers listed, the itemization is very specific as to the treatment that was rendered which clearly was for Petitioner's back injury.

The Arbitrator also notes the amounts paid by HFS are substantially lower than what would be paid under the Fee Schedule of the Act. The Arbitrator acknowledges that often times when providers accept billing payments from HFS, the bills are sent directly to the department and not to the patient.

The Arbitrator, therefore, finds that Respondent not liable for the charges of the Department of Healthcare & Family Services in the amount of $4,415.80, in the event provider has already accepted a lesser amount as payment in full.

In support of the Arbitrator's decision as to the amount of temporary total disability benefits (K), the Arbitrator finds as follows:

Petitioner is claiming temporary total disability benefits from June 5, 2014 through August 2, 2017 and permanent total disability benefits from August 3, 2017 through May 10, 2018.

Respondent is claiming temporary total disability benefits from June 5, 2014 through December 4, 2017 and maintenance benefits from December 5, 2017 through May 10, 2018.

Petitioner's claim for TTD ending on August 2, 2017 is based on the opinions of Dr. Slack who examined Petitioner on said date, while Respondent's contention that TTD ended on December 4, 2017 and maintenance began December 5, 2017 is based on the Section 12 exam of Dr. Kornblatt on the latter date.

On page 14 of Dr. Slack's deposition testimony, he opined that Petitioner has significant limitations in his day-to-day activities of daily living, difficulty standing to cook at home, needing the support of his walker in the shower and being able to sit for only twenty to thirty minutes before changing positions. Dr. Slack also testified that Petitioner was not able to walk any significant distances because of his back and leg symptoms and that coupled with the medication Hydrocodone and Tramadol, it was his opinion that Petitioner would not be able to perform any gainful employment even in a sedentary position due to these significant physical limitations.

Dr. Slack also opined that Petitioner would require ongoing treatment with a pain management physician to try to control Petitioner's pain responses which are limiting

him. Dr. Slack testified that the cause to all of Petitioner's complaints and limitations was a result of his accident of June 4, 2014.

Respondent contends that Petitioner is entitled to maintenance benefits as of December 4, 2017 based on the opinions contained in the report of said date from Dr. Kornblatt. Dr. Kornblatt opined that Petitioner had failed back surgery syndrome and bilateral avascular necrosis in his hips with secondary degenerative joint disease. Dr. Kornblatt further opined that as he stated in his earlier report of February 2, 2015, it was his opinion that the work incident did not result in a clinical surgical lesion referable to the lumbar spine. It was further his opinion that there was not a causal relationship between Petitioner's current objective findings referable to the lumbar spine and the reported accident.

Dr. Kornblatt opined that regarding Petitioner's lumbar spine, he would be limited to light and sedentary duties. He also opined that pain management would be indicated for Petitioner to maintain his level of pain referable to the lumbar spine.

The Arbitrator notes that not only was causation decided in the initial hearing under Section 19(b) and is now the law of the case, but that Respondent did not dispute causal connection in the more recent hearing. The issue of causal connection is, therefore, moot.

The Arbitrator did not find Dr. Kornblatt credible in the earlier proceeding and there is nothing in Dr. Kornblatt's December 4, 2017 IME report that would cause the Arbitrator to find him credible at this time.

The Arbitrator, therefore, adopts the findings and opinions of Dr. Charles Slack and finds that Petitioner is permanently and totally disabled from returning to any type of gainful employment. The severity of the injury (failed back syndrome) speaks for itself.

The Respondent does not appear to be disputing that Petitioner is entitled to benefits subsequent to December 4, 2017. Respondent is alleging Petitioner is entitled to maintenance benefits; however, as Petitioner is permanently and totally disabled, Petitioner would not be entitled to maintenance benefits.

The Arbitrator finds that Petitioner is entitled to temporary total disability benefits from June 5, 2014 through August 2, 2017, a period of 165 weeks.

The Arbitrator further finds that Petitioner is entitled to permanent total disability benefits from August 3, 2017 through May 10, 2018 and continuing therefrom.

Respondent is given a credit for $51,779.42 in temporary total disability benefits paid.

In support of the Arbitrator's decision as to the nature and extent of the injury (L), the Arbitrator finds as follows:

Based on Petitioner's testimony and the opinions of Dr. Slack, the Arbitrator finds that Petitioner is permanently and totally disabled from returning to any type of gainful employment.

Respondent did prepare a blind transferable skills analysis/Labor Market Survey report on April 3, 2018. The IME report of Dr. Kornblatt was reviewed along with three operative reports from August and September 2014, some physical therapy records reflecting nine sessions in 2014 and some other record reflecting a history of various medical conditions in 2000. There is nothing in this report to indicate that the individual who prepared it reviewed any current treating records of Petitioner.

The Arbitrator also notes that the writer located a variety of settings which *may* be appropriate for Petitioner. She indicated the Labor Market Survey identified *21 potentially appropriate jobs available during a one-week period in April 2018.* The Arbitrator notes the key words here are "*may and potentially appropriate.*"

The Arbitrator gives some weight to this report, as the writer did not review any current medical reports other than the report of Dr. Kornblatt. Petitioner was not interviewed. His prior job history is unknown. The Arbitrator also notes that Respondent never complied with Section 9110.10 of Rules Governing Practice before the Illinois Workers' Compensation Commission which states "when the period of total incapacity for work exceeds 365 days, a written assessment regarding medical care if appropriate and vocational rehabilitation is required to be prepared when it can be determined that the injured worker will be unable to resume his regular duties in which he was engaged at the time of the injury."

The Arbitrator finds that Petitioner became permanently and totally disabled as of August 3, 2017 and is entitled to permanent and total disability benefits of $501.34 per week for the rest of his life.

STATE OF ILLINOIS	)	BEFORE THE ILLINOIS WORKERS'
	) SS	COMPENSATION COMMISSION
COUNTY OF SANGAMON	)	

Illinois Workers' Compensation Commission,
Insurance Non-Compliance Division,
Petitioner,

vs. No: 16 INC 00393

19IWCC0229

Brian McCormick, individually and as
President and Secretary of BMPC, Inc.,
Respondent.

DECISION AND OPINION RE: INSURANCE NON-COMPLIANCE

Petitioner, the Illinois Workers' Compensation Commission (the Commission), Insurance Compliance Division, brings this action, by and through the Office of the Illinois Attorney General, against the above-captioned Respondent, alleging violations of Section 4(a) of the Illinois Workers' Compensation Act for failure to procure mandatory workers' compensation insurance. Petitioner alleges that Respondent knowingly and willfully lacked workers' compensation insurance for the following periods: (1) June 20, 2011 through May 13, 2015 (representing 1,412 days); (2) May 14, 2016 through March 3, 2017 (representing 291 days); and (3) March 3, 3018 through December 4, 2018 (representing 276 days). The total number of days of non-compliance is 1,979 days.

A hearing was held before then-Commissioner Joshua D. Luskin on December 4, 2018 in Chicago, Illinois. Proper and timely notice was given to all parties. Petitioner presented as witnesses Michael Cummins and Lolita Parham, Investigators. Respondent, Brian McCormick, appeared at the hearing and represented himself.

The Commission, after considering the record in its entirety and being advised of the applicable law, finds that Respondent, Brian McCormick, individually and as President and Secretary of BMPC, Inc. knowingly and willfully violated Section 4(a) of the Act during the periods in question. As a result, Respondent shall be held liable for non-compliance with the Act and shall pay a penalty in accordance with Section 4(d) of the Act. The Commission hereby assesses the penalty of $100.00 per day for 1,979 days, a total of $ 197,900.00.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1) On June 28, 2011, Articles of Incorporation were filed on behalf of BMPC, Inc., of Metamora, Illinois. Brian McCormick is listed as the President, Secretary, and Director. Amanda McCormick is listed as the Registered Agent. (PX 3). (PX 3).

2) Petitioner presented Michael Cummins, an Investigator for the Commission, as a witness. Mr. Cummins testified that he led the investigation into Respondent's non-compliance with the Act. Mr. Cummins testified that, in September 2016, the Insurance Compliance unit received a telephone complaint that employees of BMPC, Inc. were doing construction work in Chicago Heights without workers' compensation insurance. (Tr. 5-7).

3) Petitioner also presented Lolita Parham, Investigator. Ms. Parham testified that, following the receipt of the complaint, she went to the construction site in question on September 7, 2016. Ms. Parham stated that the site was a service station in South Chicago Heights, where she observed several workers installing an underground gas tank. She determined that BMPC, Inc. did not have workers' compensation insurance and issued a citation, which she left with the site foreman. (Tr. 38-39).

4) BMPC, Inc. did not pay the citation, and a full investigation of non-compliance was opened. (Tr. 7). Mr. Cummins testified that the purpose of the investigation was to determine whether Respondent was in compliance with the Act. During his investigation, Mr. Cummins requested information from, *inter alia*, the National Council on Compensation Insurance (NCCI) and the Self-Insurance unit of the Commission. (Tr. 8-9).

5) The Commission has designated NCCI as its agent for the purpose of collecting proof of coverage information on Illinois employers who have purchased workers' compensation insurance from carriers.

6) Petitioner's Exhibit 4 is a certified document from NCCI, signed by Cristina Granoados on July 5, 2017, stating that BMPC, Inc. had no workers' compensation insurance for the period June 20, 2011 through May 13, 2015. NCCI's records did show that BMPC, Inc. had workers' compensation insurance from **May 14, 2015 through May 14, 2016;** however, there was a cancellation filed effective December 25, 2015.

7) Petitioner's Exhibit 2 is a certified document from the Illinois Workers' Compensation Commission Office of Self-Insurance Administration, stating that BMPC, Inc. has no certificate of approval to self-insure.

8) Respondent, Brian McCormick, testified that BMPC, Inc. is a construction business; that he is the President and sole shareholder of BMPC, Inc., and that Amanda McCormick is his wife and Registered Agent for BMPC, Inc. (Tr. 47, 64).

9) Regarding individuals who worked for BMPC, Inc., Mr. McCormick testified that he himself: contacted each person directly to work for BMPC, Inc.; provided the equipment, including company-owned vehicles, to be used during construction projects; and could hire and fire the workers at will. Mr. McCormick further testified that the workers reported to a site foreman, who in turn reported to Mr. McCormick. BMPC, Inc. paid each worker directly with a company check. (Tr. 57-62; 66-68). Mr. McCormick testified he had workers' compensation insurance periodically and that his workers' compensation policies would be canceled on occasion for non-payment of premiums.

10) Notwithstanding the above testimony, Mr. McCormick claimed that the workers were not employees, but subcontractors who were expected to carry their own insurance. However, Mr. McCormick. did not check to see if the workers carried their own insurance coverage. (Tr. 51, 57).

11) Respondent submitted two exhibits into the record. Respondent's Exhibit 1 is an Acord Certificate of Liability Insurance indicating that Respondent had workers' compensation insurance, policy effective on March 3, 2017 and expiring March 3, 2018. Respondent's Exhibit 2 are documents pertaining to a lawsuit filed in June 2018 by an insurance carrier to collect premiums owing on a workers' compensation insurance policy purchased by BMPC, Inc. in mid-2015; the complaint alleges that the policy was cancelled because BMPC, Inc. failed to pay the insurance premium.

12) Mr. McCormick testified to his belief that he had documentation showing that he currently has insurance coverage, but he did not bring that documentation to the hearing.

The Commission notes for the record that, after the hearing, the parties were advised to file Briefs and Proposed Decisions. Respondent was given leave to file his brief until January 4, 2019. Petitioner timely filed its Brief and Proposed Decision. To date, no brief or other documentation from Respondent has been forthcoming.

Pursuant to Section 3 of the Act, certain employers and their employees are automatically subject to the provisions of the Act if they engage in specific businesses, including: "the erection, maintaining, removing, remodeling, altering or demolishing of any structure" *820 ILCS 305/3(1)*; "construction, excavating or electrical work" *820 ILCS 305/3(2)*; "any enterprise in which sharp edged cutting tools, grinders or implements are used, including all enterprises which buy, sell or handle junk and salvage, demolish or reconstruct machinery" *820 ILCS 305/3(8)*; "any enterprise in which statutory or municipal ordinance regulations are now or shall hereafter be imposed for the regulating, guarding, use or the placing of machinery or appliances or for the protection and safeguarding of the employees or

the public therein, each of which occupations, enterprises or businesses are hereby declared to be extra hazardous" 820 ILCS 305/3(9); and, "any business or enterprise in which electric, gasoline or other power driven equipment is used in the operation thereof." *820 ILCS 305/3(15).*

The Commission finds that, based on the use of various tools and equipment and the type of work conducted by the company, as disclosed in the testimony of Investigator Cummins, Investigator Parham, and Brian McCormick, Respondent is automatically covered under Section 3 of the Illinois Workers' Compensation Act and is required to carry workers' compensation insurance.

Regarding the employer-employee issue, given Respondent's level of control over the workers, how workers were directly engaged, the use of company equipment, and payments made to the individuals directly, Respondent employed the workers in question as employees and not as subcontractors under the Illinois Workers' Compensation Act.

Regarding the issue of penalties, Section 4(d) of the Act states in part:

> "Upon a finding by the Commission, after reasonable notice and hearing, of the knowing and willful failure or refusal of an employer to comply with any of the provisions of paragraph (a) of this Section or the failure or refusal of an employer, service or adjustment company, or an insurance carrier to comply with any order of the Illinois Workers' Compensation Commission pursuant to paragraph (c) of this Section disqualifying him or her to operate as a self insurer and requiring him or her to insure his or her liability, the Commission may assess a civil penalty of up to $500 per day for each day of such failure or refusal after the effective date of this amendatory Act of 1989. The minimum penalty under this Section shall be the sum of $10,000. Each day of such failure or refusal shall constitute a separate offense."

820 ILCS 305/4(d). Here, Mr. McCormick testified he was the owner and President of BMPC, Inc. for the entire time at issue and acknowledged that for long periods he failed to secure and maintain any workers' compensation insurance coverage despite knowing of the legal requirement to do so. The certification from NCCI shows that Respondent was without workers' compensation insurance from the time of incorporation in 2011 until mid-2015 -- specifically, there was no coverage from June 20, 2011 through May 13, 2015. NCCI records do show that Respondent was covered from May 14, 2015 through May 14, 2016. However, thereafter Respondent fell again into a period of non-coverage. (PX 4). Sometime after Investigator Cummins began his non-compliance investigation in September 2016, Respondent obtained another worker's compensation insurance policy, providing coverage from March 3, 2017 through March 3, 2018. (RX 1). That policy expired and, as of the time of the hearing, there is no evidence of any other coverage.

Accordingly, Petitioner requested that the Commission assess a penalty under Section 4(d) against Respondent for lacking workers' compensation insurance for the following periods: (1) June 20, 2011 through May 13, 2015 (representing 1,412 days); (2) May 14, 2016 through March 3, 2017 (representing 291 days); and (3) March 3, 3018 through December 4, 2018 (representing 276 days). Petitioner seeks the maximum penalty of $500.00 a day for 1,979 days of non-compliance.

The Commission finds that Respondent is liable for a penalty for failure to comply with Section 4(a) of the Act. However, the Commission declines to assess the maximum penalty as requested by Petitioner. In *IWCC v. EJC Engineering and Construction,* the Commission considered a number of factors in determining the amount of penalties to assess against an employer for such failure: "1) the length of time in which the employer had been violating the Act; 2) the number of settled/pending workers' compensation claims against the employer; 3) whether the employer had been made aware of his conduct in the past; 4) the number of employees working for the employer; 5) the employer's ability to secure and pay for future (or recently obtained) workers' compensation insurance premiums; 6) whether the employer has shown any mitigating circumstances, such as a willingness to cooperate, comply and settle; and 7) the ability of the company to pay the assessed penalty." *EJC Engineering and Construction*, 98 INC 181.

In the case at hand, the employer's failure to comply with Section 4(a) was knowing and willful. As described above, Mr. McCormick's business had no workers' compensation insurance for about the first four years of its existence. Whether this lack of coverage was due to a reasonable but mistaken belief of Mr. McCormick that his business was not subject to the Act, it is clear that by mid-2015, he had awareness that he indeed was required to procure and maintain workers' compensation insurance for BMPC, Inc. It was in mid-2015 that he finally purchased a policy that provided for a year of coverage. However, he thereafter allowed that policy to lapse and ignored the citation issued by Investigator Parham in September 2016. After a full non-compliance investigation was opened, Mr. McCormick re-instated coverage, only again to let it lapse.

For this conduct, Petitioner seeks a penalty of $989,500.00, which represents the maximum penalty of $500.00 a day for 1,979 days of non-compliance. The Commission declines to assess a penalty of this magnitude, given that there was no evidence of any worker compensation claims filed against Respondent nor evidence of an employee actually injured to date. The Commission finds a penalty of $100.00 a day to be appropriate. The Commission hereby so assesses against Respondent for a period of 1,979 days, for a total fine of $197,900.00.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent, Brian McCormick, individually and as President and Secretary of BMPC, Inc., is found to be an employer who was in non-compliance with the insurance provisions of Section 4(a) of the Act and shall pay the Commission a fine of $ 197,900.00, as stated herein and pursuant to Section 4(d) of the Act.

Pursuant to Commission Rule 9100.90, once the Commission assesses a penalty against an employer in accordance with Section 4(d) of the Act, payment shall be made according to the following procedure: 1) payment of the penalty shall be made by certified check or money order made payable to the Commission; 2) payment shall be mailed or presented within thirty (30) days of the final order of the Commission or the order of the court of review after final adjudication to:

Workers' Compensation Commission
Insurance Compliance Division
100 West Randolph Street, Suite 8-328
Chicago, Illinois 60601

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: MAY 10 2019

Marc Parker

mwp/ac
68

Deborah L. Simpson

Barbara N. Flores

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Araceli Dure,

Petitioner,

vs. No. 99 WC 53741

ITW Paslode,

Respondent.

19IWCC0230

DECISION AND OPINION ON REVIEW UNDER SECTIONS 19(h) AND 8(a)

Timely Petition for Review under sections 19(h) and 8(a) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of further permanent disability and further medical benefits, and being advised of the facts and law, denies the 19(h)/8(a) petition for the reasons set forth below.

Petitioner's application for adjustment of claim alleges a work-related back injury on August 24, 1999. On January 8, 2013, the Arbitrator filed a decision finding that Petitioner failed to prove a causal connection "between the multitude of symptoms she testified to at trial" and the work accident. The Arbitrator questioned the veracity of Petitioner's pain complaints, noting, among other things, that "all of the objective diagnostic testing performed on the Petitioner, including the November 3, 1999 lumbar MRI, the December 10, 1999 full body bone scan, the May 29, 2001 lumbar MRI, and the May 29, 2001 MRI of the brain, was reported to be normal." The Arbitrator concluded the work accident caused "at most a back strain/sprain type injury," from which Petitioner reached maximum medical improvement by March 22, 2000. The Arbitrator awarded permanent partial disability benefits representing a 5 percent disability to the person as a whole. The Arbitrator awarded no other benefits, having found: "Petitioner continued to work for the Respondent for six months following the work accident of August 24, 1999 and her treating physician, Dr. Tack, released her to full duty as of November 16, 1999." Regarding medical benefits, the Arbitrator specifically found: "Petitioner failed to prove that the medical care and treatment she received after November 16, 1999 was reasonable, necessary or

causally related to the work accident of August 24, 1999." On September 19, 2014, the Commission affirmed and adopted the Arbitrator's decision.

On July 20, 2016, the circuit court affirmed the Commission's decision. Neither party appealed the order of the circuit court.

On September 21, 2016, Petitioner timely filed a petition for review under sections 19(h) and 8(a). In her brief, Petitioner asks the Commission to increase the permanent partial disability benefits to 25 percent of the person as a whole. Petitioner also appears to seek medical expenses for ongoing treatment.

At the 19(h)/8(a) hearing on July 25, 2018, Petitioner testified on direct examination that in 2014 she moved from Illinois to Michigan, where she continued to receive medical treatment. Since the arbitration hearing on October 23, 2012, Petitioner received medical treatment from Dr. Anatoly Arber, Dr. Abraham and Dr. Mazher Hussain. Petitioner testified that since the arbitration hearing, she is in much more pain. She also has more numbness in her extremities. She has severe pain in the low back which goes to her leg. She finds it difficult to walk or sit for more than 10 to 15 minutes. She can only walk for 10 to 15 minutes, whereas before it was 40 to 45 minutes. She now needs to lie down four or five times a day, whereas before it was twice a day. She undergoes radiofrequency ablation every month or two months "because the medicine is not working much." She has severe weakness and fatigue, as well as difficulty with activities of daily living and household chores. The weakness causes her legs to shake. She suffers from worsening depression and anxiety. Petitioner felt fatigued during the 19(h)/8(a) hearing.

On cross-examination, Petitioner agreed that now and in 2012 she would get severe pain in her low back and left leg after walking two or three blocks. The difference is her leg is weaker now. Petitioner acknowledged testifying at the arbitration hearing that she felt so bad, she did not look for work. Petitioner also acknowledged that as of the time of the arbitration hearing, she had undergone numerous injections, estimating the number as close to 500. Petitioner denied giving Dr. Hussain a history of a motor vehicle accident two days earlier, which aggravated her low back pain. She also denied ever being in a car accident. On redirect examination, Petitioner acknowledged undergoing many radiofrequency ablation procedures before the arbitration hearing.

The medical records show that Petitioner continued to receive pain management from Dr. Arber, with whom she had treated since 2010 until moving to Michigan. In the patient intake questionnaire dated August 5, 2010, Petitioner rated her pain an 8-9/10, indicating it worsened with sitting or activity. She also indicated numbness, tingling, weakness and muscle spasms. She indicated many comorbid conditions, including chronic cough, high blood pressure, ulcers, joint disease, visual problems, panic attacks, chronic depression, high cholesterol, myofascial pain syndrome, "cervicogenic headache, neck, shoulder, arm syndrome," facet arthropathy, costovertebral joint inflammation, sacroiliitis and piriform syndrome. She had undergone nerve blocks, trigger point injections, radiofrequency ablation, unspecified surgery, TENS unit/electrical stimulation, chiropractic treatment and biofeedback. A lumbar MRI performed in December of 2011 was interpreted by the radiologist as showing: a suspected mild central canal narrowing at T11-T12; indentation of the anterior thecal sac at L1-L2; and indentation of the

anterior thecal sac and mild bilateral neural foraminal narrowing at L4-L5 and L5-S1. Dr. Arber variously diagnosed chronic pain syndrome, generalized body pain, fibromyalgia, possible rheumatoid arthritis, degenerative disc disease, gluteal area pain, soft tissue pain, cervical spinal stenosis, cervical facet arthropathy, cervical spondylosis without myelopathy, and depression. On October 21, 2012, the eve of the arbitration hearing, Dr. Arber issued a report to Petitioner's counsel stating: "[The patient] stated that the pain started after work related injury years ago. Over this period of time the pain from local has become generalized and persists despite efforts of different doctors including Pain Management, Rheumatologist, Psychiatrist and Surgeon, multiple procedures and a variety of pain medications directed to reduce or eliminate pain. I have not observed any progress since I have been following her. ¶ A reasonable degree of medical certainty allows me to suggest that [the patient] developed chronic pain syndrome and generalized body pain as a result of the initial trauma." As noted, the Commission has found the work accident caused "at most a back strain/sprain type injury," from which Petitioner reached maximum medical improvement by March 22, 2000.

The medical records from Dr. Bincy Joseph, a primary care physician, show Petitioner received regular primary care while in Illinois. On December 6, 2013, Petitioner presented for a check-up before moving to Michigan. Physical examination was benign.

The medical records from Dr. Hussain, whose pain management practice is in Michigan, show that on March 4, 2015, Petitioner sought treatment for back and shoulder pain. Dr. Hussain noted the following history: "Patient is a 52 year old female with a long history of low back pain, was seen for initial evaluation. *** She reports her back pain has started after she tried to lift heavy object in 1999. Says she was involved in MVA two days ago, she was the restrained driver. Another car hit her vehicle on drivers side. Says her back pain has been severe after the accident. She also reports of left shoulder pain. She went to ER. She also reports of having pain all over her body. She reports she has gone to pain management in the past in Illinois, she moved to Michigan in 2013. *** Reports feeling fatigued." Petitioner rated the pain an 8-10/10. Dr. Hussain diagnosed shoulder pain, lumbosacral spondylosis without myelopathy, degeneration of lumbar intervertebral disc, low back pain, sacroiliac joint pain and primary fibromyalgia syndrome. During follow-up visits, Petitioner complained of severe low back pain, as well as pain all over her body. Dr. Hussain performed bilateral lumbar medial branch blocks. Petitioner reported "significant improvement in lower back pain over 80% after bilateral LMBB." "However, she reports worsening of the lower back pain which interferes with ADLs. She reports that current pain is lower than that she had previously." Petitioner also reported the pain medications helped very little and only for a short period of time. Dr. Hussain then performed bilateral sacroiliac blocks. Petitioner reported only limited improvement after the sacroiliac blocks and continued to complain of severe low back pain affecting her daily functioning. Dr. Hussain then performed radiofrequency ablation.[1]

Dr. Hussain testified by evidence deposition on December 12, 2017. Dr. Hussain affirmed that Petitioner reported being injured in a motor vehicle accident two days before the initial visit. When asked for his causation opinion, Dr. Hussain stated that Petitioner reported her back pain started and persisted after lifting a heavy object. Dr. Hussain understood the motor vehicle accident further aggravated Petitioner's condition. Dr. Hussain based his causation

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[1] There are no records from Dr. Hussain after December of 2015.

opinion on the history Petitioner provided and the 2011 lumbar MRI report. Dr. Hussain did not have Petitioner's prior medical records, only some imaging reports. On cross-examination, Dr. Hussain conceded the medical documentation he had was insufficient to relate Petitioner's condition to the 1999 work accident. Dr. Hussain was unaware the Commission had found the work accident caused only a back strain/sprain. When asked about the extent of Petitioner's disability, Dr. Hussain responded: "When she presented, she has significant back problem affecting her quality of functioning and *** activities."

Respondent's section 12 examiner, Dr. Mark Levin, testified by evidence deposition on January 26, 2018. Dr. Levin, an orthopedic surgeon, testified that he reexamined Petitioner on September 11, 2017, having previously examined her in January of 2010. Petitioner reported that she never returned to work and remained "on disability." Petitioner further reported now living in Michigan and treating with Dr. Hussain. She reported getting an 80 percent temporary improvement from the periodic injections. She also reported: occasional flare-ups, "especially if she tried to overdo her lifting;" "being hypersensitive throughout her body;" difficulty sleeping; having pain with any pressure on the low back; some numbness in the legs, worse on the left; pain in the thighs; and "crying episodes when she would feel angry." She reported being able to sit for 30 to 45 minutes, stand less than an hour, walk for 45 minutes and drive for an hour. She denied any new injuries or accidents since 1999. On physical examination, Petitioner was able to walk with a normal reciprocal gait, as well as perform toe-toe and heel-heel walking. She complained of diffuse tenderness with palpation. There was no evidence of any cervical, thoracic or lumbar spasm. The range of lumbar motion was normal. Examination of the lower extremities was normal, except for tenderness and the pinprick sensation varying in a non-dermatomal fashion. There was also exaggerated pain behavior with Trendelenburg test. Straight leg raise test was normal. Dr. Levin reviewed medical records from Dr. Hussain, noting an intervening motor vehicle accident, and Petitioner's primary care records from Michigan, describing treatment for multiple subjective discomforts diagnosed as fibromyalgia, sarcoidosis and depression. Dr. Levin agreed with the diagnosis of fibromyalgia. In sum, Dr. Levin concluded: "[The claimant] had marked subjective discomforts in multiple body parts which I cannot relate to any alleged work injury dating back to August 24, 1999," and "there was no objective orthopedic pathology that was related to her current complaints of discomfort dating back to August 24, 1999." Dr. Levin therefore "could find no evidence that there was any need for any treatment related to any orthopedic condition stemming back to an injury of August 24, 1999 that would have been required between January of 2010 and her visit of September 11, 2017." On cross-examination, Dr. Levin added: "[O]rthopedically fibromyalgia is not a post-traumatic condition from alleged occurrence in this case of August 24, 1999."

The Commission gives greater weight to the opinion of Dr. Levin. Having carefully considered the entire record, the Commission finds, consistently with our prior decision, that Petitioner failed to prove a causal connection between the work accident in 1999 and her continued medical treatment. The Commission further finds that Petitioner failed to prove a material increase in her disability that is causally connected to the work accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's petition under §§19(h) and 8(a) is denied.

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.

MAY 13 2019

DATED:
o-05/01/2019
SM/sk
44

Stephen J. Mathis
Stephen Mathis

D. Douglas McCarthy
Douglas McCarthy

Deborah L. Simpson
Deborah Simpson

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ERIN WHITE,

Petitioner,

vs. NO: 16 WC 5247

STATE OF ILLINOIS,
CHESTER MENTAL HEALTH CENTER,

19IWCC0231

Respondent.

DECISION AND OPINION ON REVIEW

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

Permanent Disability

The Commission views the evidence differently with respect to Section 8.1b(b) factors (ii), (iii), and (v).

(ii) the occupation of the injured employee

Petitioner continues to work in her pre-injury job as Security Therapy Aide. The Arbitrator highlighted this job requires Petitioner to bend, interact with patients, and be on her feet 90% of the time, and she testified to ongoing low back pain while doing so.

The Commission believes analysis of this factor must also include Petitioner's unrebutted testimony that patient altercations are a daily occurrence and by the end of her shift, she feels

"sore and beat." T. 19. The Commission further finds it significant Petitioner's severe pain complaints while working have led her to seek an FMLA workday limitation of no more than eight hours per day. T. 23. The Commission finds this factor weighs in favor of increased permanent disability.

(iii) the age of the employee at the time of the injury

Petitioner was 29 years old on the date of accident. Noting Petitioner will suffer the effects of her injury for the remainder of her working and natural life, as well as Dr. Raskas cautioning of an increased likelihood further surgery may be necessary, the Arbitrator afforded significant weight to this fact.

The Commission finds the possibility of future surgery is not germane to this factor. Certainly if Dr. Raskas' prognostication came to fruition, such additional surgical intervention would properly be considered in the context of a Section 8(a)/19(h) petition. At this stage, however, we believe this is conjecture and have eliminated it from our analysis of this factor. Nonetheless, Petitioner was only 29 years old on the date of accident, and the Commission concurs Petitioner's young age means she will endure the pain and physical deficits resulting from her accidental injury for an extended period. This weighs heavily in favor of increased permanent disability.

(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 underwent an L5-S1 fusion, still has significant complaints, and although Dr. Raskas placed her at maximum medical improvement, the doctor also recommended continued monitoring and warned further surgery may be required. As detailed above, the Commission believes the potential for future adjacent-level surgery is speculative and not reliable evidence of Petitioner's current permanent disability. Even so, the Commission finds the medical records corroborate Petitioner's significant complaints and deficits and weigh in favor of increased permanent disability.

On August 10, 2016, Dr. Raskas performed an L5-S1 laminectomy with posterior lumbar interbody fusion; the post-operative diagnosis was annular tear and discogenic pain L5-S1. PX7, PX12. While Petitioner testified the surgery was beneficial, she also described ongoing symptoms which have a considerable impact. She no longer engages in the exercise program she enjoyed prior to her accident, she struggles with physical intimacy, her sleep has been greatly affected and she needs a sleeping pill to sleep, and she has difficulty keeping up with her five-year-old son. T. 19-20. The Commission finds Dr. Raskas' records corroborate Petitioner's testimony. We observe the June 30, 2017 office note memorializes Petitioner underwent a Functional Capacity Evaluation which placed her at the Light Physical Demand Level and recommended lifting restrictions; although Petitioner wished to "work through the pain and try to work at full duties," we find the FCE results significant. The Commission further emphasizes Dr. Raskas' August 11, 2017 re-evaluation report documents Petitioner "has back pain pretty much on an every day basis. She says pain is something that she is just willing to put up with and continue to work her regular job." PX7.

19IWCC0231

Having weighed the evidence and analyzed the Section 8.1b(b) factors, the Commission finds Petitioner sustained a 22.5% 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 May 14, 2018, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $492.29 per week for a period of 112.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 22.5% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $241,605.73 for the reasonable, necessary, and related medical services rendered to Petitioner as provided in Section 8(a) and subject to Section 8.2. Regarding the charges for the fusion hardware, pursuant to the clear language of Section 8.2(a-1)(5), Respondent is liable for the invoice cost plus 25%. Respondent shall be given a credit for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims from any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

Pursuant to Section 19(f)(1) of the Act, this decision is not subject to judicial review.

DATED: MAY 13 2019

LEC/mck

O: 4/8/19

43

L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WHITE, ERIN
Employee/Petitioner

Case# **16WC005247**

STATE OF IL/CHESTER MENTAL HEALTH CTR
Employer/Respondent

19IWCC0231

On 5/14/2018, 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 2.00% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

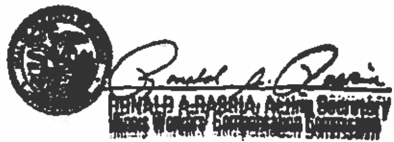
0558 ASSISTANT ATTORNEY GENERAL
KENTON J OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

MAY 14 2018



STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Erin White
Employee/Petitioner

v.

State of IL/Chester Mental Health Ctr.
Employer/Respondent

Case # 16 WC 05247

Consolidated cases: _____

19IWCC0231

An *Application for Adjustment 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 Herrin, on April 12, 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. [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 December 28, 2015, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $42,655.30; the average weekly wage was $820.49.

On the date of accident, Petitioner was 29 years of age, married with 1 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00. The parties stipulated that all TTD benefits had been 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 1, including the bill for hardware used by Dr. David Raskas in the fusion surgery, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner permanent partial disability benefits of $492.29 per week for 100 weeks because the injury sustained caused the 20% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

William R. Gallagher, Arbitrator

May 9, 2018
Date

MAY 14 2018

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment for Respondent on December 28, 2015. According to the Application, Petitioner sustained an injury to the back, face and body as a whole as a result of an altercation with a patient (Arbitrator's Exhibit 2). At trial, counsel for Petitioner and Respondent stipulated that the only disputed issues were the nature and extent of disability and the reasonableness of a portion of a medical bill from Frontenac Surgery and Spine Care Center (hereinafter referred to as "Frontenac Surgery"). As noted herein, the dispute regarding the reasonableness of the bill from Frontenac Surgery was in regard to the amount charged for the metal hardware used during the fusion surgery that was performed on Petitioner's low back (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a Security Therapy Aide. On December 28, 2015, Petitioner and another employee were attempting to restrain a patient. At that time, the patient repeatedly struck Petitioner in the face and jaw which caused Petitioner to fall. When Petitioner fell, she sustained further injuries to her neck and low back.

Petitioner was initially seen by Dr. Alex Wright, Respondent's staff physician, on the day the accident occurred. Dr. Wright directed Petitioner to go home and to follow up with her family physician (Petitioner's Exhibit 14).

Petitioner was subsequently evaluated by Valerie Bleche, a Nurse Practitioner. When seen by NP Bleche, Petitioner complained of right mandibular, thoracic and lumbar pain. NP Bleche authorized Petitioner to be off work, prescribed medication and ordered x-rays of the jaw, thoracic and lumbar spines. The x-rays were all negative for fractures. Because of Petitioner's continued low back symptoms, NP Bleche ordered an MRI scan of the lumbar spine (Petitioner's Exhibits 3 and 4).

The MRI scan was performed on January 7, 2016. According to the radiologist, the MRI revealed a disc bulge at L4-L5 and a retrolisthesis and disc bulge at L5-S1 (Petitioner's Exhibit 5).

When NP Bleche saw Petitioner on January 19, 2016, she reviewed the MRI scan. NP Bleche ordered physical therapy, but noted Petitioner should be referred to a neurosurgeon (Petitioner's Exhibit 3).

Petitioner was subsequently evaluated by Dr. David Raskas, an orthopedic surgeon, on March 7, 2016. At that time, Petitioner complained of neck and low back pain with the low back pain radiating into the right buttock. Petitioner advised she had a prior history of low back pain, but that the injury at work triggered a new onset. Dr. Raskas reviewed the MRI scan and noted it revealed a disc bulge at L5-S1. He recommended a series of epidural steroid injections at L5-S1. Because of Petitioner's neck complaints, Dr. Raskas ordered an MRI scan of the cervical spine (Petitioner's Exhibit 7).

The MRI of Petitioner's cervical spine was performed on March 15, 2016. According to the radiologist, it revealed small disc herniations at C3-C4 and C5-C6 (Petitioner's Exhibit 8).

Petitioner was seen by Dr. Patricia Hurford, a pain management specialist, who administered epidural steroid injections at L5-S1 level on March 15, April 21, and April 28, 2016. On all three occasions, Petitioner experienced significant relief of her low back symptoms; however, the relief was temporary (Petitioner's Exhibits 7 and 9).

When Dr. Raskas saw Petitioner on May 20, 2016, she continued to complain of significant low back pain. At that time, Dr. Raskas recommended Petitioner undergo a discogram at L5-S1 followed by a CT scan (Petitioner's Exhibit 7).

The discogram and CT scan were performed on July 8, 2016. They confirmed Petitioner had a retrolisthesis, an annular tear and a disc bulge/protrusion at L5-S1 (Petitioner's Exhibits 10 and 12).

When Dr. Raskas saw Petitioner on July 11, 2016, he reviewed the discogram and CT scan. At that time, Dr. Raskas noted Petitioner had received a significant amount of conservative treatment which had failed to relieve her symptoms. He recommended Petitioner undergo a laminectomy and fusion at L5-S1 (Petitioner's Exhibit 7).

On August 10, 2016, Dr. Raskas performed surgery on Petitioner which consisted of a laminectomy and fusion at L5-S1 with both metal hardware and bone grafting (Petitioner's Exhibit 13).

Following surgery, Dr. Raskas continued to treat Petitioner. Petitioner's post surgical recovery was rather prolonged. Because of her continued symptoms, Dr. Raskas prescribed various pain medications for several months. When he saw Petitioner on March 24, 2017, Dr. Raskas stated he was concerned about Petitioner's ongoing use of pain medications (Petitioner's Exhibit 7).

When Dr. Raskas saw Petitioner on May 2, 2017, he recommended Petitioner start work conditioning. He also ordered a functional capacity evaluation (FCE) (Petitioner's Exhibit 7).

Dr. Raskas subsequently saw Petitioner on June 30, 2017, and reviewed the report of the FCE. He noted that the FCE imposed a number of work/activity restrictions; however, Petitioner informed him she wanted to attempt to return to work at full duty. Dr. Raskas authorized her to do so, but stated that he would reevaluate her in six weeks (Petitioner's Exhibit 7).

Dr. Raskas last saw Petitioner on August 10, 2017. At that time, Petitioner stated she had back pain on a daily basis, but was working at her regular job. Dr. Raskas opined Petitioner was at MMI, but that long term monitoring to assure the fusion was solid would be necessary. He recommended that a CT scan be performed in the next six months to one year. Further, because of Petitioner's age, he opined another surgery in an adjacent area of the spine was likely (Petitioner's Exhibit 7).

At trial, Petitioner testified she continues to have low back pain on a daily basis and has to take Norco to sleep. Petitioner stated that it is painful for her to bend and this is an activity she performs on a regular basis while at work. Petitioner continues to have interactions with patients and is required to be on her feet for approximately 90% of her time at work which also aggravates her pain. Prior to the accident, Petitioner underwent gastric bypass surgery and was exercising afterward to help her continue to lose weight. Because of her ongoing back symptoms, Petitioner stated she is now unable to exercise.

As previously stated, Respondent disputed the reasonableness of the bill from Frontenac Surgery for the metal hardware used during the surgery performed by Dr. Raskas. The amount charged by Frontenac Surgery with $31,000.00. Respondent paid $21,033.75 leaving an outstanding balance of $9,966.25.

Petitioner took the deposition of Laurie Thiemann, the business office manager of Frontenac Surgery on February 14, 2018, and her deposition testimony was received into evidence at trial. Thiemann testified that she has worked at Frontenac Surgery for approximately eight years. She stated the operating surgeon selects the hardware to be used in the surgery, but the business manager selects the vendor from whom the hardware is purchased (Petitioner's Exhibit 15; pp 4-5, 13, 24-26).

Thiemann testified that Frontenac Surgery purchased four screws, four locking caps, two rods and a cage for the surgery performed by Dr. Raskas. The hardware was purchased from 21st Century Medical, LLC, for $24,800.00. Thiemann testified she was familiar with the Illinois Workers' Compensation fee schedule and that such implants are to be paid at 25% above the net manufacturer's price. Thiemann's testimony in this case, is that the fee schedule charge would be $31,000.00 (Petitioner's Exhibit 15; pp 10-13, Deposition Exhibit 2).

Respondent hired Foresight Medical Review (hereinafter referred to as "Foresight"), to determine an appropriate price for the hardware used by Dr. Raskas. Foresight was hired to determine a Preferred Provider Organization (PPO) reduction even though Frontenac Surgery was not such a preferred provider.

Andrew Bershaw, a senior bill review analyst employed by Foresight, was deposed on April 11, 2018, and his deposition testimony was received into evidence at trial. Bershaw is from Tampa, Florida, and counsel for both Petitioner and Respondent appeared via telephone. Bershaw testified he reviewed the data regarding the hardware used by Dr. Raskas, found like devices and opined that the reasonable cost would be $21,000.00 (Respondent's Exhibit 2; pp 7-9).

On cross-examination, Bershaw conceded he had no specific knowledge as to the Illinois Workers' Compensation Act fee schedule and what providers are paid for services and implants. He also agreed that in two of the examples he noted for hardware charges, they were for procedures performed in Utah and South Dakota (Respondent's Exhibit 2; pp 17-20).

Conclusions of Law

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

The Arbitrator concludes that all of the medical services provided to Petitioner were reasonable and necessary and that Respondent is liable for payment of medical bills incurred therewith, including the bills for the hardware used by Dr. Raskas in the fusion surgery.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 1, including the bill for the hardware used by Dr. Raskas in the fusion surgery, 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:

Dr. Raskas selected the hardware to be used in the fusion surgery which was obtained by Frontenac Surgery.

Laurie Thiemann, Frontenac Surgery's business manager credibly testified that she was familiar with the Illinois Workers' Compensation Act fee schedule and that the charge of $31,000.00 was consistent with same.

The Arbitrator was not persuaded by the testimony of Andrew Bershaw, Respondent's medical bill analyst. He suggested the use of "like" devices, was not familiar with the Illinois Workers' Compensation Act fee schedule and two of the comparable surgeries he referenced took place in Utah and South Dakota.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 20% loss of use of the person as a whole.

In support of this conclusion the Arbitrator notes the following:

Neither Petitioner nor Respondent tendered an AMA impairment rating. The Arbitrator gives this factor no weight.

Petitioner was employed as a Security Therapy Aide at the time she sustained the accident and continues to work in that capacity. Petitioner testified that she has to bend, continues to have interaction with patients and is required to stand on her feet approximately 90% of the time. That testimony was unrebutted. While Petitioner has returned to work to that job, she continues to experience low back pain. The Arbitrator gives this factor significant weight.

Petitioner was 29 years old at the time she sustained the accident and will have to live with the effects of this injury for the remainder of her working and natural life. Further, Dr. Raskas opined that, because of her age, additional surgery might be required in the future. The Arbitrator gives this factor significant weight.

There was no evidence that Petitioner's injury had any effect on her future earning capacity. The Arbitrator gives this factor no weight.

As a result of the accident, Petitioner sustained injuries to her jaw, cervical spine and lumbar spine. Obviously, the most severe injury was to the lumbar spine because she ultimately underwent fusion surgery at L5-S1. Petitioner still has significant complaints of pain referable to her low back. Even though Dr. Raskas opined Petitioner was at MMI, he noted Petitioner would require monitoring to assure that the fusion was solid and, because of her age, additional surgery might be required in the future. The Arbitrator gives this factor significant weight.

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

DELFINO GODINEZ,

Petitioner,

vs.

NO: 14 WC 5428

HIGHLAND BAKING CO., INC.;
REGENT INSURANCE COMPANY,

19IWCC0232

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 permanent partial disability (PPD) and penalties, and being advised of the facts and applicable law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission has considered the record in its entirety and has reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties, and at no point in the transcript has the Commission found any validation for the Respondent's position that would justify reversing the Arbitrator's Decision relative to penalties. While the Commission affirms the Arbitrator's Decision in its entirety, it is compelled to comment on the Respondent's actions in this matter.

Section 19(l) provides, in part:

> In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay. 820 ILCS 305/19(l).

Penalties under Section 19(l) are in the nature of a late fee. *Mechanical Devices v. Indus. Comm'n*, 344 Ill. App. 3d 752, 763 (2003). In addition, the assessment of a penalty under Section 19(l) is mandatory "[i]f the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay." *McMahan v. Indus. Comm'n*, 183 Ill. 2d 499, 515 (1998). The standard for determining whether an employer has good and just cause for a delay in payment is defined in terms of reasonableness. *Mechanical Devices*, 344 Ill. App. 3d at 763. The employer has the burden of justifying the delay, and the employer's justification for the delay is sufficient only if a reasonable person in the employer's position would have believed that the delay was justified. *Board of Education of the City of Chicago v. Indus. Comm'n*, 93 Ill. 2d 1, 9-10 (1982). The Commission's evaluation of the reasonableness of the employer's delay is a question of fact that will not be disturbed unless it is contrary to the manifest weight of the evidence. *Crockett v. Indus. Comm'n*, 218 Ill. App. 3d 116, 121 (1991).

The Commission agrees with the Arbitrator's analysis and award relative to Section 19(l). The Respondent failed to offer adequate justification for the delay in payment of benefits for the dates listed in the Arbitrator's Decision. As the Respondent failed to justify its delay in the payment of benefits, the Commission affirms the Arbitrator's award of $9,600.00 pursuant to Section 19(l).

The standard for awarding penalties under Section 19(k) is higher than the standard under 19(l). Section 19(k) of the Act provides:

> 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 the Act equal to 50% of the amount payable at the time of such award. 820 ILCS 305/19(k).

Section 16 of the Act provides for an award of attorney fees when an award of additional compensation under Section 19(k) is appropriate. 820 ILCS 305/16. "The amount of [attorney]

fees to be assessed is a matter committed to the discretion of the Commission." *Williams v. Indus. Comm'n*, 336 Ill. App. 3d 513, 516 (2003).

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. Indus. Comm'n*, 289 Ill. App. 3d 1090, 1093 (1997), *aff'd*, 183 Ill. 2d 499 (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. Indus. Comm'n*, 183 Ill. 2d 499, 514-15 (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. 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. In addition, while Section 19(l) penalties are mandatory, the imposition of penalties and attorney fees under Section 19(k) and Section 16 fees is discretionary. *Id.*

The arguments submitted by Respondent relative to penalties are not persuasive. Respondent argues that it is not conclusive that their own Section 12 examiner found Petitioner's right shoulder to be causally related to the January 1, 2014 work accident. They further argue that, as they were engaged in the pendency of the case, they were under no obligation to pay Petitioner anything, and would have suffered a loss of their own had Respondent paid benefits to Petitioner and then received an award in their favor. Respondent further argues that "[s]imply not paying Petitioner during the pendency of a case cannot be said to constitute a vexatious and reasonable delay."

Further, the Respondent's contrived arguments against the finding of an odd-lot determination are not supported by the record. The Respondent stated that Petitioner's efforts were not diligent and the vocational assessment that Petitioner made a diligent effort was based on Petitioner's own deceit. The Respondent questioned the Petitioner's English literacy stating that Petitioner "intentionally hindered the Vocational efforts by feigning his inability to communicate in English." This, they argue, demonstrated that Petitioner had no desire to find employment and he "sabotaged" vocational services as a result. Furthermore, they argue that a stable labor market was available and such a search may take longer than a year.

The Commission finds no merit in the Respondent's position as their arguments are directly contradicted by the evidence. The Commission can only conclude that Respondent's actions were unreasonable and vexatious.

As to Respondent's assertion that Petitioner was deceitful about his understanding of the English language, the record is clear that Petitioner had a limited understanding of the English

language. He openly testified that he understood some English and that he completed the job logs in English. Even Respondent's own vocational counselor testified that he assumed Petitioner understood more than he could speak, which, he noted, was not uncommon for a Spanish speaking individual. The record also indicated that Petitioner was enrolled in an ESL class for over two years to help improve his English skills. There is no deceit on Petitioner's part as claimed by the Respondent.

Also contrary to Respondent's assertion, is the fact that Respondent's own vocational expert acknowledged that Petitioner put forth a diligent job search and complied with all the requirements of vocational rehabilitation. Respondent's expert even testified that Petitioner had significant barriers to finding employment other than his lack of the English language including his restrictions—which Respondent would not accommodate, his age, and his lack of experience. Respondent's vocational counselor noted that finding an employer to work with Petitioner would be challenging and his "immense barriers" posed a significant challenge to finding employment. Respondent's vocational expert worked with Petitioner for a year with no success.

Moreover, Respondent's argument that a stable labor market may exist and that such a search could take over a year is disingenuous as Respondent terminated vocational rehabilitation in December 2017.

Turning to the medical records, there is no evidence of symptom magnification on Petitioner's part. Rather, Respondent's Section 12 examiner specifically commented that he found no evidence of symptom magnification on the Petitioner's part. Respondent's attempt to impeach the Petitioner's credibility is simply unsubstantiated.

The Respondent is entitled to put forth a vigorous defense; however, as is the case here, when that defense is based upon evidence not supported by the record, the Commission can only conclude Respondent's actions were unreasonable and vexatious. Petitioner sustained an undisputed accident and causal connection was not in dispute. Petitioner complied with every requirement that was asked of him. Despite his compliance, Respondent did not accommodate his restrictions, failed to timely pay his benefits, terminated his vocational rehabilitation, and put forth a defense that was not supported by the evidence. Therefore, the Commission affirms the Arbitrator's award of Section 19(k) penalties in the amount of $9,552.95 and affirms the award of Section 16 attorney fees of $1,910.59.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 22, 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $21,200.00. 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 the Circuit Court.

DATED: MAY 13 2019

D. Douglas McCarthy

DDM/tdm
O: 5/1/19
052

Stephen Mathis

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GODINEZ, DELFINO
Employee/Petitioner

Case# **14WC005428**

HIGHLAND BAKING CO INC REGENT INSURANCE CO
Employer/Respondent

19IWCC0232

On 5/22/2018, 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 2.08% 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:

1876 CZAPLA LAW
EDWARD ADAM CZAPLA
1821 WALDEN OFFICE SQ #400
SCHAUMBURG, IL 60173

4234 RIPES NELSON BAGGOT KALOBRATSO
MICHAEL BAGGOT
650 E DEVON AVE SUITE 110
ITASCA, IL 60143

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DELFINO GODINEZ
Employee/Petitioner

Case # 14 WC 005428

v.

Consolidated cases: -----

HIGHLAND BAKING CO., INC.; REGENT INSURANCE CO.
Employer/Respondent

19IWCC0232

An *Application for Adjustment 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 **3/15/18**. 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. [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 **1/1/14**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$35,077.12**; the average weekly wage was **$674.56**.

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

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

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

Respondent shall be given a credit of **$98,349.31** for TTD/ maintenance, and **$0.00** for other benefits, for a total credit of $98,349.31.

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

ORDER

Respondent shall pay Petitioner Permanent and Total Disability benefits of **$449.71**/week for life, commencing on March 15, 2018, as provided in Section 8(f) of the Act.

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

Respondent shall pay Petitioner attorneys' fees of **$1,910.59** as provided in Section 16 of the Act; penalties of **$9,552.95** as provided in Section 19(k) of the Act; and penalties of **$9,600.00** as provided in Section 19(l) of the Act.

Respondent shall pay Petitioner compensation that has accrued from 1/1/14 through 3/15/18, 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

05-22-18
Date

MAY 22 2018

STATEMENT OF FACTS

Petitioner, a sixty-year-old Spanish speaking bakery worker, was injured at work on January 1, 2014. Petitioner worked full time as a production worker for Highland Baking Co. Petitioner is right handed. Petitioner testified through a Spanish translator that he had to jump up to reach a tray/box above his head when he felt a "pop" in his right shoulder. The accident occurred towards the end of Petitioner's shift.

The following day Petitioner awoke with a right shoulder pain and reported the injury to Francisco Lopez, production supervisor at Highland Baking Co. Petitioner sought emergency medical treatment at Northwest Community Hospital on January 2, 2014 for the right shoulder injury. The initial history reflects "*right shoulder pain after lifting a box from overhead last p.m.*" (PX.1) X-rays were taken of the right shoulder. Examination revealed positive tenderness over the right trapezius, right cervical paraspinal muscles, right lateral and anterior soft tissues with limited range of motion. Petitioner was issued light duty work restrictions of no lifting greater than 10 pounds, no pushing/pulling greater than 10 pounds, and no use of right arm. (PX.1) Petitioner's right shoulder was placed in a sling.

Petitioner followed up with his primary care physician, Dr. Jesus Manteca-Elias, the following day complaining of right shoulder pain. (PX.2) Petitioner was diagnosed with right shoulder tendinitis and received a therapeutic injection to the right shoulder. (PX.2) Petitioner returned back to Dr. Manteca-Elias on January 17, 2014 complaining of right shoulder pain. Examination revealed tenderness on the right shoulder deltoid muscle area and posterior joint aspect with limitation on extension, abduction and internal rotation. A positive impingement sign was also noted. (PX.2) Petitioner was referred to Dr. Eugene Lopez, an orthopedic surgeon, for treatment of the right shoulder.

Petitioner saw Dr. Lopez at Midwest Sports Medicine on January 27, 2014 complaining of right shoulder pain. The history recorded at that time states *"the onset of the symptoms was sudden and related to an injury on 1/1/14. The injury occurred at work. He is a baker and states he hurt himself while pulling boxes down from a high shelf. Since the onset, the symptoms have been worsening.*" (PX.3A) Dr. Lopez diagnosed Petitioner with work-related shoulder impingement syndrome and proximal biceps tendinitis and performed a subacromial steroid injection to the right shoulder. A course of physical therapy and MRI of the right shoulder were ordered and Petitioner was restricted from all work activity. (PX.3A)

MRI of the right shoulder completed on January 30, 2014 revealed a complete tear of the supraspinatus tendon. (PX.3A) Dr. Lopez reviewed the MRI results with Petitioner and confirmed the MRI shows a full-thickness rotator cuff tear. Petitioner had tenderness over the AC joint with a positive Neer and Hawkins impingement. Positive Speed's test and positive flexion/adduction. Dr. Lopez diagnosed Petitioner with a right shoulder rotator cuff tear with impingement and recommended a right shoulder arthroscopy, subacromial decompression, distal clavicle resection, and possible rotator cuff repair and biceps tenodesis. (PX.3A) Petitioner remained restricted from all work activity.

Respondent initially failed to approve the shoulder surgery. At Respondent's request Petitioner was examined by Dr. Toninio on May 22, 2014 pursuant to Section 12 of the Act. It was Dr. Tonino's opinion that Petitioner's right shoulder condition is related to an injury occurring at work on the 1st of January 2014, based on the mechanism he described to me today, with no prior history of injuries to his shoulder. (RX.2)

Petitioner completed physical therapy treatment at Midwest Physical Therapy between May 2, 2014 and June 9, 2014. (PX.4) Due to an unrelated medical condition the shoulder surgery was postponed until July.

On July 29, 2014 Dr. Lopez performed an arthroscopic repair/reconstruction of a massive right shoulder rotator cuff tear including a 10mm clavicle resection, arthroscopic biceps tenotomy, debridement of the superior and anterior glenoid labrum, and acromial decompression. (PX.5) The operative note reflects a ***"massive rotator cuff tear extending deep into the infraspinatus tendon with advanced retraction, almost complete obliteration of the supraspinatus tendon, osteolytic deterioration of the distal clavicle with inferior spurring and 50% rupture of the biceps with anterior and superior labral tearing."*** (PX.5)

Petitioner followed up with Dr. Lopez post-operatively on August 2, 2014. The dressings were removed and the incisions cleaned. Petitioner's right shoulder was placed in an Ultra sling and he remained restricted from all work activity. (PX.3A) On September 4, 2014, Dr. Lopez recommended a course of physical therapy treatment. Petitioner completed 31 sessions between September and February 2015. (PX.4) Petitioner continued to see Dr. Lopez who prescribed Mobic for anti-inflammatory purposes and Ultram for pain. Petitioner remained restricted from all work activity. (PX.3A)

Dr. Lopez examined Petitioner on January 21, 2015 and noted Petitioner's range of motion was improving. A course of work conditioning was prescribed and Petitioner remained restricted from work. (PX.3A) Petitioner completed a month of daily work conditioning at Midwest Physical Therapy between February 10 and March 11, 2015. (PX.4)

On March 8, 2015 Petitioner advised Dr. Lopez his shoulder was doing better, however, he still could not lift it up very high and was experiencing a lot of pain with limited range of

motion in the shoulder. On May 13, 2015 Petitioner reported *"painful lifting his arm above his head and hears a clicking"* (PX.3B) Dr. Lopez continued to restrict Petitioner from work and prescribed additional work conditioning and Ultram to control the pain.

Petitioner continued to experience right shoulder pain and was unable to overhead lift without pain. (PX.3B) On July 9, 2015, Dr. Lopez ordered an additional course of work conditioning and restricted Petitioner from work. Petitioner completed another month of work conditioning at Midwest Physical Therapy between July 17 and August 14, 2015. (PX 4)

On August 6, 2015, Dr. Lopez ordered a Functional Capacity Evaluation which was completed on August 28, 2015. Petitioner demonstrated the ability to function at the **medium** physical demand level.

On October 1, 2015 Dr. Lopez issued Petitioner permanent work restrictions of no lifting more than 35 pounds floor to waist, 10 pounds waist to above shoulder, carry 35 pounds bilaterally or 20 pounds unilaterally. (PX.3B) Petitioner was also prescribed Mobic and Ultram for the ongoing shoulder pain.

MR-arthrogram of the right shoulder performed on October 16, 2015 revealed a *"completely ruptured and retracted supraspinatus tendon. A significant portion of the anterior infraspinatus also appears ruptured and retracted. Blunting of the inferior labrum which is likely torn and prominent acromioclavicular joint arthropathy with inferior spurring."* (PX.3B)

Petitioner returned to see Dr. Lopez on November 2, 2015 complaining of *"a lot of pain in his right shoulder"*. He has problem bringing it to the side and out in front of him and cannot lift over shoulder level. He cannot reach, push or pull. Dr. Lopez noted the MR-arthrogram demonstrated a massive rotator cuff tear with retraction. Dr. Lopez stated Petitioner *"will require permanent activity and work modification. It is more likely than not he will require*

further treatment for his shoulder. It is more likely he will require shoulder replacement at some point in the future as a result of this work-related problem. Patient has achieved MMI. The patient has sustained a permanent disability and will require medication and therapy for flare intermittently and or indefinitely. The patient may go on to require surgery." (PX.3B)

Petitioner returned to see Dr. Lopez on December 10, 2015 complaining of ongoing right shoulder pain. Petitioner received a corticosteroid injection to the right shoulder to relieve the pain. (PX.3B) Petitioner returned to see Dr. Lopez on January 8 and February 8, 2016 complaining of a constant intermittent sharp pain with movement. (PX.7) Dr. Lopez prescribed Mobic and Ultram to relieve the pain. Petitioner saw Dr. Gregory Nicholson at Midwest Orthopedic at Rush on March 18, 2016 for a second opinion. Petitioner was complaining of weakness and increasing shoulder pain. (PX.6) Dr. Nicholson noted Petitioner *"has a massive retracted recurrent rotator cuff tear after an attempted rotator cuff repair with severe fatty infiltration atrophy."* (PX.6) Dr. Nicholson recommended additional physical therapy and a Functional Capacity Evaluation. (PX.6)

On March 21, 2016 Petitioner received another right shoulder subacromial steroid injection. (PX.7) On May 20, 2016 Petitioner reported *"trouble lifting his arm."* On June 29, 2016 Petitioner received another right shoulder subacromial steroid injection (PX.7) On August 1, 2016, Dr. Lopez prescribed Ultram for the ongoing right shoulder pain. (PX.7) On August 31, 2016 Petitioner reported his *"right shoulder is getting much more painful"*. Examination revealed tenderness over the proximal biceps tendon, positive impingement and Speeds test. Petitioner was given Ultram for the ongoing pain. On October 6, 2016 Petitioner received a refill of his Tramadol. On November 3, 2016 Dr. Lopez prescribed Ultram for the ongoing shoulder pain. (PX.7)

Petitioner next saw Dr. Lopez on December 14, 2016 who noted Petitioner's *"right shoulder is still very painful with limited motion."* (PX.7) On May 10, 2017 Petitioner saw Dr. Lopez for ongoing severe shoulder pain. Dr. Lopez noted Petitioner *"Isn't able to use his arm to do any lifting, carrying, or twisting and if he does use the right arm, he experiences a lot of pain for the rest of the day".* (PX.7) On August 28, 2017, Petitioner received another right shoulder subacromial steroid injection. Petitioner returned to Dr. Lopez on September 21, 2017 with continued pain to the right shoulder. Dr. Lopez noted Petitioner *"still has trouble with limited motion. He cannot lift his arm higher than waist level by himself. He cannot reach out or up. He has constant pain in the front of his shoulder."* (PX.7)

Petitioner last saw Dr. Lopez on February 13, 2018. Dr. Lopez noted Petitioner can barely lift his arm up to chest level. He has a lot of pain at the top of his shoulder that travels all the way down his arm to his fingertips. He cannot reach, push, pull or carry things. He has pain most of the time. (PX.7) Petitioner received another subacromial steroid injection at that time.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (L) WHAT IS THE NATURE AND EXTENT OF THE INJURY?

THE ARBITRATOR FINDS AS FOLLOWS:

It is undisputed that Petitioner injured his right shoulder at work on January 1, 2014. Petitioner underwent an arthroscopic repair/reconstruction for a massive rotator cuff tear including clavicle resection, biceps tenotomy, debridement of the superior and anterior glenoid labrum and acromial decompression. (PX.5) Petitioner completed an extensive course of

physical therapy followed by work conditioning. Petitioner completed a Functional Capacity Evaluation which demonstrated the ability to work at a **medium** physical demand level.

On October 1, 2015, Dr. Lopez issued Petitioner the following permanent work restrictions:

No lifting more than 35 pounds floor to waist;
No lifting more than 10 pounds waist to above shoulder;
No carrying more than 35 pounds bilaterally; and
No carrying more than 20 pounds unilaterally.
(PX.3B)

Respondent did not accommodate Petitioner's permanent work restriction and allow him back to work. In January 2017, Respondent referred Petitioner to Coventry Healthcare for Vocational Rehabilitation. Dean Geroulis, a Certified Rehabilitation Counselor, prepared a written vocational rehabilitation plan and Labor Market Survey to assist Petitioner in his job search. (PX.11 and 12)

Petitioner met weekly with Dean Geroulis and a spanish interpreter at the Mt. Prospect library. Petitioner was provided job leads and began an active job search. Petitioner contacted 10 prospective employers each week which were recorded in his Daily Job Search Log Sheet. (PX.10) The jobs were predominantly light duty work as a restroom attendant, assembler, assembly/production operator, sorter, and work in the food service/restaurant industry.

Petitioner met with Dean Geroulis on a weekly basis throughout 2017. Between January 2017 and December 2017, Petitioner actively participated in vocational rehabilitation looking for suitable alternative employment. Petitioner has no computer skills to search for jobs online and submitted all job applications in person. (PX.12) Petitioner contacted over **300** prospective employers during this period but received no offers of employment. (PX.10)

During the 1-year Petitioner looked for work Coventry never obtained a suitable job offer for Petitioner. (PX.13 P.19) and (RX.1 P.14,18) Dean Geroulis acknowledged that Petitioner

faces *"significant vocational barriers that both limit the number of jobs in the labor market he may be able to perform, and place him at a disadvantage when competing for jobs. These include his limited education and lack of a high school education, his restrictions and lack of experience or marketable skills demanded for many of the types of jobs typically available within his physical capabilities and advanced age."* (PX.12 and Rx.1 P. 18-24) Dean Geroulis acknowledged that he was unsuccessful in finding suitable alternative employment for Petitioner. (RX.1 P.17, 25, 28) In December 2017 Respondent terminated vocational rehabilitation activities with Coventry. (PX.12)

At Petitioner's request, Susan Entenberg, a Certified Rehabilitation Counselor and Licensed Clinical Professional Counselor, met with Petitioner and his son on December 2, 2017. (PX.13 P.9) Petitioner was born in Mexico where he completed the 6th grade. (PX.14, P.9) Petitioner had no other education or training. (PX.14 P.9) Petitioner does not speak, read or write in English. Petitioner came to the United States in 1997.

Susan Entenberg reviewed the pertinent medical records, Petitioner's Job Search Log Sheets and the monthly Coventry Vocational reports. It was Ms. Entenberg's opinion, that Petitioner's permanent work restrictions precluded him from returning to production work as a commercial baker for Respondent. (PX.13 P.15,18-19) The constant lifting particularly the over head lifting exceeded Petitioner's permanent work restrictions. Furthermore, Respondent did not accommodate Petitioner's permanent work restrictions. (PX.13 P.15-16)

In determining that Petitioner was not an appropriate candidate for further vocational rehabilitation services, Susan Entenberg applied the factors established in National Tea v. IIC, 73 Ill.Dec.575 (1983). Ms. Entenberg opined that Petitioner has sustained a reduction in earning power and a loss of job security as a result of the injuries sustained at work on January 1, 2014.

(PX.13 P.20) Petitioner adequately participated in vocational rehabilitation under the supervision of a certified rehabilitation counselor without success and is not an appropriate candidate for training given his age, education, permanent work restriction, and work history. (PX.13 P.21) Petitioner's entire work history is in the baking industry. (PX.13 P.14) Ms. Entenberg testified that the job of a bakery production worker is unskilled, therefore Petitioner has no transferrable skills to assist him in finding alternative employment within his permanent work restrictions. (PX.12 P.18-21) Finally, Petitioner is 64 years old and has a short work life expectancy. (PX.12 P.21)

Susan Entenberg noted that Petitioner was actively engaged in job search activities and had performed a "diligent" job search. (PX. 13 P.16) However, Petitioner's advanced age (64 years old), 6th grade education, very limited English communication skills, lack of literacy and computer skills, and no transferrable skills present significant barriers to Petitioner's return to work. (PX.13 P.16-18) Consequently, it was Susan Entenberg's opinion that a stable labor market does not exist for Petitioner. (PX.13 P.20-21)

A person is totally disabled when he cannot perform any services except those for which no reasonably stable market exists. A.M.T.C. of Illinois v. Industrial Comm'n, 77 Ill.2d 482, 397 N.E.2d 804 (1979). The claimant need not, however, be reduced to total physical incapacity before a permanent and total disability award may be granted. Interlake, Inc. v. Industrial Comm'n, 86 Ill.2d 168, 427 N.E.2d 103 (1981). In determining whether a claimant is employable, his age, training, education and experience must be taken into account. E.R. Moore Co. v. Industrial Comm'n, 71 Ill.2d 253, 376 N.E.2d 206 (1978).

In Valley Mould & Iron Co. v. Industrial Comm'n, 84 Ill.2d 538, 419 N.E.2d 1159 (1981), our supreme court held that:

> Under A.M.T.C., if the claimant's disability is limited in nature so that he is not obviously unemployable, or if there is no medical evidence to support a claim of total disability, the burden is upon the claimant to establish the unavailability of employment to a person in his circumstances. However, once the employee has initially established that he falls in what has been termed the "odd-lot" category (one who, though not altogether incapacitated for work, is so handicapped that he will not be employed regularly in any well-known branch of the labor market) then the burden shifts to the employer to show some kind of suitable work is regularly and continuously available to claimant.

A prima facie case for "odd-lot" status may be established in one of two ways: (1) by showing a diligent but unsuccessful attempt to find work or (2) by showing that because of his condition, age, training, education, and experience he is unfit to perform any but the most menial tasks for which no stable market exists. Courier v. Industrial Commission, 282 Ill.App.3d, 1, 10, 668 N.E.2d 28, 5th Dist. 1996.

The Arbitrator finds that Petitioner met the burden of establishing that he fell into the "odd-lot" category and was totally and permanently disabled. Petitioner conducted a thorough and exhaustive job search over 1 year and was unsuccessful finding suitable employment. Petitioner contacted over 300 prospective employers during that period but received no job offer. Susan Entenberg, an experienced certified rehabilitation counselor and licensed clinical professional counselor, testified that Petitioner is not a good candidate for vocational rehabilitation and no stable labor market exists for him (PX.13) The Arbitrator finds that Petitioner has sustained his burden of proof that no stable job market exists and he is incapable of obtaining gainful employment. Alano v. Industrial Commission, 282 Ill.App.3d 531,668 N.E.2d 21, 217 Ill.Dec. 836 (1996).

Once the claimant shows that he falls into the "odd-lot" category, the burden shifts to the employer to show that some kind of suitable work is regularly and continuously available to the claimant. Valley Mould v. Industrial Commission, 84 Ill.2d at 547, 419 N.E.2d 1159, 1981. The

Arbitrator finds that Respondent failed to meet their burden of proof in establishing that a suitable and stable labor market exists for Petitioner. The Arbitrator finds Petitioner's testimony and the opinions of Susan Entenberg to be more persuasive than those of Dean Geroulis.

Therefore, the Arbitrator finds that Petitioner is permanently and totally disabled as an "odd lot" pursuant to Section 8(f) of the Act. Respondent shall pay Petitioner $449.71/week for life, commencing March 15, 2018, as provided in Section 8(f) of the Act.

WITH RESPECT TO ISSUE (M) SHOULD PENALTIES OR FEES BE IMPOSED UPON RESPONDENT?

THE ARBITRATOR FINDS AS FOLLOWS:

It is undisputed that Petitioner injured his right shoulder at work reaching for a tray/box above his head on January 1, 2014. Petitioner was issued light duty work restrictions which Respondent did not accommodate. On January 27, 2014. Dr. Lopez restricted Petitioner from all work activity. Respondent failed to issue Petitioner temporary total disability benefits. Consequently, Petitioner filed a 19(b) Petition for emergency hearing.

Initially, Respondent delayed payments of Petitioner's temporary total disability benefits for the following periods:

1/2/14 – 3/5/14 (63 days): $3,686.40;

3/6/14 – 4/30/14 (56 days); $3,276.80;

5/1/14 – 7/28/14 (89 days); $5,107.77; and

7/29/14 – 8/25/14 (28 days) $1,638.40.

Total: (236 days) $13,709.37 (RX.3.)

Respondent failed to issue Petitioner's temporary total disability benefits despite Petitioner's repeated request for the outstanding benefits.

Respondent also terminated payment of Petitioner's maintenance benefits without written notice in violation of Section 7110.70 for the following periods:

9/26/17 – 11/6/17 (42 days); $2,698.26 and

11/7/17 – 12/18/17 (42 days); $2,698.26

Total: (84 days) $5,396.52 (RX.3)

Petitioner requested timely payment of Petitioner's weekly maintenance benefit and filed a Petition for Penalties and Attorney's fees on October 24, 2017.

Pursuant to Section 19(l) of the Act *"In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse or reasonably delay payment of benefits under Section 8(a)... The Arbitrator or 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) have been so withheld or refused, not to exceed $10,000."* Pursuant to Section 19(l) *"A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay."* 820 ILCS 305/19(l). Respondent delayed payment of Petitioner's temporary total disability benefits for 236 days and delayed payment of maintenance benefits for 84 days. Therefore, Petitioner is entitled to 19(l) penalties of **$9,600.00** (236 days + 84 days = 320 days x $30/day = $9,600.00).

Furthermore, Respondent unreasonably and vexatiously delayed Petitioner's temporary total disability and maintenance benefits in the absence of any medical opinion in support of the denial of benefits in violation of Section 19(k). McMahan v. Industrial Commission, 183 Ill.2d 499,702 N.E.2d 545, 234 Ill.Dec.205 (1998) In fact, Respondent's own Section 12 examiner found Petitioner's right shoulder injury was causally related to the January 1, 2014 accident at work. (RX.2) Therefore, Petitioner is entitled to Section 19(k) penalties of 50% of the delayed

temporary total disability and maintenance benefits in the amount of **$9,552.95** ($13,709.37 + $5,396.52 = $19,105.89 x 50% = $9,552.95).

Finally, Petitioner is entitled to Section 16 attorney's fees of **$1,910.59** representing 20% of the 19(k) penalties ($9,552.95 x 20% = $1,910.59).

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

DIANNE SMITH,

Petitioner,

vs.

NO: 14 WC 21346
15 WC 20262

LURIE CHILDREN'S HOSPITAL,

Respondent.

19IWCC0233

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) of the Act having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical, and temporary total disability (TTD) 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. Indus. Comm'n*, 78 Ill. 2d 327 (1980).

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (4th Dist. 1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n*, 51 Ill. 2d 533, 536-37 (1972).

The Commission affirms the Arbitrator's Decision relative to the issues of causal connection and medical expenses incurred. However, the Commission affirms in part and modifies in part the Arbitrator's award for prospective medical care. The Commission notes that Petitioner's treating orthopedic surgeon, Dr. Ronald Silver, had recommended arthroscopic surgery for Petitioner's right shoulder as a result of her work injury on March 1, 2014. The Commission further notes that based on the evidence and Petitioner's testimony, Petitioner has not returned to Dr. Silver since October 8, 2014. The Commission therefore finds that Petitioner is entitled to further examination and diagnostic testing as Dr. Silver may deem necessary in order for him to decide whether arthroscopic surgery remains reasonably necessary to cure or relieve Petitioner from the effects of her accidental injury pursuant to Section 8(a) of the Act.

The Commission further modifies the Arbitrator's award for TTD. The Arbitrator found that Petitioner was entitled to TTD from March 1, 2014 through May 17, 2018. The Commission finds that Petitioner is entitled to TTD commencing March 4, 2014 through May 17, 2018, or 219 3/7 weeks. Petitioner first sought treatment at Northwestern Corporate Health Services on March 4, 2014. The physician at the occupational health clinic gave Petitioner light duty restrictions of no overhead work or lifting with the right arm. Respondent did not accommodate her restrictions. Therefore, the Commission awards Petitioner TTD from March 4, 2014 through May 17, 2018, or 219 3/7 weeks. The Commission strikes the Arbitrator's award of prospective TTD benefits as indicated on Page 13 of the Arbitrator's Decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on June 25, 2018, is hereby modified as stated above; all else is affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay all reasonable and necessary medical services of $5,131.00 to Advance Spine & Rehab Center, $2,252.00 to Athletico Physical Therapy, $654.00 to Northshore Orthopedics, and $8,724.00 to University of Chicago Hospital, for a total amount of $16,761.00, pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall receive a credit for any medical benefits that have been paid, and the Respondent shall hold the Petitioner harmless from any claims by any providers of the services for which the Respondent is receiving this credit, as provided in Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to further examination and diagnostic testing as Dr. Silver may deem necessary in order for him to decide whether arthroscopic surgery remains reasonably necessary to cure or relieve Petitioner from the effects of her accidental injury pursuant to Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to temporary total disability benefits of $280.55 per week for 219 3/7 weeks, commencing March 4,

2014 through May 17, 2018, 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 receive a credit of $3,943.24 for TTD previously paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all other amounts, including $6,944.17 in nonoccupational indemnity disability benefits, paid 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 the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $67,500.00. 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.

DATED: MAY 13 2019

DDM/pm
O: 5-1-19
052

D. Douglas McCarthy

Stephen Mathis

L. Elizabeth Coppoletti

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

SMITH, DIANE
Employee/Petitioner

Case# **14WC021346**
15WC020262

LURIE CHILDREN'S HOSPITAL
Employer/Respondent

19IWCC0233

On 6/25/2018, 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 2.07% 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:

1067 ANKIN LAW OFFICE LLC
JILL B WAGNER`
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

2965 KEEFE CAMPBELL BIERY & ASSOC
MATTHEW IGNOFFO
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

DIANNE SMITH.
Employee/Petitioner

v.

LURIE CHILDREN'S HOSPITAL.
Employer/Respondent

Case # 14 WC 21346

Consolidated cases: 15 WC 20262

19IWCC0233

An *Application for Adjustment 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-Eric Seal**, Arbitrator of the Commission, in the city of **Chicago**, on **May 17, 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] Is Petitioner entitled to any prospective medical care?

L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

M. [ ] Should penalties or fees be imposed upon Respondent?

N. [ ] Is Respondent due any credit?

O. [x] Other **Prospective Medical Care**

FINDINGS

On the date of accident, **March 1, 2014** , Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $ **21,882.64** ; the average weekly wage was $ **420.82** .

On the date of accident, Petitioner was **52** 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 $ **3,943.24** for TTD, $ **0.00** for TPD, $ **0.00** for maintenance, and $ **6,944.17** for other benefits, for a total credit of $ **10,887.41** .

Respondent is entitled to a credit of $ **10,887.41** under Section 8(j) of the Act.

ORDER

Medical benefits

The respondent shall pay reasonable and necessary medical services of $ 16,761.00 , as provided in Section 8(a) of the Act.

The respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $ 5,131.00 to Advance Spine & Rehab Center , $ 2,252.00 to Athletico Physical Therapy , $654.00 to Northshore Orthopedics, and $ 8,724.00 to University of Chicago Hospital , as provided in Sections 8(a) and 8.2 of the Act.

The respondent shall be given a credit for any medical benefits that have been paid, and the respondent shall hold the petitioner harmless from any claims by any providers of the services for which the respondent is receiving this credit, as provided in Section 8(j) of the Act.

Temporary Total Disability

The respondent shall pay the petitioner temporary total disability benefits of $ 280.55 /week for 219 5/7th weeks, commencing March 1, 2014 through May 17, 2018 , as provided in Section 8(b) of the Act.

The respondent shall pay the petitioner the temporary total disability benefits that have accrued from March 1, 2014 through May 17, 2018 , and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $ 3,943.24 for temporary total disability benefits that have been paid.

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

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

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

Signature of Arbitrator

June 20, 2018
Date

ICArbDec19(b)

JUN 25 2018

STATEMENT OF FACTS

The parties stipulated that the petitioner was 52 years old when she suffered an accident arising out of and in the course of her employment with the respondent March 1, 2014. (TA 4; AX1) She was a support service tech (TA 10) and maintained IV pumps, cleaned floors, organized equipment, etc. On the date of accident, she hurt her right shoulder when she picked up a 20 to 30-pound IV pump. (TA 11-12; 26) The petitioner's arm was bent back and she felt pain. She was able to finish her shift – but then she went home and still felt a lot of pain. (TA 12-13)

On March 4, 2014, the petitioner went to Northwestern Memorial Physicians Group, Dr. Meredith Belber, complaining of pain in her right arm after lifting a pump at work. (RX6) Dr. Belber diagnosed right arm strain and gave her light duty restrictions of no overhead work or lifting with the right arm for one week. She followed up March 11, 2014, and Dr. Jane Cullen also diagnosed right arm strain and gave her light duty work restrictions of no overhead work, no lifting over one to two pounds with her right hand, and to only use her right hand for fine motor skills/writing/desk work. (RX6) On March 18, 2014, Dr. Belber referred her to an orthopedic surgeon, ordered physical therapy, and continued her light duty work restrictions. (TA 14; RX6) The petitioner completed a course of physical therapy at Athletico Physical Therapy from March 25, 2014, through June 13, 2014. (PX5) On March 26, 2014, Dr. Belber discharged the petitioner from her care and deferred care to her orthopedic doctor. (RX6) The petitioner testified that the respondent never accommodated her light duty work restrictions. (TA 13)

The petitioner saw Dr. Anna Rosenbloom at the University of Chicago Medicine on March 25, 2014. (TA 15; PX2) She diagnosed right shoulder pain after an injury at work on March 1, 2014, and ordered MRI of the right shoulder and physical therapy. (TA 16; PX2) Dr.

Lewis Shi was present and agreed and signed the note electronically. MRI of the right shoulder was completed March 27, 2014, and it revealed rotator cuff tendinosis with a partial thickness insertional tear, biceps tendinosis with suspected interstitial tearing, subacromial/subdeltoid space fluid and possible debris versus synovitis, glenohumeral joint effusion, and labral abnormalities. (PX2)

On April 8, 2014, the petitioner saw Dr. Christian Skjong at University of Chicago. (PX2, pg. 16-17) Dr. Skjong reviewed the MRI and diagnosed rotator cuff tendinosis. The doctor noted increased signal at the insertion of the petitioner's supraspinatus with a small bursal sided tear and biceps tendinosis secondary to an injury at work. (PX2) The doctor gave her an injection in her right shoulder and recommended physical therapy, pain medications, and off work restrictions for one month. (TA 17) Again, Dr. Shi was present, agreed, and signed electronically.

The petitioner followed up May 9, 2014, and Dr. Shi diagnosed her with right shoulder rotator cuff partial tear and biceps tenosynovitis and noted that the injection provided her with 50% pain relief. He continued her off work restrictions for two months. (PX2) Dr. Shi administered another injection to her right shoulder June 6, 2014, and he continued her off work restrictions until July 1, 2014. He also discussed the possibility of surgery with the petitioner. The petitioner testified that the injections helped her pain a little for about a week or two but then her pain came back. (TA 17-18) She attended physical therapy with Dr. Jamie VanDenElzen at Advance Spine and Rehabilitation Center June 14, 2014, through August 23, 2014. (PX3)

The petitioner then sought a second opinion with Dr. Ronald Silver at Orthopaedic Specialists of the Northshore on July 19, 2014. (PX4) Dr. Silver reviewed her prior medical records and MRI in conjunction with his examination and diagnosed her with work related

rotator cuff impingement with partial thickness tear of the rotator cuff. (PX4) In his deposition, he testified that her MRI showed significant pathology and that:

> It demonstrated what appeared to be partial thickness tearing of the rotator cuff was present, inflammation of the rotator cuff was present. So – and there may have been a labral tear. So, the MRI had, I'd say, tons of relevant, important findings. (PX6, pg.14)

Based on his findings and the fact that her symptoms persisted after five months of conservative care, he recommended arthroscopic surgery of the right shoulder. (PX4) In addition to surgery, he recommended physical therapy, pain medications, and off work restrictions. Dr. Silver testified that it was his opinion that she had failed conservative care by the time of her first visit on July 19, 2014. (PX6, pg. 11-12) She followed up with him on August 29, 2014, and October 8, 2014, with continued pain complaints and limited motion and he continued to recommend arthroscopic surgery, pain medications, and off work restrictions.

On June 30, 2014, the petitioner presented for examination under section 12 of the act with Dr. William Heller at Midland Orthopedic Associates. (TA 18; RX3) Dr. Heller reviewed the MRI and agreed that it showed mild partial thickness insertional tearing of the supraspinatus tendon and mild tenosynovitis, but diagnosed her with a right shoulder strain with mild subacromial impingement syndrome. He noted that she had an injury at work lifting pumps, she sought prompt medical attention, her symptoms were consistently reported, but opined that her MRI did not show significant pathology; and, therefore, he could only causally relate the March 1, 2014, injury to residual pain complaints, but that those would not be significantly limiting in terms of right shoulder function. (RX3)

He further opined that Dr. Shi's treatment had been reasonable and necessary and he noted that he would question further therapy, but if she had evidence of adhesive capsulitis or other pathology causing stiffness and limitation of motion, he would recommend further therapy.

He recommended four more weeks of anti-inflammatory medication and ice, but opined that she did not need more injections or surgery. Finally, he opined that she could work light duty of no lifting or pulling over 20 pounds for four weeks and then could return to full duty work and be at maximum medical improvement. (RX3)

During his deposition, Dr. Heller confirmed that he anticipated MMI for the petitioner four weeks after his June 30th examination. However, he admitted that if he was the treating physician and a patient came back to him after four weeks with continued pain complaints, his next step would be to obtain more diagnostics tests. (RX3, pg. 32) He testified, "It's possible that I would have recommended more studies or even arthroscopy down the road." (RX3, pg. 33) He further testified that if the patient continued to have pain for three to six months, most practitioners would use that timeframe as an indication for arthroscopic surgery. (RX3, pg. 39) When asked how he would treat the petitioner if she was his patient with persistent pain for some length of time, he testified, "If she was my patient and I was her treating doctor and she still had disabling pain, then yes, I would recommend arthroscopy." (RX3, pg. 40)

The respondent obtained two Utilization Reviews from Dr. Yousuf on October 14, 2014. (PX7) Dr. Yousuf completed one UR for the recommended surgery and another for recommended medications. (PX7) For UR of the surgery, he considered ODG-TWC guidelines, the fact that her pain had persisted after conservative treatment for some time, and her MRI findings. Based on these findings, he opined that she had failed conservative care and recommended certification of the arthroscopic surgery. Dr. Yousuf then completed UR for Protonix, Hydrocodone, Terocin cream and patches, and Ketorolac DMSO gel, which were recommended by Dr. Silver. (PX7) He again used ODG-TWC guidelines and denied certification for these medications, but later certified Meloxicam and Ultram. (PX7)

The petitioner testified that initially she received temporary total disability benefits from the respondent, but that they ended at the end of July 2014. (TA 20) Her employment was terminated by the respondent. (TA 20) She received long term disability benefits from her employer for a period of time then began receiving social security disability benefits for her unrelated diabetes through the date of arbitration. (TA 21, 36)

On cross examination, the petitioner admitted to treating with Dr. A.K. Mathew for her diabetes and Guillain-Barre Syndrome. (TA 27-28) She explained her Guillain-Barre Syndrome as a nerve condition causing tingling and weakness in her extremities. (TA 28-29) She had this condition since 2001 and it is treated with a healthy lifestyle of exercising and eating right. (TA 44) She testified that of her 34 physical therapy visits that she had at Athletico, two were for her legs, and the rest were for the shoulder. (TA 32) The therapy helped her pain a little, but it never went away completely. (TA 32, 44)

The petitioner testified that the nerve pain she experiences from her diabetes and the Guillain-Barre Syndrome does not affect her right shoulder or cause it any pain. (TA 23) Before her injury March 1, 2014, she said she never had any pain in her right shoulder and could work for the respondent full duty while living with her diabetes and Guillain-Barre Syndrome. (TA 23) As of the date of arbitration, she still has right shoulder pain and cannot drive or do basic tasks due to her pain. (TA 24) She testified that if she was awarded the recommended surgery, she would get that treatment right away. (TA 25) When asked if she wanted to stay on social security disability and remain out of the work force, she said, "I'm not going to stay on disability for the rest of my life. I'm going to work at it and get better." (TA 37)

CONCLUSIONS OF LAW

In support of Decision of Arbitrator with regard to (F) causal connection, the Arbitrator makes the following conclusions of law:

It is the burden of every petitioner before the Worker's Compensation Commission to establish with evidence every disputed issue litigated at trial, including the issues establishing the respondent's liability for benefits. ***Board of Trustees of the University of Illinois v. Industrial Commission,*** 44 Ill.2d 207, 254 N.E.2d 522 (1969); ***Edward Don v Industrial Commission,*** 344 Ill.App.3d 643, 801 N.E.2d 18 (2003) For an employee's workplace injury to be compensable under workers' compensation, the petitioner must establish that the injury is due to a cause connected with the employment such that it arose out of the employment. ***Hansel & Gretel Day Care Center v Industrial Commission,*** 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991) "[A] claimant must demonstrate that his risk of the injury sustained is peculiar to his employment or that it is increased as a consequence of work." ***Brady v. Industrial Commission,*** 143 Ill. 2d 542, 550 (1991)

The Arbitrator finds that the petitioner's current condition of ill-being is causally related to her work accident. A causal connection between work duties and a condition of ill-being may be established by a chain of events including the petitioner's ability to perform the duties before the date of the accident, and inability to perform the same duties following that date. ***Pulliam Masonry v. Industrial Comm'n.,*** 77 Ill.2d 469, 471 (1979)

Per the previous findings of fact, accident and notice to the respondent are not in dispute. (AX1) Within a few days of March 1, 2014, the petitioner sought medical treatment and was given pain medications and put on light duty work restrictions. She was continued on light duty work restrictions through March 18, 2014, and was referred to an orthopedic surgeon for further care. (PX6)

She presented to University of Chicago on March 25, 2014, with continued pain complaints. Dr. Rosenbloom diagnosed her with right shoulder pain after an injury at work on March 1, 2014, and ordered MRI of the right shoulder and physical therapy. That MRI revealed rotator cuff tendinosis with a small partial thickness insertional tear, biceps tendinosis with suspected interstitial tearing, subacromial/subdeltoid space fluid and possible debris versus synovitis, glenohumeral joint effusion, and labral abnormalities. Dr. Shi reviewed the MRI and diagnosed her with a work injury, right shoulder rotator cuff partial tear and biceps tenosynovitis, and recommended physical therapy, pain medications, off work restrictions, and injections. He administered two injections to her right shoulder on April 8, 2014, and June 6, 2014, which the petitioner testified gave her temporary relief. Her pain persisted and Dr. Shi noted that they discussed surgery as a possible course of treatment. (PX2)

She then sought a second opinion with Dr. Ronald Silver on July 19, 2014. He diagnosed her with work related rotator cuff impingement and a partial thickness tear of the rotator cuff. (PX4) Again, per the previous findings of fact, he recommended arthroscopic surgery of the right shoulder. He also recommended physical therapy, pain medications, and gave her off work restrictions. She followed up on August 29, 2014, and October 8, 2014, with continued complaints of pain and limited motion and he continued to recommend arthroscopic surgery, pain medications, and off work restrictions. (PX4)

The respondent's examiner under section 12 of the act, Dr. William Heller, on June 30, 2014, saw the petitioner and reviewed medical records and diagnostic test results. He agreed that her MRI showed a partial thickness tear of the supraspinatus tendon as well as tenosynovitis. Dr. Heller diagnosed her with a work related right shoulder strain with mild right shoulder subacromial impingement syndrome and mild longhead biceps tenosynovitis. (RX3) He stated

that she had an injury at work lifting pumps, she sought prompt medical attention, her symptoms were consistently reported. He opined that her MRI did not show significant pathology. Therefore, he could only causally relate the March 1, 2014, injury to residual pain complaints, but that those would not be significantly limiting in terms of right shoulder function. (RX3)

The petitioner testified that she never had pain or treatment to her right shoulder prior to March 1, 2014. (TA23) She admitted that she also suffers from unrelated diabetes and Guillain-Barre Syndrome, a rare nerve condition that can cause numbness and tingling in the extremities, and that she has been treating that with Dr. A.K. Matthew. The respondent introduced prior treatment records from Dr. Matthew, but none of those records showed any prior treatment to her right shoulder prior to the work injury on March 1, 2014. While Dr. Matthew's records less than two weeks prior to this accident date note right arm pain for three weeks, beginning in January 2014, there is no indication of any treatment and no indication of any incident or trauma. (RX5)

The petitioner testified that neither condition has caused pain to her right shoulder. (TA 44-45) This is further evidenced by her testimony that before her injury on March 1, 2014, she was able to work full duty with the respondent. Even if the petitioner experienced and reported some prior complaints of pain in her arm, this does not preclude a finding of accident and causation.

Further, on cross examination, the respondent's section 12 examiner, Dr. Heller, testified that if a patient's pain complaints persisted over a period of time then most practitioners would use that timeframe as an indication for arthroscopic surgery, and that he would recommend arthroscopy if the patient was his. In addition, the respondent's UR by Dr. Yousuf also certified that right shoulder arthroscopic surgery would be appropriate.

Taking the record as a whole, the petitioner proved that her current condition of ill-being is causally related to her work injury. While Dr. Heller disputes any further care, he did causally relate his diagnosis of right shoulder impingement and tenosynovitis to the work injury and agrees that the MRI shows a partial thickness rotator cuff tear. (RX3) And, on cross examination he makes some concession regarding surgery. Further, the petitioner proved causation by the fact that she was working full duty as of March 1, 2014, sustained an undisputed work accident, and is now unable to work following that injury.

In support of Decision of Arbitrator with regard to (J) medical, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that medical services provided to the petitioner have been reasonable and necessary. Due to her work-related injury, she has required treatment in the form of doctor's visits, injections, diagnostic testing, medication, and physical therapy.

After her March 1, 2014 work injury, the petitioner sought care within a few days and was diagnosed with a right shoulder strain, given pain medications, physical therapy, and eventually was referred to an orthopedic surgeon. She presented to the University of Chicago and was diagnosed with a right shoulder strain and ordered physical therapy as well as MRI of the right shoulder. March 27, 2014, MRI revealed rotator cuff tendinosis with a partial thickness tear and labral abnormalities. Dr. Shi continued to treat the petitioner and recommended physical therapy, pain medication, and two injections. The petitioner received injections on April 8, 2014 and June 6, 2014, with some relief for a time. She completed a course of physical therapy at Athletico from March 25, 2014, through June 13, 2014.

On July 19, 2014, the petitioner saw Dr. Ronald Silver for a second opinion. He diagnosed the petitioner with work related rotator cuff impingement with partial thickness tearing of the rotator cuff. Dr. Silver recommended pain medications, physical therapy, and

arthroscopic surgery. The petitioner completed a course of physical therapy at Advance Spine & Rehabilitation Center from June 14, 2014, through August 23, 2014. She testified that the physical therapy gave her some temporary relief. She testified that as of the date of trial she has good days and bad days but that she still has pain. (TA 24)

On June 30, 2014, the petitioner complied with examination under section 12 of the act by Dr. Heller on behalf of the respondent. He diagnosed the petitioner with a right shoulder strain with mild right shoulder subacromial impingement syndrome and mild right shoulder longhead biceps tenosynovitis. He agreed with treatment recommendations of Dr. Shi up to the date of his examination and recommended further anti-inflammatory medication, ice, and light duty work restrictions to treat her condition. He did not agree that she needed further physical therapy or surgery. Dr. Heller saw the petitioner before Dr. Silver's treatment began.

Dr. Yousuf did Utilization Review at the respondent's request on the medications prescribed by Dr. Silver. Dr. Yousuf then completed UR for Protonix, Hydrocodone, Terocin cream and patches, and Ketorolac DMSO gel, which all were recommended by Dr. Silver. He again used ODG-TWC guidelines and denied certification for these medications but later certified Meloxicam and Ultram.

Here, all doctors agree that the course of treatment that the petitioner received was reasonable and necessary through the respondent's June 30, 2014, examination under section 12 of the act. Further, Dr. Heller did not estimate MMI until at least August 2014, per his report and deposition.

Dr. Silver treated the petitioner after this section 12 examination. He knew that she still had pain despite conservative measures she had undertaken as well as Dr. Heller's recommendations. Dr. Silver testified that there was nothing left to do but proceed with the

arthroscopic surgery. Dr. Heller did not know if her symptoms persisted past his recommendations of four weeks of ice and pain medications. He admitted that if she was his patient, he would then order more treatment to adequately treat her and diagnose her pain generator. Finally, he admitted that if the petitioner was his patient he would recommend arthroscopy. The respondent's UR physician, Dr. Yousuf, board certified in orthopedics, certified the petitioner's arthroscopic surgery.

Accordingly, the preponderance of the evidence establishes that the petitioner sustained a right shoulder partial thickness rotator cuff tear with impingement, failed conservative medical care, and now requires arthroscopic surgery. The Arbitrator therefore finds that the petitioner's medical care has been reasonable and necessary. The Arbitrator finds that the respondent has not paid all appropriate charges. The petitioner testified that her medical bills have not been paid as of the date of arbitration. (TA 24) The petitioner produced an itemization of all medical bills that remain unpaid. (PX1) This evidence indicates charges, various adjustments, payments, and outstanding balances. Since the treatment she received is deemed reasonable and necessary, the Arbitrator hereby awards the petitioner the amount(s) of her medical providers' outstanding balances listed in PX1: $5,131.00 to Advance Spine & Rehab Center; $2,252.00 unpaid balance to Athletico Physical Therapy; $654.00 to North Shore Orthopedics; and $8,724.00 to University of Chicago Hospital. (PX1)

In support of Decision of Arbitrator with regard to (K) prospective medical, the Arbitrator makes the following conclusions of law:

The evidence in this case supports the reasonableness, causal relationship, and necessity of further care for the petitioner in the form of the recommended arthroscopic surgery that the respondent's UR physician, Dr. Yousuf, certified, and the respondent's section 12 examiner, Dr. Heller, admitted on cross examination he would recommend. The petitioner exhausted

conservative treatments that only temporarily helped her symptoms, and she still has work restrictions. She testified that as of the date of arbitration, she was still experiencing pain and had been since she last saw Dr. Silver.

The evidence shows an undisputed accident where all doctors, including both of the respondent's experts, agree that her condition is causally related to the work injury and that she needs further treatment in the form of arthroscopic surgery to her right shoulder. The petitioner testified that as of the date of trial she would complete the recommended treatment right away if authorized by the respondent. Based on all of the above evidence, the Arbitrator awards prospective medical in the form of arthroscopic surgery as recommended by Dr. Silver.

In support of Decision of Arbitrator with regard to (L) TTD, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that the petitioner is entitled to weekly TTD compensation benefits from March 1, 2014, through May 17, 2018, a period of 219 5/7th weeks. The petitioner proved by a preponderance of the evidence that her current condition of ill-being is causally related to her work injury. She initially was placed on light duty work restrictions by Northwestern Memorial Physicians Group on March 4, 2014, which the respondent could not accommodate. Shortly thereafter, she was taken off work by doctors at University of Chicago, including Dr. Lewis Shi, on April 4, 2018, and she was continued off of work by him through July 19, 2014. She then presented to Dr. Ronald Silver on July 19, 2014. He continued her off work restrictions and indicated that she should continue to be off of work pending surgery. As of the date of arbitration, the petitioner still was pending surgery that the respondent's UR physician certified but was never authorized. The petitioner testified that she initially received temporary total disability checks from the respondent, but that they stopped sometime in July 2014. She did not receive any further temporary total disability benefits after that date.

The petitioner's medical records establish that she has been either on light duty work status or has been off of work since the date of injury through the date of arbitration on May 17, 2018. Therefore, the petitioner is entitled to weekly TTD compensation benefits for the time period ranging from March 1, 2014, through May 17, 2018, and pending arthroscopic surgery recommended by her treater, Dr. Silver.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF COOK	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GUILLERMINA ARROYO,

Petitioner,

vs. NO: 08 WC 24099

LA ESPANOLA TAPAS BAR,

Respondent.

19IWCC0234

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 reinstatement and being advised of the facts and applicable law, affirms and adopts the Arbitrator's denial of Petitioner's Petition to Reinstate as stated on the record, and which is made a part hereof.

Per the Amended Application for Adjustment of Claim filed August 7, 2008, Petitioner, Guillermina Arroyo was a 24-year old, single female with 2 dependents under the age of 18. Petitioner alleged injury to her right hand and her right knee while working on May 17, 2008.

Procedurally, this case was originally dismissed by Arbitrator Kurt Carlson for want of prosecution on June 16, 2011. It was reinstated on January 18, 2013. The case was then dismissed for a second time on August 11, 2015 and reinstated on December 8, 2015. It was then dismissed for a third time on May 9, 2016.

Petitioner subsequently filed her Petition to Reinstate on August 16, 2016. Per the Petition to Reinstate, Petitioner's attorney, James Ellis Gumbiner alleged that one of his associates, Eduardo Salgado was originally handling this case and was no longer employed by his firm. Attorney Gumbiner stated that attorney Salgado believed that this matter was returned to the call on May 9, 2016 and that he was in settlement negotiations with the Respondent. Attorney

Gumbiner argued that this matter should be reinstated as they have been diligent and have a meritorious claim.

Petitioner's Petition to Reinstate was heard before Arbitrator Carlson on September 12, 2016 and a record was made. At the hearing, Petitioner's attorney, Sal Phillips of James Ellis Gumbiner & Associates, argued that his predecessor thought the matter was returned to the call in May 2016 as they were in settlement negotiations with the Respondent. The Arbitrator denied the Petition to Reinstate.

In support of reinstating the claim, Petitioner's attorney argues that they were in settlement negotiations and a settlement was nearing. Further, Petitioner's attorney stated that the original attorney believed the case was returned to the call on May 9, 2016 as they were in settlement negotiations. He tendered to Respondent's counsel the medical records and made a settlement demand at that time. Therefore, they argue that the Commission should reinstated this case.

In response, Respondent argues that the case has been pending since May 29, 2008 and has been dismissed three times. They argue there have been no ongoing settlement negotiations, and there was one telephone conversation between the parties on March 30, 2016. During the telephone conference, Petitioner's counsel advised that this matter had to be litigated as the evidence showed that his client arrived to work drunk and was never allowed to clock in or begin her work. She was told to leave until she was sober. Petitioner's counsel sent a letter stating that they would be present at the Commission on May 4, 2016 to set this matter for hearing. No one appeared however, and the case was dismissed for a third time. As no medical reports or paperwork have been exchanged and Petitioner was not prepared for trial, the Respondent argues that the Commission should affirm the denial of the Petition to Reinstate.

Rule 9020.90 of the Rules Governing Practice before the Illinois Workers' Compensation Commission dictates the form and substance of Petitions to Reinstate. Subsection (c) states, in part: "The Arbitrator shall apply standards of fairness and equity in ruling on the Petition to Reinstate and shall consider the grounds relied upon by Petitioner, the objections of the Respondent, and the precedents set forth in Commission decisions."

On a Petition to Reinstate, the burden is on the claimant to allege and prove facts justifying the relief sought. *Banks v. Indus. Comm'n*, 345 Ill. App. 3d 1138, 1140 (2004). The decision to grant or deny a timely Petition to Reinstate is a matter which rests within the sound discretion of the Commission, and its determination will not be disturbed on review absent an abuse of that discretion. *Id.*; *See also Conley v. Indus. Comm'n*, 229 Ill. App. 3d 925, 930 (1992).

The Supreme Court in *Bromberg v. Indus. Comm'n* made it a point to note the following, citing the Decision of the Circuit Court, in its opinion in support of denying reinstatement in that claim:

> The endless delays, the endless failures of attorneys to appear without excuse, either real or apparent, to inform a hearing officer as to the reasons for delay has reflected for years adversely upon the effective administration of justice and continues to do so and will

> continue to do so until the Appellate Courts start acting to see to it that lawyers fulfill their responsibilities to their clients and appear on the days and dates set for hearing that move hearings to a proper conclusion. 97 Ill. 2d 395, 400 (1983).

This case was filed on May 29, 2008 and has been dismissed 3 times. The Petitionér claims that they exchanged medical records and were in settlement negotiations with Respondent. Respondent denied those statements. The Petitioner offered no evidence to support his statements. Petitioner's attorney only offered self-serving testimony that the former attorney thought this matter was continued and that they were in settlement negotiations. Here, Petitioner has the burden of justifying reinstatement of her claim after the Arbitrator had dismissed it for a third time. Absent some evidence justifying reinstatement of this matter, the Commission affirms the Arbitrator's denial of Petitioner's Petition to Reinstate.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator is hereby affirmed and adopted; and, the Petition for Reinstatement of the above-referenced claim is 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: MAY 16 2019

Douglas McCarthy

DDM/tdm
O: 5/1/19
052

Stephen Mathis

Elizabeth.Coppoletti

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TERRI ANDERSON,

Petitioner,

vs. NO: 15 WC 20617

WAL-MART STORES, INC., d/b/a WAL-MART,

19IWCC0235

Respondent.

DECISION AND OPINION ON REVIEW

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

CONCLUSIONS OF LAW:

I. Causation

A work-related injury need not be the sole or principal causative factor, as long as it was *a* causative factor in the resulting condition of ill-being. Sisbro, Inc., 207 Ill. 2d 193, 205 (2003). Thus, even if the claimant had a preexisting degenerative condition which made her more vulnerable to injury, recovery for an accidental injury will not be denied as long as she can show her employment played a role in aggravating or accelerating the preexisting condition. Id. at 204-5.

In denying the claim, the Arbitrator found it "significant that on cross-examination Dr. Li [Petitioner's treating physician following her second fall in May of 2015] testified that he would not be paid for his treatment of Petitioner's right knee unless it was found to be causally related to

the injury on 3/17/15." *See* Decision on Arbitration, p. 12. The Arbitrator also found it significant that Dr. Li admitted that no MRI was recommended for the right knee until after Petitioner reached maximum medical improvement for the injury on March 17, 2015, and after Petitioner sustained an intervening twisting injury to her right knee on or about May 1, 2015; and that Dr. Li could not say the injury on March 17, 2015 caused the meniscal tear. Id. This finding was premised on the Arbitrator's belief that Dr. Li's causal connection opinions were not based on the credible medical evidence.

There is no real question Petitioner had pre-existing degenerative disease in her right knee, or that she sustained a direct fall to her right knee on March 17, 2015. When she was seen the following day for treatment, she complained of stabbing pain and bruising over her right kneecap. Her examination revealed discoloration over the patella along with tenderness to palpation of the patella. X-rays were performed. Ultimately, she was diagnosed with a contusion and fracture of the right patella. (PX 3)

When she was released by the doctors at IWIN on April 20, 2015, she reported her symptoms were the same and that walking caused increased pain. She also told her physical therapist that her knee locked up and wouldn't move, bend or straighten, and that her right knee was still sore. It was sore on the outside of her knee. (T. 20, Px4, 4/20/15 visit) Petitioner returned to the hospital on April 21, 2015, with continued complaints of knee pain, despite being discharged at maximum medical improvement on April 20, 2015. (Px5)

While she did have an accident at home on or about May 1, 2015, it involved a twisting mechanism and not a direct blow to the patella. An MRI done on May 20, 2015 showed injuries to the lateral and medial femoral condyles with a subluxated patella. She was then seen by Dr. Li on May 27, 2015 and he noted her complaints of ongoing pain. His diagnosis was a stress fracture of the lateral femoral condyle as well as severe osteoarthritis of the patellofemoral joint. He also diagnosed a tear of the lateral meniscus. Ultimately, she had surgery on June 12, 2015. Dr. Li testified that he found chondral changes to the patella and femoral trochlea, as well as tear to the lateral and medial menisci. (Px 1 at 7,8)

The opinions of Dr. Li, Petitioner's treating physician, were more persuasive than those of Dr. Cohen, Respondent's Section 12 examiner. Dr. Li believed that the fall of March 17, 2015, was so severe as to cause a permanent aggravation to her underlying pathology. He based this belief, in part, on the fact that when Petitioner was first seen at IWIN, the concern for a fracture was significant enough that she was immediately referred out to an orthopedist. (Px1, p. 19) Dr. Li credibly testified that Petitioner had acute on chronic degenerative changes. (Px1, p. 15) In the work accident of March 17, 2015, Petitioner sustained a permanent aggravation of underlying damage of cartilage to the patella and femoral trochlea. Petitioner may or may not have had pre-existing medial and lateral meniscus tears, as well as chondral injury to the medial femoral condyle, and the fall aggravated that condition. (Px1, p. 17) Petitioner's pain was essentially the same in May of 2015 as it had been in March of 2015. (Px1, p. 17) Dr. Li testified that the Petitioner's fall onto her knees impacted her right femoral trochlea. He said that the fall caused damage to the cartilage under the patella and femoral trochlea. (Id. at 19, 34) With respect to the Petitioner's fall at home, Dr. Li testified that it did not significantly change her condition. (Id. at 17)

Dr. Cohen testified that Petitioner's work-related injury from the March 17, 2015 fall would not have resolved for approximately six weeks, which would have been the end of May. (Rx1, T. 51 and DepxEx2) Petitioner's injury from the March 17, 2015 fall had not resolved at the time of her second fall. It is unclear when the meniscal tear occurred, or whether Petitioner had sustained a fracture to her patella in the March 17, 2015 fall. (Rx1, p. 30, Px1, p. 17)

"Thus, when an employee's condition is weakened by a work-related accident, a subsequent accident, whether work related or not, that aggravates the condition does not break the causal chain. [citations omitted]. '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 ensuing condition.' citing *Global Products*, 392 Ill. App. 3d at 412." *PAR Electric v. Illinois Workers' Compensation Commission*, 2018 IL App (3d) 170656WC, ¶ 64. Petitioner's surgical findings and resulting treatment were consistent with the injuries sustained by Petitioner due to the mechanism of her fall at work. Based upon those surgical findings, Dr. Li's testimony, as well as Petitioner consistent complaints of pain notwithstanding the unsupported finding of MMI, the Commission finds Petitioner's fall at home failed to break the chain of causation between the accident and Petitioner's current condition of ill-being.

The Commission finds Petitioner proved by a preponderance of the evidence that her work activities were *a* factor in her current condition of ill-being with regards to her right knee.

II. Temporary Disability

On the Request for Hearing, Petitioner alleges entitlement to Temporary Total Disability benefits from June 12, 2015 through August 8, 2015. Petitioner underwent right knee arthroscopy with partial medial and lateral meniscectomy on June 12, 2015. (Px7) She was released back to work with restrictions on August 7, 2015. (Px9) Petitioner was unable to work as a result of the surgery and post-operative care, which was causally related to her March 17, 2015 injury. As Petitioner's stipulated average weekly wage is $664.00, the Commission finds Petitioner is entitled to Temporary Total Disability benefits of $442.67 per week from June 12, 2015 through August 7, 2015.

III. Medical

Having analyzed the medical records, the Commission finds Petitioner's treatment was reasonable and necessary pursuant to Section 8(a) and causally related to Petitioner's work injury. Respondent is ordered to pay the expenses associated therewith as outlined in Px10, subject to Section 8.2. Respondent shall have credit for amounts previously paid.

IV. Permanent Disability

Petitioner's work accident occurred after March 17, 2015; therefore, Section 8.1b is applicable. Section 8.1b(b) requires permanent partial disability be determined following

consideration of five factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. 820 ILCS 305/8.1b(b).

Section 8.1b(b)(i) – §8.1b(a) impairment report

Respondent submitted a §8.1b(a) impairment report showing an Impairment Class 0 with 0% Whole Person Impairment. The Appellate Court has held that an impairment report is not a prerequisite to an award of permanent partial disability benefits, but only that the Commission consider a report that complies with §8.1b(a). *Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, ¶48. As this impairment rating was prepared by the occupational medicine physician prior to when Petitioner was actually at maximum medical improvement, the Commission gives this factor no weight.

Section 8.1b(b)(ii) – occupation of the injured employee

Petitioner returned to her pre-accident job as a cashier. The Commission finds Petitioner's successful return to work is significant and gives this factor some weight.

Section 8.1b(b)(iii) – age of the employee at the time of the injury

Petitioner was 50 years old on the date of her accidental injury. Petitioner has several more working years and will therefore face any residual disability for a longer period. The Commission gives this factor greater weight in favor of increased permanent disability.

Section 8.1b(b)(iv) - future earning capacity

No evidence was offered to suggest the injury had any impact on Petitioner's future earning capacity. The Commission gives this factor no weight.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

Petitioner reported ongoing pain in her knee even when seen on April 21, 2015, by Dr. Hauter. On April 6, 2015, Petitioner reported ongoing knee pain localized to her right knee, while treating with the physical therapist. The physical therapy assessed Petitioner as suffering from subacute derangement of the knee related to trauma. Petitioner had ongoing complaints of right knee pain and ultimately underwent surgery on June 12, 2015, with post-operative therapy. She was returned to work August 7, 2015, albeit with restrictions. On that date Dr. Li noted some improvement to the Petitioner's pain but also some mild atrophy to the right quadricep. He recommended she continue with Mobic and do exercises at home. (Px 9) The Commission gives this factor greater weight.

Based on the above, the Commission vacates the Arbitrator's award of 5% loss of use of the right leg and finds that Petitioner sustained permanent partial disability to the extent of 15%

loss of use of the right leg under §8(e).

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $442.67 per week for a period of 8 1/7 weeks, from June 12, 2015 through August 7, 2015, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $398.40 per week for a period of 32.25 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 15% loss of use of the right leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $39,551.81 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 $56,105. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 16 2019

D. Douglas McCarthy

Stephen J. Mathis

L. Elizabeth Coppoletti

DDM/dmm
O:040919
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ANDERSON, TERRI
Employee/Petitioner

Case# **15WC020617**

WAL-MART STORES INC DBA WAL-MART
Employer/Respondent

19IWCC0235

On 5/24/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
JEAN A SWEE
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

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

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

TERRI ANDERSON,
Employee/Petitioner

v.

WAL-MART STORES, INC., dba WAL-MART
Employer/Respondent

Case # 15 WC 20617

Consolidated cases: _____

19IWCC0235

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Bloomington**, on **4/25/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [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 3/17/15, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $34,528.00; the average weekly wage was $664.00.

On the date of accident, Petitioner was 50 years of age, *single* with no dependent children.

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

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

Respondent shall be given a credit of $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 she is entitled to temporary total disability benefits from 6/12/15 through 8/8/15, as provided in Section 8(b) of the Act, given the fact that petitioner reached maximum medical improvement on 4/20/15 for her right injury on 3/17/15. The petitioner's claim for temporary total disability benefits is denied.

Respondent shall pay reasonable and necessary medical services for petitioner's right knee from 3/17/15 through 4/20/15, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $398.40/week for 10.75 weeks, because the injuries sustained caused the 5% 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.

Maureen H. Pulia

Signature of Arbitrator

5/8/17
Date

ICArbDec p. 2

MAY 2 4 2017

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 50 year old cashier, sustained an accidental injury to her right knee, that arose out of and in the course of her employment by respondent on 3/17/15. Respondent stipulates that petitioner sustained an accidental injury to her right knee on 3/17/15, and that all medical treatment and temporary total disability benefits paid through on or about 5/1/15 was reasonable and necessary and causally related to the injury petitioner sustained on 3/17/15. Respondent claims that there exists no causal connection, reasonable and necessary medical expenses, temporary total disability benefits, or nature and extent due on or after 5/1/15 due to an intervening injury petitioner sustained on that date.

Petitioner has worked for respondent on 26 years. She is a cashier on the 3rd shift. On 3/17/15 petitioner was working in the self-check area. She tripped on a floor mat and fell on her knees and outstretched arms on the linoleum floor. Petitioner tried to catch herself but was unable. Petitioner noticed immediate soreness in her knees. She also testified that she skinned her elbows. Petitioner continued working her shift. While she was working she noticed that her right knee was black and blue about the patella. She reported the injury to her employer and completed an accident report.

On 3/18/15 petitioner presented to Matthew Carr RN, APN, at IWIN for treatment. She gave a consistent history of the injury. She rated her pain at a 7/10 upon the initial onset. Her current pain was 0/10 with rest and walking, and 8/10 when climbing stairs. She complained of a stabbing tight pain with bruising on her right knee cap. Petitioner gave a history of lymphedema and arthritis in her left knee. An examination revealed moderate staging ecchymosis and tenderness over the patella. No edema was noted. Range of motion was normal and no crepitus was noted. There was no increased motion at MCL and LCL. An x-ray of the right knee showed moderate degenerative spurring throughout. Also noted was a fracture of the medial patella. Petitioner was assessed with a right knee contusion and right knee patella fracture. Petitioner was told to continue with over the counter meds for pain. Petitioner was given an ice pack to use for comfort and pain relief. She was referred to an orthopedic surgeon, and restricted to sedentary duty, lifting 10 pounds occasionally, and sitting mostly. Respondent accommodated her restrictions.

On 3/19/15 petitioner presented to Dr. Joseph Novotny at McLean Orthopedics for her right knee. She reported right knee pain post fall at work. Dr. Novotny examined petitioner and assessed petitioner with an injury to her right knee at work. Dr. Novotny was of the opinion that this was an exacerbation of her degenerative arthritis. He prescribed Toradol and assessed right knee pain.

On 3/24/15 petitioner returned to Carr at IWIN. She reported that her right knee was still sore with increased pain on stairs, or if the knee is bumped. She rated her pain at 7/10. She stated that she had seen Dr.

Novotny and was taking Naproxen prescribed by him. She stated that Dr. Novotny told her there was no fracture, just arthritis. She reported moderate pain with walking. Petitioner was examined and assessed with an improving right knee contusion. She was continued on Naproxen and given self care/home management for her right knee with ROM exercises, as needed for comfort. Petitioner was released to regular duty. She stated that she was able to self-modify her activities to avoid aggravating her right knee.

On 3/31/15 petitioner followed-up with Carr at IWIN. She reported that at times her right knee seemed worsened, mainly on the stairs. She stated that her right knee was swollen last night. She rated her pain at 5-6/10. She stated that she takes Aleve and Naproxen, and was working regular duty. Petitioner was examined and her assessment remained the same. Physical therapy was prescribed to speed up recovery. Petitioner was continued on regular duty.

On 4/2/15 petitioner followed up with Dr. Novotny for her right knee. She provided a consistent history of the injury on 3/17/15. New x-rays of petitioner's right knee were taken. Dr. Novotny examined petitioner. His assessment was that petitioner had persistent pain with her right knee after her work related injury. He believed this was just, an acute on chronic advanced degenerative joint disease. Dr. Novotny was of the opinion that petitioner was able to return to some her work activities, but was not able to push pallets at this time. He prescribed Relafen. He assessed osteoarthritis of the right knee and right knee pain.

On 4/6/15 petitioner presented for physical therapy with a history of constant, worsening right knee symptoms with weightbearing and rising motions. The therapist examined petitioner and assessed a provisional MT classification of derangement. He noted that her injury status was subacute. Further therapy was prescribed. The therapist was of the opinion that petitioner's rehab potential was inconclusive at that time. On 4/8/15 petitioner returned to physical therapy and reported that her symptoms were improving. She stated that her symptoms decreased with respect to stair use and transfers from sit to stand. She reported improved tolerance to standing at work. On 4/13/15 petitioner reported to the physical therapist that her symptoms were improving. She reported moderate complaints of lateral knee pain yesterday without cause. The therapist noted that petitioner was increasing her reps with right knee extension and flexion with no increased pain. The therapist noted that petitioner was making steady progress toward rehab goals.

On 4/13/15 petitioner returned to Carr at IWIN for evaluation of her right knee contusion. She stated that her symptoms had worsened the night before with lateral pain and tightness. However, her symptoms were now better. She denied any tightness in her right knee. Her only complaint was a little pain in the outside of the knee when walking. She had no pain to palpation on the knee. She reported increased pain at work. She rated her pain at a 3/10. She stated that she was taking anti-inflammatory medication prescribed by Dr. Novotny. She

also stated that she was working regular duty. Petitioner was assessed with an improving right knee contusion. Dr. Hauter anticipated discharging petitioner the next week. Petitioner was again released to work without restrictions.

On 4/20/15 petitioner reported to her therapist that her symptoms were better overall, despite her knee locking up the night before. Petitioner demonstrated no provocation with sit to stand. The therapist assessed that petitioner's rehab goals had been achieved. Petitioner was discharged with a home exercise program including instructions for monitoring recurrence of symptoms and appropriate frequency of exercises.

On 4/20/15 petitioner returned to Carr and saw Dr. Hauter at IWIN. She reported that her symptoms were the same. She complained of soreness in her knee. No patella pain remained. She noted that she had been released by ortho and physical therapy. She stated that she was working her regular job. Dr. Hauter examined petitioner and assessed resolved right knee contusion, and degenerative disease of the knees not caused or aggravated by the injury on 3/17/15. Dr. Hauter was of the opinion that petitioner's current symptoms were caused by her bilateral degenerative disease in her knees. He released petitioner without restrictions to her pre-injury baseline.

On 4/21/15 petitioner was referred for determination of her final impairment rating for the injury on 3/17/15. It was noted that petitioner's functional status had returned to baseline without persistent problems functioning. No limitations were noted. Petitioner was noted to be at maximum medical improvement. Petitioner was assessed with resolved right knee contusion and released without restrictions. She was also assessed with degenerative disease of the knees, not caused or aggravated by the injury of 3/17/15, that was identified as the cause of her ongoing symptoms, and with chronic lymphedema with suspicion for a recurrent infection. She was referred to her primary care physician for the lymphedema concerns. Petitioner's Impairment Rating was found to be 0% whole person impairment by Dr. Hauter.

On 4/21/15 petitioner presented to her primary care physician Dr. Madagula's office at CSF, Fort Jesse, and was seen by Nurse Practitioner Kendrick. Petitioner complained of leg swelling and bilateral knee pain. She noted that Dr. Novotny saw no fracture and advised her to lose weight. Petitioner reported worsening swelling of her left leg since Friday. Petitioner followed up for her left leg on 4/24/15 and 4/28/15.

On 5/8/15 petitioner returned to Dr. Madagula's office and was seen by Nurse Practitioner Kendrick and gave a history of catching her pants on her deck, falling and twisting her right knee, one week ago. She reported that she fell on her side, but twisted her right knee when she fell. She experienced immediate pain and swelling in her right knee. She stated that this was her first treatment for this injury. She also stated that she tried Norco

for the pain, which helped. An exam revealed positive lateral point tenderness, no effusion, no instability, and no platellofemoral crepitus. Petitioner was assessed with a right knee strain and prescribed hydrocodone-acetaminophen.

On 5/20/15 petitioner underwent an MRI of the right knee. The impression was insufficiency fracture in the lateral femoral condyle with intense marrow edema; subchondral injury in the posterior aspect of the medial femoral condyle; tear in the anterior horn of the lateral meniscus; and laterally subluxed patella with severe osteoarthritis at the patellofemoral compartment.

On 5/27/15 petitioner presented to Dr. Lawrence Li for her right knee pain. She reported that she fell and hurt her knee. She complained of pain mainly over the lateral aspect of her knee, worse with weightbearing. Petitioner was examined and assessed with right knee underlying osteoarthritis with a stress fracture of the lateral femoral condyle, and a lateral meniscus tear. He recommended a right knee arthroscopy. He also recommended the use of a walker.

On 6/2/15 petitioner returned to Dr. Magadula's office. The MRI of the right knee was reviewed. Petitioner stated that she was referred to Dr. Li following her most recent fall. She was examined and assessed with a tear of the right lateral meniscus, and osteoarthritis of the knee.

On 6/12/15 petitioner underwent a right knee arthroscopy with partial medial and lateral menicectomy, and abrasion chondroplasty of the medial femoral condyle, patella and femoral trochlea. This procedure was performed by Dr. Lawrence Li. Her diagnosis was right knee medial meniscus tear, lateral meniscus tear; Grade 3 chondral injury to the medial femoral condyle; Grade 4 chondral changes in the femoral trochlea; and Grade 3 changes in the patella. Petitioner followed up post-operatively with Dr. Li on 6/19/15. Petitioner also underwent a course of physical therapy. Petitioner returned to full duty work on 8/7/15.

On 9/4/15 petitioner last followed-up with Dr. Li. Petitioner reported that she was doing well and had no complaints. She reported that she was back to work without any problems. Dr. Li instructed petitioner to continue her home exercises, and return for followup as needed.

On 9/25/15 Dr. Li drafted a letter to petitioner's attorney, Jean Swee. He noted that he reviewed his office notes, and those of Dr. Novotny for 4/2/15; Matthew Carr of 3/18/15 and 3/24/15; and, Kristin Kendrick of 5/8/15 and 6/2/15. Based on these records, Dr. Li opined that the findings on 6/12/15 and petitioner's right knee are related to the work accident on 3/17/15 when she fell and injured her right knee. He further opined that all treatment that she had undergone with him was related to the work injury of 3/17/15.

On 1/21/16 the petitioner underwent a Section 12 examination performed by Dr. James Cohen, at the request of the respondent. Petitioner provided a consistent history of the accident on 3/17/15. She stated that she had pain in both knees before the accident. Petitioner provided a history of her treatment to date and her fall at home on her deck onto her knees. Dr. Cohen performed a record review and physical examination. His impression was that petitioner sustained a contusion on her right knee that resolved by 4/20/15. He was also of the opinion that this soft tissue contusion to her right knee did not aggravate her preexisting degenerative condition of her right knee as her symptoms returned back to normal. Dr. Cohen was of the opinion that petitioner clearly had a subsequent injury on 5/8/15 (sic) that aggravated her condition. These opinions were based on petitioner's history and his medical record review. Dr. Cohen opined that the current condition of petitioner's right knee did not bear any causal relationship to the 3/17/15 incident, based on the fact that she stated that she was having pain in her right knee prior to the injury on 3/17/15. He opined that she sustained a contusion to her right knee as a result of the injury on 3/17/15 that resolved by the end of May(sic). He noted that she subsequently had a significant trauma to her knees in May as noted in the May 8, 2015 report of Ms. Kendrick. He opined that he did not agree with any opinion that her right knee arthritis was exacerbated by the 3/17/15 fall. He opined that if petitioner was a surgical candidate it was not related to the injury on 3/17/15. He was of the opinion that there is no indication that she had a meniscus tear prior to the May 2015 incident when she slipped and fell on her deck. He opined that the care petitioner received for her right knee from 3/17/15 through April of 2015 was related to the 3/17/15 injury, and any care after April 2015 was not related to the 3/17/15 injury, but was related to a combination of her preexisting arthritis as well as the fall that occurred in early May 2015. Dr. Cohen was of the opinion that petitioner did not need any restrictions for her right knee as a result of 3/17/15 incident. He did not relate any restrictions to the left knee as there has been no change in her left knee status as a result of the 3/17/15 incident. He believed petitioner reached MMI for her right knee injury on 3/17/15 by 4/20/15. With respect to an impairment rating, Dr. Cohen noted that he would not apportion any of it to the incident that occurred on 3/17/15 because he did not believe that injury caused medial or lateral meniscus tears, nor did it aggravate her preexisting arthritis of the knee. He apportioned "zero" impairment to the 3/17/15 incident.

On 8/15/16 the evidence deposition of Dr. Lawrence Li was taken on behalf of petitioner. He stated that petitioner told him she fell and hurt her right knee on 3/17/15, had an MRI, and then followed-up with him. He noted that she reported that her pain was worse with walking, and her pain was in the lateral aspect of the knee. He testified that petitioner told him that her pain was sharp and aching, frequent, and an 8/10. He testified that she reported that since her injury her pain had remained the same, and was not any better or any worse. Dr. Li was of the opinion that petitioner had underlying osteoarthritis before the injury on 3/17/15. Dr. Li opined that

petitioner's diagnosis with respect to the injury on 3/17/15 was a permanent aggravation of underlying damage of the cartilage to the patella and femoral trochlea. He further opined that petitioner may or may not have pre-existing medial and lateral meniscus tears, as well as a chondral injury to the medial femoral condyle. He thought that the fall aggravated that condition on a permanent basis. He based these opinions on petitioner's continued pain since March of 2015. He believed that the pain petitioner had when he saw her was basically the same as it was since March. He believed her condition was essentially unchanged from the accident date until he saw her. He did not believe her accident in May substantially changed anything. Dr. Li opined that the accident on 3/17/15 contributed to or caused the need for the surgery he performed on 6/12/15. He further opined that the accident also caused a permanent aggravation of her pain and that led to the surgery on 6/12/15. He opined that the blow on the patella and the femoral trochlea on 3/17/15 would have caused further injury to the cartilage on the patella and femoral trochlea. He could not say if the blow caused the meniscus tears, but believed it was likely that it caused the stress injury to the lateral femoral condyle.

On cross examination Dr. Li testified that if he has not yet been paid for petitioner's treatment he will not be paid if petitioner's claim is not found fully compensable. He testified that his opinions with respect to causation are reliant entirely upon an accurate history as provided by petitioner. Dr. Li noted that Dr. Novotny never recommended an MRI, and that it was only recommended after the fall on 5/1/15. Dr. Li agreed that a patient can have an acute injury superimposed on a degenerative pathology, and then the acute injury heals, and the underlying pathology remains. Dr. Li testified that he could not say that the injury on 3/17/15 caused petitioner's meniscus tears. Dr. Li agreed that petitioner fell and twisted her right knee on 5/1/15, and that a twisting motion is a mechanism for a tear of a medial meniscus or a lateral meniscus. He also agreed that petitioner did not twist her right knee on 3/17/15, and there was no recommendation for an MRI of the right knee until after the twisting fall on 5/1/15. Dr. Li opined that as a result of the injury on 3/17/15 petitioner fell on her patella, impacting the femoral trochlea, and sustained further damage to those two structures. He also felt that it was likely the fall that caused the stress injury to the lateral femoral condyle, which would have healed with time. Dr. Li did not believe Dr. Novotny's findings suggest that petitioner's knee was healing. Dr. Li noted that petitioner weighed 330 pounds and that more weight causes more stresses on the joints.

On 11/16/16 the evidence deposition of Dr. Cohen, an orthopedic surgeon, was taken on behalf of respondent. Dr. Cohen reported that petitioner's complaints on 5/8/15 with respect to tenderness over her lateral aspect of the knee was noted for the first time. He was of the opinion that before this petitioner's complaints were with respect to tenderness over the patella. Dr. Cohen noted that when he reviewed the x-rays of the right knee from 3/18/15 there were osteophytes off the medial and lateral compartments, but no narrowing of the

medial or lateral compartments. He also noted that there was significant lateral patellar facet narrowing on the lateral view, and degenerative changes at the patellofemoral joint. Dr. Cohen was of the opinion that all conditions associated with petitioner's injury on 3/17/15 had resolved by 4/20/15. He opined that petitioner's condition of ill-being after 4/20/15 with respect to her right knee is not related to the injury on 3/17/15, but rather to her subsequent injury on 5/1/15. He opined that her surgery to her right knee was not related to the injury on 3/17/15. Dr. Cohen noted that following her fall on 5/1/15 she had immediate pain and swelling in her right knee that required the use of Norco. He also noted that the injury of 3/17/15 had no twisting involved, whereas the injury on 5/1/15 involved a significant twisting injury to her right knee. He opined that lateral and medial meniscus tears are more consistent with a twisting injury than a direct fall on the anterior aspect of the knee which occurred on 3/17/15. Dr. Cohen opined that petitioner reached MMI as a result of the right knee injury on 3/17/15 by 4/20/15 when Dr. Novotny placed her at MMI on 4/20/15.

On cross-examination, Dr. Cohen opined that petitioner sustained a contusion of her right patella as a result of the injury on 3/17/15. Dr. Cohen was of the opinion that a fall that injures the patella, such as the fall on 3/17/15 could cause a fracture. He agreed that she had swelling over the patella after the fall on 3/17/15. He was of the opinion that even if she had a nondisplaced fracture, it would have healed by six weeks.

Petitioner testified that currently her right knee is sore after a day of work. She also testified that bending, and walking too much makes her right knee worse. Petitioner has received raises since the date of accident and now makes $18.02 an hour. She continues to work as a cashier for respondent. Petitioner does nothing for her right knee pain. Petitioner testified that she received short term disability benefits from 6/12/15 through 8/8/15. These benefits were all paid in one check after she returned to work. Some of petitioner's medical bills were paid by Blue Cross Blue Shield, WalMart's indemnity insurance. Petitioner testified that Dr. Li was a doctor of her own choosing after she fell on her deck.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Petitioner alleges that her current condition of ill-being as it relates to her right knee is causally related to the injury she sustained on 3/17/15. Respondent claims that petitioner's current condition of ill-being as it relates to her right knee is causally related to the injury she sustained on 3/17/15 only through 4/20/15. The respondent claims petitioner was found to have reached maximum medical improvement with respect to her right knee on 4/20/15, and was released to full duty work without restrictions. The respondent further claims petitioner sustained an intervening accident to her right knee on or about 5/1/15 that broke the causal connection between her current condition of ill-being and her accident on 3/17/15.

Prior to the accident petitioner weighed over 300 pounds and had preexisting degenerative arthritis in her right knee that was symptomatic. Nonetheless, on 3/17/15 petitioner sustained an unrebutted accident to her right knee when she tripped on a floor mat and fell on her knees and outstretched arms on the floor. Petitioner did not twist her right knee. Instead, she fell right on her knees and also skinned her elbows. She noticed immediate soreness in her knees. Petitioner completed her shift.

She first sought treatment for her right knee the next day. She reported no pain at rest or walking, but did report pain of 8/10 when climbing stairs. She also reported bruising on her right knee cap. Tenderness and ecchymosis was noted, as well as tenderness over the right knee patella. No swelling was noted, and her range of motion was normal. There was no increased motion at the MCL or LCL. An x-ray of the right knee showed moderate degenerative spurring throughout. Petitioner was initially diagnosed with a fracture of the medial patella at the emergency room, but when Dr. Novotny examined her on 3/19/15 he noted that there was no fracture of the patella, only arthritis. He assessed her with an exacerbation of her degenerative arthritis.

On 3/24/15 Dr. Novotny assessed an improving right knee contusion and released petitioner to regular duty work. On 3/31/15 she reported increased pain, mostly with climbing stairs. At that time she was working regular duty and rated her pain at 5-6/10. Petitioner began a course of physical therapy.

On 4/2/15 Dr. Novotny assessed petitioner with an acute on chronic advanced degenerative joint disease. Petitioner continued in physical therapy for her right knee. On 4/8/15 she reported to the physical therapist that her symptoms were improving. On 4/13/15 petitioner told Dr. Novotny that her only complaint was a little pain in the outside of her knee when walking. She rated her pain at a 3/10. She reported that she was still working regular duty. On 4/20/15 petitioner reported that her symptoms were better overall. The therapist noted that petitioner's rehab goals had been achieved. Petitioner was discharged with a home exercise program. That same day she returned to Dr. Hauter and reported some soreness in her right patella. She reported that she was still working her regular job. Dr. Hauter assessed a resolved right knee contusion, and degenerative disease of the knees, not caused or aggravated by the injury on 3/17/15. Petitioner was released without restrictions to her pre-injury baseline.

On 4/21/15petitioner underwent a final impairment rating. It was noted that petitioner's functional status had returned to baseline without persistent problems with functioning. No limitations were noted. Petitioner was noted to be at maximum medical improvement. Petitioner was assessed with a resolved right knee contusion and released without restrictions. She was also assessed with degenerative disease of the knees, not caused or aggravated by the injury of 3/17/15, that was identified as the cause of her ongoing symptoms. Petitioner's Impairment Rating was found to be 0% whole person impairment by Dr. Hauter.

On 5/8/15 petitioner presented to Dr. Madagula's office and gave a history of catching her pants on her deck, falling, and twisting her right knee, one week ago. She reported that she fell on her side, and twisted her right knee when she fell. She reported that she had immediate pain and swelling in her right knee.

Following this twisting injury to her right knee on or about 5/1/15 petitioner underwent an MRI of the right knee on 5/20/15. It showed an insufficiency fracture in the lateral femoral condyle with intense marrow edema; subchondral injury in the posterior aspect of the medial femoral condyle; tear in the anterior horn of the lateral meniscus; and laterally subluxed patella with severe osteoarthritis at the patellofemoral compartment. Dr. Li assessed a right knee underlying osteoarthritis with stress fracture of the lateral femoral condyle and lateral meniscus tear. He recommended a right knee arthroscopy and a walker. Petitioner underwent a right knee arthroscopy with partial medial and lateral meniscectomy, and abrasion chondroplasty of the medial femoral condyle, patella and femoral trochlea. Dr. Li's diagnosis was right knee medial meniscus tear, lateral meniscus tear, Grade 3 chondral injury to the medial femoral condyle, Grade 4 chondral changes in the femoral trochlea, and Grade 3 changes in the patella.

By 9/4/15 petitioner reported that she was doing well and had no complaints. She reported that she was back to work without any problems.

Dr. Li opined that the findings on 6/12/15 and petitioner's right knee were related to the accident at work on 3/17/15, and all treatment she had undergone with him was related to the injury on 3/171/5. Dr. Li testified that after petitioner fell on her right knee of 3/17/15 she had an MRI and then followed up with him. He noted at that time her pain was worse with walking, was sharp, aching and frequent; and her pain level was at an 8/10. He also testified that petitioner told him her pain had remained the same since the accident on 3/17/15. Dr. Li testified that his causal connection opinion was based on petitioner's pain since 3/17/15. He believed her pain in her right knee from 3/17/15 until she saw him on 5/27/15 was essentially the same and that the injury in May did not essentially change anything. However, he could not opine that the blow to petitioner's right knee when she fell on 3/17/15 caused the meniscus tears.

The arbitrator finds it significant that on cross examination Dr. Li testified that he would not be paid for his treatment of petitioner's right knee unless it was found to be causally related to the injury on 3/17/15. The arbitrator also finds it significant that Dr. Li admitted that no MRI was recommended for the right knee until after she reached MMI for the injury on 3/17/15, and after she sustained an intervening twisting injury to her right knee on or about 5/1/15; that he could not say that the injury on 3/17/15 caused petitioner's meniscal tear; that a twisting motion is a mechanism for a tear of a medial meniscus or lateral meniscus, and petitioner did not

twist her right knee on 3/17/15; and that petitioner's fall on 3/17/15 likely caused the stress injury to the lateral femoral condyle, but that would have healed with time.

The arbitrator finds Dr. Li's causal connection opinions are not based on the credible medical evidence. The arbitrator finds it significant that following the accident on 3/17/15 petitioner's symptoms did in fact improve; that no MRI was recommended until after the injury on or bout 5/1/15; that petitioner was released to full duty work without restrictions after the 3/17/15 accident; that the injury on 3/17/15 did not involve any twisting mechanism; that petitioner was found to have reached MMI for her 3/17/15 accident on 4/20/15; and that on 4/21/15 Dr. Hauter assessed resolved right knee contusion, and provided an impairment rating of 0% of the whole person for her right knee injury on 3/17/15.

It was only after the twisting and falling injury on or about 5/1/15 that petitioner's right knee had swelled up and an MRI of the right knee was recommended that showed underlying osteoarthritis with a stress fracture of the lateral femoral condyle, and a lateral meniscus tear. Again, the arbitrator finds it significant that it was only after the injury on or about 5/1/15, and after the MRI of the right knee, that surgery was recommended for the first time and petitioner underwent a partial medial and lateral meniscectomy, and abrasion chondroplasty of the medial femoral condyle, patella and femoral trochlea.

Dr. Cohen opined that petitioner's complaints on 5/8/15, with respect to tenderness over her lateral aspect of the right knee, were only made for the first time after the injury on or about 5/1/15, since before that her only complaints were with respect to tenderness over the patella. He opined that all conditions associated with petitioner's injury on 3/17/15 had resolved by 4/20/15, and that her condition after that date with respect to her right knee was not related to her injury on 3/17/15, but rather to her subsequent injury on 5/1/15. Dr. Cohen opined that the injury on 3/17/15 involved no twisting, and the injury on or about 5/1/15 involved a significant twisting injury to her right knee, and that lateral and medial meniscus tears are more consistent with a twisting injury than a direct fall on the anterior aspect of the right knee which occurred on 3/17/15. Dr. Cohen did admit that a fall that injures the patella, such as the fall on 3/17/15, could cause a fracture, but it would have healed within six weeks.

Based on the above, as well as the credible evidence, the arbitrator finds the opinions of Dr. Cohen far more persuasive than those of Dr. Li, especially given the fact that Dr. Li clearly did not have a clear understanding of petitioner's medical condition as it relates to her right knee from 3/17/15 through 5/27/15, the first date he saw her. The arbitrator finds the opinions of Dr. Li are based on a belief that petitioner's condition between 3/17/15 and 5/27/15 remained unchanged, and this belief is clearly unfounded based on the credible medical evidence which shows that petitioner had sustained a right knee contusion or fracture of the patella that

essentially resolved by 4/20/15 with conservative treatment. On that day, petitioner told the physical therapist that her symptoms were better overall, and she had no difficulty sitting or standing. In fact, the physical therapist assessed that petitioner's rehab goals had been achieved. Petitioner also told Dr. Hauter that same day that she still had some soreness in her right knee, but no patella pain remained. At that time petitioner was also working full duty without restrictions. Dr. Hauter released petitioner without restrictions to her pre-injury baseline and was of the opinion that petitioner's current symptoms were caused by her bilateral degenerative disease in her knees.

Based on the above, as well as the credible evidence the arbitrator finds the petitioner's current condition of ill-being as it relates to her right knee is causally related to the injury she sustained on 3/17/15 only through 4/20/15, the date Dr. Hauter determined petitioner had reached maximum medical improvement and released her from his care, and released her to return to work without any restrictions. The arbitrator further finds all treatment after 4/20/15, other than the impairment rating of Dr. Hauter on 4/21/15, casually related to the intervening twisting accident petitioner sustained to her right knee on or about 5/1/15 when she caught her pants on her deck, falling and twisting her right knee.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Having found the petitioner's current condition of ill-being as it relates to her right knee is causally related to the injury she sustained on 3/17/15 only through 4/20/15, that arbitrator finds all medical services petitioner received to her right knee from 3/17/15 through 4/20/15 were reasonable and necessary to cure or relieve petitioner from the effects of the injury she sustained on 3/17/15. The arbitrator finds all treatment to petitioner's right knee after 4/20/15 not reasonable and necessary to cure or relieve petitioner from the effects of the injury she sustained on 3/17/15.

Respondent shall pay all reasonable and necessary medical services to petitioner's right knee from 3/17/15 through 4/20/15 pursuant to Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of $4,086.09 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner claims she is entitled to temporary total disability benefits for the period 6/12/15 to 8/8/15. Having found the petitioner's current condition of ill-being as it relates to her right knee is causally related to the injury she sustained on 3/17/15 only through 4/20/15, that arbitrator finds the petitioner is not entitled to any temporary total disability benefits for the period 6/12/15 to 8/8/15.

The arbitrator further finds the respondent shall be given a credit for short term disability benefits that have been paid from 6/12/15 through 8/8/15, 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

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 0% of a whole person as determined by Dr. Hauter, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. The Arbitrator notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation. The doctor noted that petitioner's functional status on 4/21/15 had returned to baseline without persistent problems functioning. He noted no limitations, and found petitioner was at maximum medical improvement. Dr. Hauter also assessed a resolved right knee contusion and noted that petitioner was released without restrictions. He assessed degenerative disease of the knees, not caused or aggravated by the injury of 3/17/15. Because of this, the Arbitrator therefore gives greater 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 cashier at the time of the accident and that she was able to return to work in her prior capacity as a result of said injury. The Arbitrator notes that following the injury on 3/17/15 petitioner was released back to full duty work without restrictions within a week of the injury. Because of this, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was50 years old at the time of the accident. Because of the fact that petitioner is currently working her regular duty job as a cashier without any restrictions or limitations, 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 the petitioner has received wage increases since the date of injury. Because of this, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that on 4/20/15 petitioner told the physical therapist that her symptoms were better overall. She demonstrated no provocation with sitting or standing. That same day she reported to Dr. Hauter that her symptoms were the same, and she still had some soreness in her knee, but had no patella pain. Petitioner was assessed with a resolved right knee contusion. However, the arbitrator finds it more likely than

not that petitioner also sustained a nondisplaced fracture of the medial patella that had healed by 4/20/15. Because of this, the Arbitrator therefore gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 5% loss of use of the right leg pursuant to §8(e) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Michael Vicich,
Petitioner,

19IWCC0236

vs.

NO: 12 WC 25657

SOI Sheridan Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 2, 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: MAY 17 2019
o4/18/19
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0236

VICICH, JOHN MICHAEL
Employee/Petitioner

Case# 12WC025657

SOI SHERIDAN CORRECTIONAL CENTER
Employer/Respondent

On 4/2/2018, 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 1.89% 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:

2839 DREW J FERRACUTI LAW FIRM
PO BOX 903
OTTAWA, IL 61350

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH P BLEWITT
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1350 CENTRAL MANAGEMENT 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

APR 2 - 2018

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

STATE OF ILLINOIS)
)SS.
COUNTY OF LASALLE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

John Michael Vicich
Employee/Petitioner

v. Case # **12** WC **25657**

State of Illinois, Sheridan Correctional Center
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Kankakee**, on **February 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. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [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 **July 21, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**54,934.90**; the average weekly wage was $**1,056.44**.

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**704.29**/week for **203 2/7** weeks, commencing **July 13, 2011** through **June 10, 2015**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $**64,168.50**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $**11,488.68** for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of $**704.29**/week for life, commencing **June 11, 2015**, as provided in Section 8(f) of the Act.

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

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

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

Arbitrator Anthony C. Erbacci

March 21, 2018
Date

APR 2 - 2018

FACTS:

Petitioner testified that on July 12, 2011 he was employed by the Illinois Department of Corrections as an Officer at Sheridan Correctional Center. He became employed with the Department of Corrections in 2004 after successfully passing a training program and physical exam.) He testified with regard to his duties as a Correctional Officer which involved extensive lifting, bending, stooping and climbing. He described the job as requiring custody, security and control of the offenders within the institution.

Petitioner testified regarding his educational and vocational experience. At the age of 17 he dropped out of high school to help support his family. Initially, he worked a variety of jobs including waiting on tables and dishwashing. Thereafter, he became employed with Caterpillar doing factory work and thereafter decided to become a union laborer. As a union laborer he engaged in general labor work eventually becoming a foreman and thereafter a steward. In 1981, he became Local 393 Business Manager until June 1, 1997 when he decided to retire due to family issues. Thereafter, he worked various jobs and in 2001 engaged in drug and alcohol counseling at a State of Illinois Department of Correctional facility which led to employment as a Correctional Officer.

On July 12, 2011 he was injured while attempting to restrain an inmate who was attacking another officer. Incident to the struggle, he went to the ground while attempting to handcuff the inmate and at that time he felt pain in the neck and shoulders. He described the pain as sharp. Prior to July 12, 2011 he had never sustained any significant injury to his neck and shoulders.

Following the accident, he sought treatment at Ottawa Regional Hospital emergency room. The emergency room records reflect Petitioner's initial complaints of pain in the neck and shoulder areas rated as 7 out of 10. Petitioner was examined, restricted from work and prescribed medication and follow up with a physician.

Thereafter, Petitioner came under the care of Dr. Paul Perona on July 18, 2011. Dr. Perona examined Petitioner and made an initial diagnosis of bilateral shoulder and neck pain. He prescribed pain mediation, no work and an MRI of the right shoulder. MRI of the shoulder on August 8, 2011 revealed possible articular surface tear supraspinatus tendon along with tendinosis. There was also noted some irregularity of the proximal tendon within the bicipital groove and a partial tear could not be excluded. Thereafter, Dr. Perona prescribed medication, physical therapy, no work, and MRI of the cervical spine. An MRI of the cervical spine was performed on September 9, 2011 which revealed posterior protrusion at C-4, C-5, C-6 discs along with desiccation and degenerative changes at various disc levels. Dr. Perona prescribed further physical therapy, medication, no work and referral to Dr. Jason Bergandi. Dr. Bergandi examined Petitioner on two occasions, December 15, 2011 and April 11, 2012 and prescribed no work, further diagnostic testing and referral to Dr. Eugene Becker.

Petitioner was examined by Dr. Becker on January 9, 2012 and prescribed epidural steroid injections, medication and no work. Petitioner received an initial injection on January 17, 2012 and was prescribed a TNS unit as well as medications and no work restriction. This treatment continued through May of 2012 when Petitioner was examined by Dr. Gunnar Andersson on May 17, 2012 at the request of the Respondent. Dr. Andersson's medical exam noted tenderness over the cervical spine and left shoulder with range of motion of the cervical spine severely decreased. It was noted that 1 of 6 non-organic physical signs were positive. Dr. Andersson agreed with Dr. Bergandi's treatment recommendations and also opined Petitioner may have injured his shoulder and neck on July 12, 2011. He felt that Petitioner had not reached medical maximum improvement.

Thereafter, Petitioner came under the care of Dr. George DePhillips on referral by Dr. Becker. Petitioner testified that Dr. Bergandi had a personal problem and could no longer treat him. Dr. DePhillips saw the Petitioner on August 28, 2012 through the early part of 2013 and noted multiple cervical disc protrusions and prescribed further diagnostic testing, physical therapy and follow up with Dr. Becker. Dr. DePhillips provided a physician statement to the State of Illinois on January 8, 2013 setting forth diagnosis of cervical radiculopathy and chronic neck pain with class 5 severe limitation of functional capacity and opined that Petitioner was totally disabled from his regular occupation and it is unknown when he would be able to resume any occupation.

Thereafter, Petitioner continued under the care of Dr. Becker and did not see Dr. DePhillips after January of 2013 as Dr. DePhillips moved his practice out of state. Petitioner testified that he continued to see Dr. Becker on a regular basis in 2013, 2014 and 2015. Dr. Becker prescribed medication, physical therapy, restriction from work and cervical injections on regular intervals.

On June 10, 2015, Dr. Becker provided a physician statement to the Illinois Department of Central Management Services setting forth that Petitioner was totally and permanently disabled from not only his regular occupation but also from any occupation. He reiterated those opinions in another physician statement on December 3, 2015.

Petitioner testified that he has continued under the care of Dr. Becker from 2016 through the date of arbitration hearing and has continued to be prescribed medication, restriction from any employment and injections on a regular basis. The last time Petitioner saw Dr. Becker prior to arbitration hearing was in December of 2017. Dr. Becker's treatment records and deposition testimony confirm this treatment history. Dr. Becker discussed referral to a surgeon and Petitioner testified that treatment discussed included the possible need for a fusion which he was "scared" to explore and preferred a conservative treatment program.

Dr. Becker testified that his diagnosis of Petitioner included degenerative disc disease in the cervical spine, herniated cervical disc, spondylosis of the cervical spine and myofascial pain along with cervical radiculopathy. He also opined that the accident was the primary cause of the injury sustained and the problems for which he has been treating Petitioner since the accident. Dr. Becker testified that Petitioner is permanently unable to return to any employment position.

Respondent obtained a record review opinion by Dr. Kern Singh on December 13, 2017. Dr. Singh diagnosed resolved cervical muscular strain and denied causal relationship and felt that treatment had been excessive in nature. He opined that Petitioner could perform regular full duty work without restriction and had reached maximum medical improvement with guarded prognosis.

Petitioner testified that at the present time he has difficulty sleeping because of symptoms in his neck with pain rating of 7 to 8. He stated that he wakes up sore and essentially lives in the downstairs level of his home. He stated that he has lost strength and activities around the house such as laundry, doing dishes and taking out garbage are difficult. He does not do any major house cleaning and does not do any yard work. He notices that his movement is limited and even dressing and lifting is difficult. He also reported that weather affects his condition causing pain in his neck and shoulder as well as tingling and numbness in his hands. He confirmed that since the work accident, he has not sustained any other accidents up to the date of arbitration hearing. Petitioner acknowledged that in the winter he travels to Mexico for a period of time to experience better weather as the snow and cold "kills me." The Petitioner testified that Petitioner Exhibit 1, medical bills summary was an accurate account of the charges for treatment for his neck and shoulders following the work accident.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

The Arbitrator finds that the Petitioner's current condition of ill being is causally related to the accidental injury. This finding is supported by Petitioner's credible testimony, the medical treatment records, and the opinion testimony of Dr. Eugene Becker.

Petitioner testified to an altercation at work when he injured his neck and shoulders. Respondent did not dispute accident and the initial Ottawa Regional Hospital emergency room records confirm accidental injury to the neck and shoulders with pain level of 7 out of 10.

Prior to July 12, 2011, the date of injury, the Petitioner had never sustained any significant injury to his neck and shoulders and he was able to perform all of the duties of his employment as a Correctional Officer. The Petitioner testified that he has not been able to return to work since his injury and that he has not sustained any other accident since July 12, 2011. Respondent did not offer any evidence to refute the Petitioner's testimony.

Dr. Eugene Becker testified that the diagnosed injuries to the Petitioner's neck and shoulders were causally related to the work accident and Dr. Becker records also support this opinion. In addition, the treatment records of Dr. Bergandi and Dr. DePhilllips reflect similar history of accident and injury diagnosis.

Respondent offered the report of Dr. Gunnar Andersson who examined the Petitioner and the record review report of Dr. Singh. Dr. Andersson's report confirms accidental injury and Dr. Andersson opined, "I do think that the patient may have injured his neck and shoulders on July 12, 2011." Though Dr. Singh opinined no causal connection, the Arbitrator gives little weight to his report completed over 6 years after the accident. In addition, the doctor ignores various treatment records and tests including MRI exams which support causation and a different diagnosis. Dr. Singh did, however, acknowledge history of accidental injury with guarded prognosis.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

The Arbitrator finds that the medical services provided were reasonable, necessary and required. This finding is based upon Petitioner's testimony as well as the testimony of Dr. Becker and the treatment records.

Dr. Becker testified that he believed his treatment as well as the treatment of the other physicians was reasonable, necessary and required.

Petitioner testified at arbitration that Petitioner Exhibit 1, medical bill exhibit accurately reflected the medical treatment and charges that he received following the accident involving his neck and shoulders.

Respondent's Independent Medical Examiner, Dr. Andersson opined that the Petitioner may have injured his shoulder and neck in 2011 and concurred with the treatment being prescribed by Dr. Bergandi. He also felt that Petitioner had not reached Maximum Medical Improvement as of his exam. Dr. Andersson did not render a conclusive opinion as to treatment received and the need for future treatment. Though Dr. Singh opined that the Petitioner's treatment was not reasonable and necessary, the Arbitrator does not give much weight to his opinion as he had never examined the Petitioner and his opinion seems unclear and unreliable given his statement of guarded prognosis.

Based on the aforementioned, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Respondent shall pay reasonable and necessary medical services totaling $64,168.50 and Respondent is entitled to a credit for payment of $11,488.68 as set forth in Petitioner Exhibit 1. Though Respondent offered Exhibit 4 which purports to be a summary of medical payments, the Arbitrator gives greater weight Petitioner's Exhibit 1 regarding amount of charges and worker's compensation payment credit. Respondent did not offer any evidence supporting its claimed credits under Section 8(j) of the Act.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Respondent shall pay Petitioner temporary total disability benefits of $704.29 per week for 203 and 2/7ths weeks commencing July 13, 2011 through June 10, 2015 as provided in Section 8(j) of the Act. This finding is based upon Petitioner's and Dr. Becker's testimony as well as various treatment records of Dr. Perona, Dr. Becker, Dr. DePhillips and Dr. Bergandi.

The Respondent stipulated at trial that it has not paid any temporary total disability benefits, temporary partial disability benefits or maintenance and therefore, no credit is awarded.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The Respondent shall pay Petitioner permanent and total disability benefits of $7()4.29 per week for life, commencing June 11, 2015 as provided in Section 8(f) of the Act. Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments paid by the rate of adjustment fund, as provided in Section 8(g) of the Act.

This finding is supported by Petitioner's testimony as it relates to the injury and his current physical limitations. It is also based upon Petitioner's employment experience, training and capabilities and age. An employee is totally and permanently disabled for the purpose of worker's compensation benefits when he is unable to make some contribution to industry sufficient to justify payment to him of wages. In arriving at a determination of an award for permanent and total disability, consideration must be given to the extent of the Claimant's injury, the nature of his employment, his age, experience, training, and capabilities. At the time of arbitration hearing, Petitioner was 67 years of age with education limited to G.E.D. In addition, his work experience is limited to physically demanding work including factory work, union laboring and as a Correctional Officer. In addition, Dr. Eugene Becker testified and opined in various records that as of June 10, 2015, Petitioner became totally and permanently disabled from any employment. Petitioner is also a Social Security Recipient.

The Respondent did not offer credible evidence to support a contrary permanency award. The Independent Medical Examination of May 17, 2012 set forth significant physical limitations and Dr. Andersson opined that Petitioner had not reached maximum medical improvement. Though Dr. Singh opined the Petitioner could return to work full duty, his opinion is based upon a record review which has little support given that Petitioner's treating doctors have opined that he could not return to work as Correctional Officer after June 10, 2015 and Dr. Becker opined that Petitioner is permanently unable to return to any gainful employment. Further, Dr. Singh opined that Petitioner's prognosis was guarded. Therefore, the Arbitrator gives little weight to Respondent's evidence regarding nature and extent of the injury.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF SAGAMON	)		

☒ 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

Alex Tolar, Jr.,
Petitioner,

19IWCC0237

vs.

NO: 17 WC 13114

City of Springfield,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 14, 2018, is hereby affirmed and adopted.

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

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

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

DATED: MAY 17 2019
o5/8/19
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

19IWCC0237

TOLAR JR, ALEX
Employee/Petitioner

Case# 17WC013114

CITY OF SPRINGFIELD
Employer/Respondent

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:

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

0332 LIVINGSTONE MUELLER ET AL
DENNIS O'BRIEN
620 E EDWARDS PO BOX 335
SPRINGFIELD, IL 62705

19IWCC0237

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

Alex Tolar, Jr.
Employee/Petitioner

v.

City of Springfield
Employer/Respondent

Case # **17** WC **13114**

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 **Springfield**, on **5/29/18**. By stipulation, the parties agree:

On the date of accident, **10/6/14**, 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 $**20,899.84**, and the average weekly wage was $**401.92**.

At the time of injury, Petitioner was **57** years of age, ***single*** with **no** 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 permanent partial disability benefits of $241.15/week for 25 weeks, because the injuries sustained caused the 5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall reimburse Illinois Medicaid, according to the fee schedule, for payments made for treatment by the Orthopedic Center of Illinois on 3/31/15 and Springfield Clinic on 2/18/15. Respondent shall further reimburse Molina Healthcare, according to the fee schedule, for payments made to Memorial Physician Services on 9/9/15.

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

10/11/18
Date

NOV 14 2018

ICArbDecN&E p.2

FINDINGS OF FACT

The Petitioner, Alex Tolar, is a sixty year old former employee of the Respondent, City of Springfield. Petitioner has a high school diploma and attended on year of Community College, during which time he did not earn any diplomas or certificates. Petitioner is currently employed by the Office of Speaker Madigan of the Illinois House of Representatives as a night shift custodian. Prior to his employment with the Respondent, Petitioner spent the majority of his career employed with the Illinois Department of Corrections and also worked for a period of time as a corrections officer in Atlanta, Georgia.

During his tenure with the Respondent, Petitioner worked as a "weed wacker" performing yard maintenance at Oak Ridge Cemetery. He began his employment with Respondent in May of 2014. Petitioner testified that the position was temporary and that he continued to work for Respondent until the job ended in November 2014.

Petitioner testified he was working for Respondent on October 5, 2014. He testified there had been a storm and a number of branches had fallen. He testified he was dragging a rather large branch which he estimated weighted approximately 50 pounds, when he backed over a stump and fell onto his back. Petitioner testified he felt a sharp pain in his lower back that did not radiate into his legs or buttocks. He also experienced pain in his wrist from attempting to break his fall.

On October 10, 2014, Petitioner presented to Midwest Occupational Health Associates (MOHA) for an initial evaluation of his lumbar spine. PX 1. Petitioner was evaluated by Dr. Jeffrey A. Brower. PX 1. Petitioner reported falling backwards while pulling a tree branch and falling onto his buttocks. PX 1. He further testified he had attempted to catch himself with his left hand. PX 1. Petitioner reported his hand was initially swollen, but it had since resolved. PX 1. Petitioner further reported feeling pain in his lower back at the time of the injury that had persisted. PX 1. He reported no radicular complaints. PX 1. He reported the pain was worse on the right than the left. PX 1. He further reported he was having trouble sleeping secondary to pain. He reported his pain as six to seven out of ten. PX 1.

Upon physical examination, Dr. Brower noted tenderness to palpation over the paraspinous muscles, especially on the right. PX 1. Further, Petitioner has some limited range of motion secondary to discomfort, especially on extension of the back, lateral side-to-side bending, and twisting of the torso. PX 1. Examination of the left hand was normal. PX 1. Dr. Brower diagnosed Petitioner with a lumbar strain. PX 1. He recommended Petitioner use ice or heat on the affected area and take over the county Tylenol. PX 1. Dr. Brower further prescribed naproxen and cyclobenzaprine. PX 1. Dr. Brower placed work restrictions of no living over 25 pounds and no repetitive waist bending. PX 1. Petitioner was also advised to avoid heavy lifting, pulling, or pushing. PX 1. Petitioner testified he was able to return to work with Respondent within these restrictions.

Petitioner returned to MOHA on October 17, 2014 where he was evaluated by Dr. Kristen Ferguson. PX 1. He reported that his wrist was completely back to normal, but he was continuing to experience discomfort in his low back. PX 1. He reported he could feel stiffness if he moved in a certain direction and he had to adjust when standing up. PX 1. Petitioner reported his pain was alleviated by medications. PX 1. Dr. Ferguson recommended Petitioner undergo physical therapy and prescribed Naproxen and acetaminophen. PX 1.

On October 29, 2014, Petitioner presented to Memorial Industrial Rehab for initial evaluation for physical therapy. PX 2. He subsequently began physical therapy on October 31, 2014 and continued to receive physical therapy from Memorial Industrial Rehab until November 12, 2014.

On October 31, 2014, Petitioner returned to MOHA for follow-up evaluation and was seen by Nurse Practitioner Rhonda Ryan. PX 1. Petitioner reported no change in his condition since his last visit, however he reported he had only had a physical therapy evaluation and had not yet begun therapy. PX 1. He further reported taking naproxen twice per day along with Tylenol. He testified he was unable to take his muscle relaxant as it made him very groggy in the mornings. PX 1. He further reported having trouble sleeping at night due to discomfort. PX 1. On physical examination, Petitioner continued to exhibit tenderness to palpation over the lumbar paraspinal muscles. He had increased pain with any extension or rotation. PX 1. NP Ryan recommended Petitioner move forward with physical therapy and continued work restrictions of no lifting over 25 pounds. PX 1. Petitioner was prescribed Skelaxin to replace cyclobenzaprine, in order to avoid morning grogginess. PX 1.

Petitioner returned to MOHA on November 14, 2014 and was seen by Dr. Ferguson. PX 1. He reported he was continuing to experience back pain. He reported having a good deal of discomfort throughout the day when he had to do a lot of activity. PX 1. He reported his symptoms were better with rest. PX 1. Petitioner continued to exhibit tenderness of the paraspinal muscles on exam. PX 1. Dr. Ferguson continued Petitioner's work restrictions and prescribed naproxen, Tylenol, and prednisone. PX 1.

On December 11, 2014, Petitioner returned to MOHA and was evaluated by Dr. Ferguson. PX 1. Petitioner reported some help from prednisone. PX 1. He continued to have trouble sleeping. PX 1. The pain continued to be located in the lumbar spine without radiation. PX 1. On exam, Petitioner exhibited a painful grimace when asked to lean backwards or bend over and touch his toes. PX 1. He was able to perform the activities, but it caused pain and soreness. PX 1. Dr. Ferguson recommended Petitioner undergo an MRI of his lumbar spine. PX 1. Dr. Ferguson further prescribed amitriptyline and refilled Petitioner's prescription for naproxen. PX 1.

Petitioner underwent an MRI of his lumbar spine on January 2, 2015 at Midwest Imaging. PX 3. The MRI revealed a mild disc bulge and facet hypertrophy resulting in mild canal stenosis at L4-5. PX 3.

Petitioner returned to Dr. Ferguson at MOHA on January 7, 2015. Dr. Ferguson reviewed Petitioner's MRI, which revealed an annular tear and mild disc bulge at L4-5 resulting in mild canal stenosis. PX 1. She opined this may be the cause of his ongoing discomfort. PX 1. Dr. Ferguson referred Petitioner to Dr. Koteswara Narla, a neurologist and pain management specialist, for evaluation for possible injections. PX 1. Dr. Ferguson restricted Petitioner from lifting greater than fifty pounds. PX 1.

On February 18, 2015, Petitioner presented to Dr. Narla. Petitioner reported his history of injury and ongoing lumbar back pain. PX 4. He noted no symptoms of radiation into the legs. PX 4. Petitioner rated his pain as seven to eight out of ten. Dr. Narla reviewed Petitioner's January 2, 2015 MRI and noted minimal disc bulging and degeneration at L4-5 with ligamentum flavum thickening, producing mild stenosis. PX 4. On examination Dr. Narla noted Petitioner felt some discomfort on straightening up after bending and had some tenderness in the low lumbar area. PX 4. Dr. Narla diagnosed Petitioner with persistent lumbar back pain, mostly axial in nature, secondary to degeneration and minimal disc bulging with annular tear at L4-5. PX 4. Dr.

Narla noted that as Petitioner's back pain was primarily axial, there was a minimal chance he would receive relief from a steroid injection. PX 4. Petitioner testified that he refused the offer of an injection as Dr. Narla had advised it would not likely provide relief. Dr. Narla prescribed Tramadol, cyclobenzaprine, and meloxicam, which Petitioner testified he took until completed. PX 4.

On September 9, 2015, Petitioner presented to Dr. Avinash Viswanathan, his primary care physician, with complaints of flank and lower back pain. PX 5. He indicated the pain was slightly better with urination, and further noted that he was unable to put weight on his lower extremity without losing balance. PX 5. He denied any pressure, pain, or burning with urination. PX 5. On physical examination Dr. Viswanathan noted left flank pain with light touch. He further noted that Petitioner was favoring his left side with transferring and wanted to stand through the appointment. PX 5. Dr. Viswanathan diagnosed Petitioner with left flank discomfort and lumbar back pain. Dr. Viswanathan ordered an x-ray of the lumbar spine and a urinalysis to rule out rule out a urinary tract infection. PX 5. The lumbar x-rays showed mild lumbar spondylosis and the urinalysis was within normal limits in all aspects. PX 5. Further, Dr. Viswanathan recommended Petitioner take over the counter medications for symptoms. PX 5.

Petitioner continues to experience pain in his lumbar spine. He testified that he will have pain after sitting for a long period of time. He testified that he was experiencing pain while sitting in the chair during Arbitration. Further, he generally experiences some pain and stiffness when he gets out of bed in the morning. Petitioner testified he continued to take over-the-counter pain medication, as well as Tramadol. Of note, Petitioner has been prescribed Tramadol for an unrelated shoulder condition, but testified the Tramadol helps alleviate his back pain as well. Petitioner testified he takes pain medication once a day.

Petitioner testified that he is not currently under any work restrictions. He testified that his current custodial job involves primarily lifting small trash cans of approximately one foot in height and wiping desks. He testified his job does not require him to do heavy lifting. He testified that occasionally other custodians assist in moving furniture between offices, but he is allowed to forego this activity by his supervisor.

CONCLUSIONS

Medical Benefits

The Arbitrator finds that all medical treatment set forth in the Findings of Fact above was reasonable and necessary medical treatment causally related to Petitioner's October 6, 2014 accident. Petitioner's Exhibit 6 sets forth the medical bills for said treatment. The Arbitrator notes that Respondent has paid all medical bills, with the following exceptions:

Date of service March 31, 2015 at the Orthopedic Center of Illinois was paid by Medicaid.

Date of service February 18, 2015 at Springfield Clinic was paid by Medicaid

Date of Service September 9, 2015 was paid by Molina Healthcare.

As the above treatment was related to Petitioner's work accident, the Respondent is ordered reimburse Illinois Medicaid, according to the fee schedule, for payments made for treatment by the Orthopedic Center of

Illinois on 3/31/15 and Springfield Clinic on 2/18/15. Respondent shall further reimburse Molina Healthcare, according to the fee schedule, for payments made to Memorial Physician Services on 9/9/15.

Nature and Extent

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 the record reveals that Petitioner was employed as a groundskeeper at the time of the accident. Petitioner was able to return to work with Respondent light duty, and continued his position with Respondent until the planned end-date of the position. The Petitioner is not under any current work restrictions and has returned to full duty work as a night shift custodian for the House of Representatives. The Arbitrator notes that the Petitioner's current position is rather low impact, and only involves lifting of small trash cans and light cleaning. The Arbitrator further notes that the Petitioner self-limits his work activities, as he does not take part in moving furniture at the end of term. Because Petitioner has returned to full duty work in a less strenuous position and continued to self-limit his work activities. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 57 years old at the time of his injuries. The Arbitrator notes that at his age, the Petitioner is not expected to have a large number of working years ahead of him. Petitioner has obtained a less strenuous position and is not expected to work for a great number of years. 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 continues to experience pain in his lumbar spine, particularly when he gets up in the morning and after sitting for a long period of time. Petitioner continues to take over-the-counter pain medication and Tramadol for his pain daily. Petitioner's current complaints are consistent with his medical records. The MRI taken January 2, 2015 showed an annular tear and mild disc bulge at L4-5 resulting in mild canal stenosis. PX 3. Dr. Ferguson opined that this may be the cause of Petitioner's discomfort. PX 1. Further, when Petitioner presented to Dr. Narla on February 18, 2015, he continued to complain of lumbar back pain without radiculopathy. PX 4. Dr. Narla diagnosed persistent lumbar back pain of a mostly axial nature. PX 4. Dr. Narla noted that Petitioner's condition was due to degenerative disc disease and his annular tear and disc bulging at L4-5. Petitioner continues to complain of axial lumbar pain, which Dr. Ferguson and Dr. Narla have found consistent with Petitioner's MRI findings. Because the medical

records and evidence taken as a whole corroborate the Petitioner's complaints, the Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 5% loss of use of the person as a whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF PEORIA	)		

[X] 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	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joshua Taylor,
Petitioner,

19IWCC0238

vs.

NO: 14 WC 36844

Westaff,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 5, 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.

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: MAY 17 2019
o5/9/19
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0238

TAYLOR, JOSHUA
Employee/Petitioner

Case# **14WC036844**

WESTAFF
Employer/Respondent

On 6/5/2018, 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 2.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
HANIA SOHAIL
3100 N KNOXVILLE AVE
PEORIA, IL 61603

1886 LEAHY EISENBERG & FRANKEL LTD
MICHAEL MEHLICK
33 W MONROE ST SUITE 1100
CHICAGO, IL 60603

19IWCC0238

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

Joshua Taylor
Employee/Petitioner

v.

Westaff
Employer/Respondent

Case # **14** WC **36844**

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **April 17, 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. [x] Was timely notice of the accident given to Respondent?

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

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

K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

L. [x] What is the nature and extent of the injury?

M. [ ] Should penalties or fees be imposed upon Respondent?

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On **April 7, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* 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 $**Petitioner did not work 52 weeks prior to the accident**; the average weekly wage was $**644.70**.

On the date of accident, Petitioner was **31** years of age, *married* with **5** 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 $**2,445.48** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $55,011.67, as provided in Section 8(a) and 8.2 of the Act. The medical bills are to be paid to the Petitioner directly.

Respondent shall pay TTD benefits for a period totaling up to 27 weeks in the amount of $429.80/week

Respondent shall pay Petitioner PPD benefits for a period totaling up to 20.5 weeks in the amount of $386.82 per week representing 10% loss of Petitioner's right hand and pay Petitioner PPD benefits for a period totaling up to 18.975 weeks in the amount of $386.82 per week representing 7.5 % loss of use of Petitioner's right arm Pursuant to Section 8(e) of the Illinois Workers' Compensation 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.

20.5
18.975
39.475

Signature of Arbitrator

5/31/2018
Date

JUN 5 - 2018

Joshua Taylor v Westaff
14 WC 36844

Arbitrator Finding of Facts

Petitioner filed an Application for Adjustment of Claim claiming accidental injuries while working for Westaff on or about April 1, 2014, as a result of repetitive grinding, painting and sanding of frames. Petitioner alleged that the injuries he sustained involved his right arm and right hand. The Arbitrator notes that the parties prior to proceeding to a hearing filled out a stipulation sheet that was entered and admitted into the evidence as Arbitrator's Exhibit 1. The stipulation sheet filled out by parties' lists issues in dispute to be of accident, notice, causal connection, liability for medical bills, TTD and nature and extent of injuries.

Petitioner testified that he worked for Westaff from June 13, 2013 through May 4, 2014. The wage records entered into evidence confirmed the dates of employment. (PX 15) Petitioner testified that Westaff is a staffing agency and throughout his employment at Westaff he was actually performing work at Case CNH. Petitioner testified that at Case CNH his job title was that of a quality control personnel and painter. Petitioner testified that his job would require approximately 60% of painting job duties and 40% of quality control job duties. Petitioner testified that while working for Westaff, he would work anywhere from 8-12 hours per day 50-60 hours per week with 30 minutes of lunch and two 15 minute breaks.

As to Petitioner's job duties as a painter Petitioner testified that he would be responsible for painting very large tractor parts with electrostatic gun. Petitioner testified that he would use the electrostatic gun approximately 60% of the time. While painting, he used his dominant right hand to hold the gun which he activated by squeezing a trigger. He said that he would work with his right elbow flexed. With regards to Petitioner's job as quality control personnel, Petitioner testified that he would be required to use pneumatic tools like sanders, pneumatic hand- held grinders and needle guns. Petitioner testified that he did the Quality Control job 40% of the time. Petitioner testified that the pneumatic handheld grinder that he would use was approximately 3 feet long and required Petitioner to forcefully grip while he was grinding. Petitioner testified that this grinder would produce a significant amount of vibration. Petitioner testified that the pneumatic needle gun that he would use was 6 inches long and 4 inches wide. It would produce constant vibration and would require him to flex and extend his elbows. Petitioner testified that essentially all of the tools that he used while performing the job of a quality control personnel produced significant vibration.

The Arbitrator notes that Petitioner filled out Petitioner's Job Description Form was entered and admitted into the evidence as Petitioner's Exhibit 2. In reviewing this document, the Arbitrator notes that Petitioner's job duties were consistent with his testimony.

Petitioner testified that during the performance of his job duties he started experiencing problems with his right hand and right arm. Petitioner classified those problems as feeling constant throbbing in his right hand that would radiate down to his right arm. Petitioner testified that his symptoms would also include numbness and tingling in his fingers. Petitioner testified that when he was experiencing problems with his right hand and right arm he notified his supervisor, Bob McKinney. The Arbitrator notes that even though the Respondent disputes notice, Respondent did not present any testimony from Bob McKinney or from any other individual stating that notice was not provided to the Respondent. Petitioner said that he went to Mr. McKinney prior to the time he went to Dr. Kahn, his family doctor. Dr. Kahn's notes show that he first saw the Petitioner on April 7, 2014, at which time he complained of numbness and pain in his hands and forearms. (PX 5) Petitioner testified that he told Bob McKinney that he believed those problems to be related to his job duties that he was performing.

The Arbitrator notes that Petitioner's Exhibit 5 medical records of Dr. Khan reflect that Petitioner presented to Dr. Khan on April 7, 2014. The history noted by Dr. Khan indicates that Petitioner presented for complaints related to numbness followed by some pain in both hands and forearms for past 2 weeks. Petitioner indicated to Dr. Khan that the pain and numbness starts in his hands and then worsens and goes into his forearms as he continues to use his extremities. Dr. Khan noted that Petitioner currently works as painter and that Petitioner did not have similar episodes in the past. It was noted that Petitioner's symptoms were worse in right compared to the left and that Petitioner is a right-handed person. Dr. Khan during this visit diagnosed the Petitioner with bilateral numbness in his hands and forearms and prescribed Petitioner medication, a wrist brace and advised Petitioner to take a 2 to 3 minute break to stretch his upper extremities during work every half hour. Dr. Khan also noted that he will consider an EMG if Petitioner's symptoms fail to improve.

Petitioner testified that after the initial visit with Dr. Khan, he continued to have symptoms. Petitioner testified that he was trying to get in to go back to see Dr. Khan but was unable to and at Dr. Khan's recommendation went to Pekin Urgent Care. The Arbitrator notes that medical records of Pekin Urgent Care were entered and admitted into the evidence as Petitioner's Exhibit 6. The medical records reflect that. Petitioner presented to Pekin Urgent Care on April 24, 2014. During that visit, it was noted that Petitioner was having right arm pain for approximately 1 ½ months. Petitioner during this visit at Pekin Urgent Care was diagnosed with right tennis elbow and was provided medication. It was also noted that patient's complaints were due to a work-related injury.

Petitioner testified and medical records reveal that after going to Pekin Urgent Care Petitioner followed up again with Dr. Khan on June 4, 2014. During that visit, it was noted by Dr. Khan that Petitioner was experiencing bilateral elbow pain and had been using the brace that he recommended during the previous visit. Petitioner was provided additional medication and was recommended that Petitioner follow up with Dr. Khan in 3 months. Petitioner next followed up with Dr. Khan on September 18, 2014 at which time it was noted that Petitioner was there to follow up on his elbow pain. Petitioner was having bilateral elbow pain, worse on the right. It was noted that

Petitioner was using elbow brace regularly without any improvement and that he was taking Meloxicam without any improvement. It was noted that Petitioner's elbow pain is also associated with some tingling in his fingers every now and then. Petitioner during this visit was provided Ultram and was provided a prescription for an x-ray of the right elbow and an EMG. At the recommendation of Dr. Khan, Petitioner underwent the x-ray of the right arm at Pekin Hospital on September 18, 2014 and underwent the EMG study on October 13, 2014.

The Arbitrator notes that the EMG study performed on October 13, 2014 at IPMR was entered and admitted into the evidence as Petitioner's Exhibit 12. The EMG study noted that Petitioner is seeking medical attention for his right arm and wrist and that his current symptoms started sometime in March 2014. The EMG was positive for mild to moderate right median neuropathy. Dr. Russo, who performed the test, also noted that the Petitioner had clinical signs and symptoms compatible with right humeral epicondylitis. After the EMG study, Petitioner followed up again with Dr. Khan on October 20, 2014. Dr. Khan reviewed the EMG study with Petitioner and referred Petitioner to Great Plains Orthopaedics.

Petitioner testified and the medical records of Great Plains Orthopaedics reflect that he presented to Dr. Anane-Sefah on October 29, 2014. The history was that Petitioner was a 32 year old right hand dominant painter/quality control technician who had noticed increased painful paresthesia in his right hand radiating from the forearm to his finger. The pain was noted to be thumb, index and middle finger. It was noted that during his job at a temp agency Petitioner was performing a lot of painting as well as a lot of gripping. Dr. Anane-Sefah, after performing a physical examination and reviewing imaging studies, diagnosed Petitioner with right carpal tunnel syndrome and right lateral epicondylitis. Dr. Anane-Sefah recommended that Petitioner undergo a right carpal tunnel release and a right lateral epicondylitis injection.

At the recommendation of Dr. Anane-Sefah on November 20, 2014 at Unity Point Health, Petitioner underwent right carpal tunnel release and right lateral epicondylitis injection. Post-operatively Petitioner followed up with Dr. Anane-Sefah on December 1, 2014. At that time, it was noted by Dr. Anane-Sefah that the patient did not have any more numbness or tingling that was awakening him at night. It was noted that patient still had numbness in the ulnar 2 fingers and the radial 3. During this visit Petitioner's sutures were removed. Petitioner was to continue to remain off work. Petitioner next followed up with Dr. Anane-Sefah on January 5, 2015. During that visit, it was noted that Petitioner was still experiencing pain. During this visit Petitioner was recommended to attend physical therapy and was recommended to return to work with 25 pound limiting restriction.

The Petitioner attended physical therapy at ICPR in Pekin from January 16, 2015 to March 6, 2015. Petitioner next followed up with Dr. Anane-Sefah on February 5, 2015 at which point it was noted that Petitioner's right epicondylitis has returned. Petitioner was provided with another right epicondylitis injection and was instructed that

he could return to work with 25 pound lifting restriction. Petitioner was to follow up with Dr. Anane-Sefah in 6 weeks for a repeat check.

The medical records of Dr. Anane-Sefah's office reflect that on March 5, 2015 there was communication between Dr. Anane-Sefah's office and Petitioner stating that Petitioner would no longer be able to see Dr. Anane-Sefah since patient's insurance is out of network. Dr. Anane-Sefah testified that the Petitioner told his office that he was now lifting 50 pounds in therapy. Dr. Anane-Sefah then released him to return to work without restrictions and discontinued physical therapy. (PX 11 at 13)

Petitioner testified and medical records reflect that after being released from Dr. Anane-Sefah, he followed up with his primary care doctor on July 27, 2015, at which point he was complaining of right elbow pain. Dr. Khan noted that Petitioner had been having right elbow pain for 10-12 months but now cannot go to Great Plains Orthopedics due to Petitioner's insurance. During this visit Dr. Khan noted that Petitioner was to take Tramadol for pain and eventually will need to see orthopedic surgeon. Petitioner next followed up with Dr. Khan on August 6, 2015. Dr. Khan again noted that Petitioner was having epicondylitis pain in both elbows right worse than left. It was noted that Petitioner was trying to locate an orthopedic surgeon who will accept his insurance. Dr. Khan recommended that patient continue using elbow brace and he was to refer him to an orthopedic that will accept Petitioner's insurance. Petitioner testified that subsequently Petitioner was referred by Dr. Khan to Dr. Johnson at OSF Medical Group in Galesburg.

Medical records of OSF Medical Group were entered and admitted into the evidence as Petitioner's Exhibit 7. Medical records reflect that Petitioner presented to Dr. Johnson on October 6, 2015 complaining of right lateral elbow pain. Dr. Johnson's medical records note that patient initially had an injection in right epicondylitis when he underwent surgery for right carpal tunnel syndrome. It was noted that Petitioner had no improvement since that. Dr. Johnson during this visit administered a right lateral epicondylitis injection. Petitioner next followed up with Dr. Johnson on December 4, 2014. During that visit, another right lateral epicondylitis injection was performed. Petitioner testified and medical records reflect that subsequently Petitioner was referred to Dr. Potaczek at OSF Medical Group. Petitioner saw Dr. Potaczek on March 25, 2016. During this visit another right epicondylitis injection was administered. Petitioner testified that shortly after that he was able to go see Dr. Anane-Sefah again. Great Plains Orthopaedics was bought out by OSF Orthopedics, a place his insurance company allowed him to treat

Petitioner testified and medical records reflect that Petitioner followed up with Dr. Anane-Sefah on October 26, 2016. During this visit Dr. Anane-Sefah noted that Petitioner's condition with regards to his right elbow have been going on for over 2 years. He noted that Petitioner had multiple steroid injections by himself, Dr. Johnson and Dr. Potaczek with only very minimal relief. Dr. Anane-Sefah after noting failed conservative care recommended that Petitioner undergo a right lateral epicondylitis debridement with release.

At the recommendation of Dr. Anane-Sefah, Petitioner underwent surgical intervention at OSF on November 11, 2016 in the form of right lateral epicondylitis debridement with release. Post-operatively Petitioner followed up with Dr. Anane-Sefah on November 21, 2016. Petitioner then followed up with Dr. Anane-Sefah on December 29, 2016. During that visit, it was noted that Petitioner continued to progress very well with regards to his right lateral epicondylitis. Subsequently Petitioner last saw Dr. Anane-Sefah with regards to his right lateral epicondylitis on January 30, 2017. At that time Dr. Anane-Sefah opined that Petitioner could resume his regular activities as tolerated. During this visit Petitioner was discharged from care of Dr. Anane-Sefah for his right elbow. Petitioner testified and medical records reveal that Petitioner did not follow up with Dr. Anane-Sefah with regards to his right elbow after January 30, 2017.

The Arbitrator notes that Petitioner presented testimony of witness, Paul Pettyjohn. Mr. Pettyjohn testified that he worked at Westaff for approximately 6 months with Petitioner. Mr. Pettyjohn testified that Petitioner's job involved 60% working as a painter and 40% performing job duties of quality control. Mr. Pettyjohn testified that the quality control job duties required Petitioner to use tools such as a sander, needle gun and grinder. Mr. Pettyjohn testified that all of those tools did produce significant vibration.

As to present physical symptoms the Petitioner testified that after the surgery he obtained significant relief for both his right hand and right arm. Petitioner testified that currently he is not in need of any more treatment and is not taking any over the counter medication.

At the request of the Respondent Petitioner presented to Dr. Lawrence Li for an Independent Medical Evaluation on April 3, 2015. Dr. Li during this visit diagnosed Petitioner with right carpal tunnel syndrome and opined that if Petitioner did work, in fact, 40% in quality control and that required the use of pneumatic sanders, grinders and needle guns and the Petitioner's exposure was 24 hours a week then Petitioner's job would be causally related to Petitioner's right carpal tunnel syndrome.(RX 1) Dr. Li further opined that if Petitioner only painted at his job then the condition of right carpal tunnel syndrome would not be related to Petitioner's job as a painter. Dr. LI in his Independent Medical Evaluation report noted that Petitioner did not engage in any symptom magnification. The Arbitrator notes that Dr. Li also rendered an addendum on June 7, 2015. In that addendum Dr. Li discussed some emails that he received from Mr. Howzer and Clayton Adams. The emails suggest that Petitioner occasionally worked the air dry vac and used a piece of sandpaper for Scotch Brite pad but never 40% of the time performed job duties in quality control. Neither e-mail was placed into evidence. Dr. Li in his addendum report also noted that Petitioner never worked 40 hours per week, based again on an e-mail which was never introduced into evidence.

The Arbitrator notes that the evidence deposition of Dr. Li was taken and was entered and admitted into the evidence as Respondent's exhibit 3. During the deposition Dr. Li testified that if Petitioner did work 40% of the time using pneumatic

sanders, grinders and needle gun then those job duties would be causally related to Petitioner's right carpal tunnel syndrome. Dr. Li Dep. Tr. Pg. 15, 27. Dr. Li during his deposition admitted that he did not give any causation opinion with regards to Petitioner's right lateral epicondylitis. He also testified that prior to rendering his addendum report he did not review any paystubs to calculate the number of hours that Petitioner worked. Dr. Li admitted that occupational factors of carpal tunnel include exposure to vibration. Dr. Li Dep. Tr. Pg. 26. He also testified that constant gripping can also cause carpal tunnel syndrome. Id. Dr. Li in his deposition admitted that his ultimate causation opinion would be based on whether he believes the emails he received or believes Petitioner. The Arbitrator notes that the emails that Dr. Li received from various individuals discussing Petitioner's jobs were not entered and admitted into the evidence.

The Arbitrator notes that the deposition of Dr. Jason Anane-Sefah was entered and admitted into the evidence as Petitioner's Exhibit 11. Dr. Anane-Sefah during his deposition testified that his final diagnosis for the patient was right carpal tunnel syndrome and right lateral epicondylitis. Dr. Anane-Sefah Dep Tr. Pg. 19. Dr. Anane-Sefah during his deposition reviewed Petitioner's job description that was entered and admitted into the evidence as Petitioner's Exhibit 2. Dr. Anane-Sefah testified that he has previously looked at this document. He testified that the job duties that Petitioner filled out in Petitioner's Exhibit 2 are consistent with the job duties Petitioner advised Dr. Anane-Sefah that he performed at the employer. Dr. Anane-Sefah Dep Tr. Pgs. 19-20. Dr. Anane-Sefah testified that he has previously treated patients who had used tools similar to ones that Petitioner was using. He testified that he is familiar with the kind of exposure these tools produce and is familiar with the fact that these tools produce constant sustained grip along with vibration. Dr. Anane- Sefah testified that Petitioner's activities that he performed at the employer were causally related to his development of carpal tunnel syndrome and lateral epicondylitis. Dr. Anane-Sefah Dep Tr. Pgs. 24-25. He testified that his opinion is based on the work activities, his description that he could not perform those activities at work secondary to pain that he is experiencing in both of his nerve distribution with his painting activities as well as the pain in his lateral aspect of his elbow with lifting activities.

The Arbitrator notes that Petitioner presented an employee pay summary record as Petitioner's Exhibit 15. The Arbitrator notes that the pay summary record prior to the alleged accident date ran from June 9, 2013 through April 4, 2014. In calculating the number of hours Petitioner worked in this time period, it appears that Petitioner worked a total of an average of 40.69 hours per week. It further shows that the Petitioner worked during 41 pay periods during which time he was paid for overtime hours on 26 of those periods.

CONCLUSIONS OF LAW

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

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

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

In a repetitive trauma claim, the issues of accident and causation are considered together. A finding of accident requires a finding of a manifestation date. The manifestation date is the date the Petitioner knew or should have known of the injuries and that they were related to his work duties. The Arbitrator finds that Petitioner did sustain repetitive trauma accident related to his work duties for the Respondent, and that the manifestation date would have been April 7, 2014 when he was seen by Dr. Kahn.

The Arbitrator notes that Petitioner presented unrebutted testimony regarding his job duties. The Arbitrator notes that Petitioner's testimony, Petitioner's Exhibit 2 and the testimony of subpoenaed witness, Paul Pettyjohn are all consistent. The Arbitrator finds that Petitioner's job at the employer required him to work 60% of the time as a painter and 40% at quality control, where Petitioner was using tools that produced significant vibration. The Arbitrator notes that Respondent did not produce any evidence to rebut the evidence Petitioner presented regarding his job duties. The Arbitrator notes that Petitioner testified that on or about April 1, 2014 prior to going to see Dr. Khan when he was experiencing problems with his right arm and right arm he notified his supervisor, Bob McKinney. The Arbitrator notes that Respondent did not offer any testimony to rebut Petitioner's testimony regarding notice.

Consistent with Arbitrator's findings of facts the Arbitrator notes that Petitioner presented unrebutted opinion from Dr. Anane-Sefah regarding right lateral epicondylitis. The doctor opined that lifting with a constant sustained grip with the arm away from the body, along with repetitive elbow and wrist motion were the occupational factors associated with lateral epicondylitis. (PX 11 at 23) He went on to say that both the Petitioner's jobs as a painter and quality control person were causative factors. (Id at 24, 25) While the Petitioner was released without restrictions after his carpal tunnel release in March of 2015, Dr. Anane-Sefah noted during his last office visit in February that the Petitioner's lateral epicondylitis had returned. Thus there was no gap in symptoms from the time the Petitioner left his job with the Respondent until he ultimately had surgery on the elbow in November 2016. The Arbitrator notes that Respondent did not produce any evidence that Petitioner's condition of right lateral epicondylitis was not causally related to the job that Petitioner performed at Respondent.

With regards to Petitioner's right carpal tunnel syndrome. The Arbitrator notes that Dr. Li and Dr. Anane-Sefah both testified that if Petitioner performed quality control job 40% of the time then his condition is causally related to the work that Petitioner performed at the Respondent. Dr. Li changed his opinion based upon some e-mails from representatives of the Respondent which were never admitted into evidence.

Respondent argues that the Petitioner lacked credibility and as a result has failed to meet his burden of proof. With regards to the time the Petitioner worked, Respondent correctly argues that the Petitioner did not work 50 to 60 hours per week, as was his testimony. However, the Arbitrator notes that the Petitioner did average over 40 hours per week during the nine months prior to the onset of symptoms, and did use tools on each job which the doctors agreed could cause carpal tunnel. Dr. Li originally opined that 24 hours per week dong just the quality control job could cause the condition. The wage records, referenced in the facts statement, along with the testimony of the Petitioner and Mr. Pettyjohn, established that averaged close to that amount.

In addition, he primarily used his right hand while performing his entire job and his right arm was the one which was injured.

The Respondent argues several other reasons as to why the Petitioner lacked credibility. The Arbitrator finds those reasons to be insignificant. Most people underestimate their smoking history. The Petitioner denied filing a prior workers compensation claim but the evidence presented by the Respondent only established that claims in 2004 and 2007 were established by workers comp insurance carriers. Importantly, no medical evidence was presented to show any ongoing right upper extremity treatment between 2007 and 2014.

The critical testimony as to the work exposures came from Mr. Pettyjohn, a disinterested co-worker. He confirmed the percentage of the job which required the Petitioner to work with vibrating tools.

Based upon the above, the Arbitrator finds that the Petitioner has proven an accidental injury which manifest itself on April 7, 201 which was causally related to his job duties while with the Respondent, for which notice was given.

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

Regarding the issue of medical bills, the Arbitrator having found that there was an accident, notice and causal relationship between the accident and the Petitioner's conditions of ill-being, the Arbitrator awards medical bills as found in Petitioner's Exhibit 20 to the Petitioner with any credit given to the Respondent for any medical bills previously paid by the Respondent.

MEDICAL BILL LIST – Level 1

CLIENT: Joshua Taylor

DATE March 6, 2018

NAME OF PROVIDER	ACCOUNT NUMBER	DATE OF SERVICE	TOTAL AMOUNT OF BILL
Great Plains Orthopaedics	341284	10/29/14-02/05/15	$2,415.00
ICPR	TAYJOS0002	1/16/15-3/06/15	$1,318.00
IPMR	IPM536411/001	10/13/14	$1,068.00
OSF Healthcare	823069	10/06/15-01/30/17	$3,421.00
OSF St. Francis	31149895	10/04/16	$1,080.00
OSF St. Francis	31457678	11/11/16	20,988.71
OSF St. Francis	31583518	11/30/16	$307.00
OSF St. Francis	31583530	12/06/16/-12/27/16	$1,652.00
OSF St. Francis	31865273	01/03/17-01/24/17	$1,071.00
OSF St. Francis	31897392	01/11/17	$3,430.00
Pekin Hospital	6186357-0001	4/24/14	$102.00
Pekin Hospital		05/17/14	$224.60
Pekin Hospital	6248758-0001	11/04/14	$120.00
Pekin ProHealth	161649	04/08/14-10/19/16	$1,720.96
Unity Point Health – Methodist	308498093	11/20/14	$16,093.40
		Totals:	**$55,011.67**

The Arbitrator orders the Respondent to pay the Petitioner directly medical bills in the amount of $55,011.67 for reasonable and necessary medical treatment. The

medical bills are to be paid to the Petitioner directly at a rate prescribed by the Illinois Workers' Compensation Commission fee schedule.

(K) What temporary total benefits are in dispute?

Petitioner testified and the medical records reveal that Petitioner was taken off work by Dr. Anane-Sefah and was to remain on restrictions for his right carpal tunnel syndrome from November 20, 2014 to March 9, 2015 and with regards to his right lateral epicondylitis from November 11, 2016 to January 30, 2017. Based on that the Arbitrator finds that Petitioner is entitled to TTD benefits for a period totaling up to 27 weeks in the amount of $429.80 per week.

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

Pursuant to 820 ILCS 305/8.1(b) the Arbitrator finds the following factors in considering the Petitioner's nature and extent of the injury in this case:

The reported level of impairment pursuant to an AMA assessment.

The Arbitrator notes that there has been no AMA assessment performed in this case by either party. Therefore, the Arbitrator does not have any facts to consider as it relates to an AMA assessment.

The occupation of the injured employee.

The Arbitrator notes that Petitioner at the time of the accident was a painter and working in quality control. Petitioner testified that currently he works as a car detailing supervisor. The occupation does require the use of the right upper extremity, so the Arbitrator attached moderate weight to this factor.

The age of the employee at the time of the accident was 31 years old. As a younger individual, the Petitioner will have to work with is condition for a longer period than would an older worker.

The employee's future earning capacity.

The Arbitrator notes that no evidence is presented to reflect that Petitioner sustained a loss of earning capacity as a result of work related accident.

The evidence of disability corroborated with treating physicians' medical records.

Petitioner testified that he had a successful result after his right carpal tunnel release and right lateral epicondylitis debridement. The Arbitrator specifically noted that this testimony, which was consistent with the medical records from the

treating doctors as their treatment ended, supports the credibility of the Petitioner.

The Arbitrator notes that when Petitioner law saw Dr. Anane-Sefah on 1/30/17, it was noted that Petitioner was recommended to stay away from repetitive activities. With regards to Petitioner's right carpal tunnel syndrome Petitioner was last seen by Dr. Anane-Sefah on February 5, 2015. Petitioner was noted to have moderate tenderness about the pillar region.

Based on all of this and pursuant to Section 8.1 (b) of the Illinois Workers' Compensation Act, the Arbitrator awards Petitioner 10% loss of use of the right hand and 7.5% loss of use of the right arm.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

William Wemheuer,

Petitioner,

vs. NO: 17 WC 13999

Advanced Technology Services,

19IWCC0239

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 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. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 17, 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.

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

DATED: MAY 17 2019
TJT:yl
o 5/7/19
51

Thomas J. Tyrrell

Maria E. Portela

Deborah L. Simpson

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

WEMHEUER, WILLIAM
Employee/Petitioner

Case# **17WC013999**

ADVANCED TECHNOLOGY SERVICES
Employer/Respondent

19IWCC0239

On 7/17/2018, 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 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:

2208 CAPRON & AVGERINOS PC
STEPHEN SMALLING
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

0264 HEYL ROYSTER VOELKER & ALLEN
JESSICA M BELL
300 HAMILTON BLVD PO BOX 6199
PEORIA, IL 61601

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)

William Wemheuer
Employee/Petitioner

Case # **17** WC **13999**

v.

Consolidated cases: ____

Advanced Technology Services
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Bloomington**, on **June 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. [x] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of 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 31, 2016**, Respondent *was not* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**76,612.64**; the average weekly wage was $**1473.32**.

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 $ **to be determined by the parties** 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 $ **to be determined by the parties** under Section 8(j) of the Act.

ORDER

The arbitrator finds that Illinois had jurisdiction over the Petitioner and Respondent, as is stated in the accompanying Findings of Fact and Conclusions of Law.

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

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

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

Signature of Arbitrator

July 11, 2018
Date

JUL 17 2018

ADDENDUM

WILLIAM WEMHEUER VS. ADVANCED TECHNOLOGY SERVICES
I.C. NO.: 17 WC 013999

FINDINGS OF FACT

In June or July of 2015, the Petitioner initially applied for a job with the Respondent online in anticipation of relocating to Tampa, Florida. Following a visit to the proposed job site, Petitioner declined to accept the position and in lieu thereof applied for the position of traveling maintenance technician. At that point, Paola Alexandra Medina, a recruiter retained by the Respondent became involved in the hiring process. In addition, Petitioner spoke via telephone with Duncan Stace who was a supervisor with the Respondent. At this time, Plaintiff resided in Nevada, Duncan Stace was located in Peoria, Illinois and Paola Alexandra Medina was located in Mexico.

Following the initial recruiting process, the Petitioner was offered a job with the Respondent which was memorialized in correspondence dated August 25, 2015 from Ms. Medina to the Petitioner. (P.X. 1, R.X. 1) Petitioner did not draft or negotiate the terms of P.X. 1. This correspondence was executed by the Petitioner on that date and electronically returned to Ms. Medina.

Following the execution of this correspondence, Petitioner underwent a drug screen and background check while he resided in Nevada.

On September 21, 2015, the Petitioner traveled to Peoria, Illinois to engage in a mandatory week of onboarding activities conducted by the Respondent. Petitioner testified that he participated in a number of events including a safety program, lockout/tag out program, preparation of company documentation and completion of insurance and tax forms. Petitioner also executed various documents including a Non-

Disclosure/Restrictive Covenant agreement identified as Petitioner's Exhibit 3 dated September 21, 2015. Petitioner understood that as a condition of his acceptance of employment, he had to execute that agreement. Additional documentation generated during the onboarding week was executed by the Plaintiff as reflected in Petitioner's Exhibit 4 which consists of a screenshot of his "Workday" profile maintained by the Respondent. Petitioner testified all documents identified therein were provided to him the week of September 21, 2015 while present in Peoria. He further confirmed that all the information contained in the document profile was generated by the Respondent. Petitioner testified he understood he would not be assigned a job until all those activities had been completed and he had signed off on the Non-Disclosure Agreement. (P.X. 3) Petitioner was introduced as a new employee by the owner of the company and received his first work assignment at the completion of the onboarding week.

Kristin Mitchell testified on behalf of the Respondent. Ms. Mitchell is employed as a benefit specialist and is familiar with the Respondent's hiring procedures. She testified a prospective employee would initially be contacted by a recruiter who sets up an interview with the hiring manager. The recruiter then extends an offer if authorized to do so. Once the offer letter is returned, the recruiter marks them as hired in the recruiting application which triggers a notification to the HR system to upload the individual as an employee. Ms. Mitchell confirmed Petitioner's employee contract was dated 9-21-15 in the "Workday" system. (P.X. 4) This information would have been entered into the system by the Respondent. She further confirmed that if the Non-Disclosure Agreement (P.X.3) is not executed, the applicant is terminated.

Jason Scales testified on behalf of the Respondent. He was employed as an eFactory supervisor for the Respondent but had no personal involvement with the hiring and training of the Petitioner. He testified that before an applicant is placed into Respondent's "Workday" system, they would have to pass the background check, drug screening and accept the offer letter. To his knowledge, the only paperwork completed by an applicant in the hiring process is the signing of the offer letter and some insurance information. Mr. Scales did not address the conditional provisions contained in the offer letter nor execution of the Non-Disclosure Agreement mandated as part of the Petitioner's hiring process.

It is stipulated that the Petitioner sustained injuries in Indiana on October 31, 2016 while employed for the Respondent. The accident was entered into the Respondent's system "Industry Safe" which tracks accidents or safety issues of its employees. Petitioner has filed this claim with the Illinois Workers' Compensation Commission seeking benefits under Illinois law. The Respondent disputes the claim is subject to Illinois jurisdiction and in reliance thereon, has authorized payment of benefits pursuant to the workers' compensation laws of the State of Florida where Petitioner currently resides. The sole issue presented to the arbitrator is whether Illinois has jurisdiction over the subject claim. The parties reserved the right to address any other issues at a later date as Petitioner continues to receive temporary total disability and medical benefits pursuant to the laws of Florida.

CONCLUSIONS OF LAW

With respect to the issue of "O", does Illinois have jurisdiction over this claim, the Arbitrator finds as follows:

Illinois has jurisdiction over claims under the Act asserted by persons whose employment is outside the State of Illinois "where the contract of hire is made within the State of Illinois." 820 ILCS 305/1(b)(2) (West 2008) See also Mahoney vs. Industrial Comm'n, 218 Ill. 2d 358, 843 N.E.2d 317 (2006) A contract for hire is made where the last act necessary for the formation of the contract occurs. Cowger vs. Industrial Comm'n, 313 Ill. App. 3d 364, 728 N.E.2d 789 (1st Dist. 2000) In order for parties to enter into a valid binding contract, it is necessary that there be an offer, a **strictly conforming acceptance**, and consideration. Hedlund & Hanley, LLC vs. Board of Trustees of Community College District No.508, 376, Ill. App. 3d 200, 876 N.E.2d 1 (4th Dist. 2007) (emphasis added). Strict conformance between offer and acceptance is required for contract formation in Illinois. Snow vs. Shulman, 325 Ill. 63, 185 N.E. 62 (1933)

In addressing the issue of a formation of a contract, a distinction must be drawn between preliminary negotiations toward an agreement and the actual existence of a final contract. No contract is formed until an execution and delivery of a formal agreement where the parties' intention is that neither will be legally bound until such execution and delivery of a formal document. Leekha vs. Wentcher, 224 Ill. App. 3d 342, 586 N.E.2d 557 (1st Dist. 1991) In Illinois, an offerer has right to prescribe in his offer any conditions as to time, place, quantity, **mode of acceptance**, or other matters which it may please him to insert in and make a part thereof, and the **acceptance**, to conclude the agreement, must, in every respect, meet and correspond with the offer, neither falling short of, or going beyond the terms proposed but exactly meeting them at all points and

closing with them just as they stand. Martin vs. Sparrow, 258 Ill. App. 482 (2nd Dist. 1930) (emphasis added)

In this case, the offer of employment extended to the Petitioner by the Respondent is set forth in Petitioner's/Respondent's Exhibit 1. This offer of employment, drafted by the Respondent, specifically and unambiguously provides that **acceptance of the offer was conditioned** upon Petitioner doing the following:

1) Petitioner "will be required to sign a Non-Disclosure/Restrictive Covenant Agreement." and
2) Petitioner "will also be required to complete our new employee webinar course which will be part of your first week onboarding activities". (P.X.1/R.X.1)

The Petitioner's acceptance of Respondent's offer of employment could not be deemed final until such time as he satisfied the conditions incorporated into the offer by the Respondent. The last act necessary for the formation of this employment contract drafted by the Respondent occurred upon the execution of the Non-Disclosure Agreement by the Petitioner and his completion of the New Employee Webinar Course. The evidence established that this took place while the Petitioner was in Peoria, Illinois engaged in the onboarding activities commencing September 21, 2015. Petitioner's Exhibit 3 consists of the Non-Disclosure/Restrictive Covenant Agreement executed by the Petitioner and a representative of the Respondent on September 21, 2015. The Petitioner further testified that he completed the "New Employee Webinar Course" during his onboarding activities in Peoria during the week of September 21, 2015. These acts constituted final satisfaction of conditions promulgated by the Respondent in its offer of employment. (R.X.1)

Petitioner's Exhibit 4 identifies documentation generated in conjunction with Petitioner's contract of hire with the Respondent. Ten separate items, including

Petitioner's Exhibit 3, are identified therein, all of which were executed by the Petitioner during the week of September 21, 2015 in Peoria, with the exception of the mobile agreement signed on February 9, 2016. Petitioner testified to his participation in various activities while present in Peoria. Respondent's Exhibits 6, 7 and 8 consist of documents confirming the completion of certain activities all which occurred during the week of September 21, 2015 in Peoria, Illinois.

The Petitioner testified it was his understanding he would not be allowed to perform services on behalf of the Respondent until such time as he had completed all of the onboarding activities while in Peoria, Illinois during the week of September 21, 2015. He did not receive his first directive from Duncan Stance, his supervisor, until the conclusion of that week. Kristen Mitchell identified Petitioner's Exhibit 5 as being a true and accurate depiction of the Petitioner's job profile on the Human Resources website maintained by the Respondent. This Exhibit confirms that the Respondent designated the Petitioner's original hire date to be September 21, 2015 which triggered his continuance service date effective thereafter. There is no information contained in Exhibit 5 which reflects that the Petitioner was hired prior to completing the onboarding activities while present in Peoria, Illinois during the week of September 21, 2015.

It is clearly stated in the offer of employment letter that the Petitioner had to sign a Non-Disclosure/Restrictive Covenant Agreement "As a condition of your acceptance of this position…" (RX 1) While the Petitioner may have received the agreement before he traveled to Illinois, it is clear that it was executed by both him and the Respondent on September 21, 2015 in Peoria, Illinois. (PX 3) The language in the offer letter is unambiguous. The above referenced non disclosure agreement was a condition precedent

to the employment contract. The last act necessary to form the agreement took place in Illinois.

Given the foregoing, the Arbitrator finds that the Respondent was operating under and subject to the Illinois Workers' Compensation Act at the time the Petitioner sustained his injuries of October 31, 2016 arising out of and in the course of Petitioner's employment by the Respondent.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF COOK	)		

[X] 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	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sandra Bintz,

Petitioner,

vs.

NO: 17 WC 25014

19IWCC0240

Jewel-Osco,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 26, 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.

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

DATED: MAY 17 2019
TJT:yl
o 4/23/19

Maria E. Portela

Barbara N. Flores

DISSENT

I respectfully dissent from the opinion of the majority and would reverse the Decision of the Arbitrator in its entirety. After carefully considering the evidence, I believe Petitioner met her burden of proving that the August 1, 2017, right shoulder injury occurred due to an accident arising out of and in the course of her employment. Petitioner's testimony as well as the video evidence submitted by Respondent support a finding that Petitioner sustained a compensable right shoulder injury on the date of accident.

I believe the majority unnecessarily focuses on minor inconsistencies in Petitioner's testimony and disregards the irrefutable evidence of a compensable work injury. The majority has fixated on the fact that Petitioner was wearing a walking boot on her right foot instead of slip resistant shoes, and that Petitioner placed a plastic garbage bag around her right foot and leg while working. When one evaluates all the evidence, it is clear Petitioner's injury is compensable pursuant to the Act.

There is no question that Petitioner's right shoulder injury occurred in the course of her employment. After all, it is clear from the video evidence that Petitioner's right shoulder was uninjured when she began her shift. Petitioner is seen performing various duties throughout her shift with no apparent right arm or shoulder pain. It is also clear that sometime after 4:30 a.m., Petitioner injured her right shoulder in the prep kitchen away from the video camera. Thus, the true dispute is whether Petitioner's injury is the result of an accident arising out of her employment. I believe Petitioner's injury is the result of a distinct employment-related risk.

There are three types of risks to which an employee may be exposed: 1) risks distinctly associated with one's employment, 2) risks that are personal to the employee, and 3) neutral risks that have no personal or employment characteristics. *Nee v. Ill. Workers' Comp. Comm'n*, 2015 IL App (1st) 132609WC, ¶ 21. The evidence supports a finding that Petitioner's injury is the result of a distinct employment risk. Petitioner's position requires her to work in the refrigerated prep

kitchen while chopping and packaging fresh fruit. Respondent does not dispute Petitioner's detailed description of her job duties as a fruit chunker. At the beginning of each shift, Petitioner gathered and sanitized the fruit she needed prior to chopping and packaging the fruit. Petitioner testified that she always wore winter boots in the prep kitchen to avoid slipping on the floor. Respondent's witness, Brent Smith, testified that all employees working in the produce department are required to wear slip-resistant shoes. Thus, it is clear the company recognizes that the floors in the areas with produce present a heightened risk of an employee slipping. It is highly likely that any area where employees wash, cut, and package fresh fruit will have a wet or sticky floor.

The fact that Petitioner wrapped her foot and leg in a plastic bag during her work shift has little, if any, bearing on the proper risk analysis. Petitioner testified that she wrapped her foot and leg to protect her right foot from becoming wet from the water and various fruit juices in the prep kitchen. Petitioner also testified that she received an accommodation regarding her use of the walking boot instead of her regular work boots. Even if Petitioner's use of the plastic bag around her leg contributed in any way to her work injury, the injury is still the result of a risk distinctive to her employment. After all, Petitioner only wrapped the foot due to the messy nature of her work and the surrounding work area. I also note that the way employees drape the garbage bags in the garbage containers presents a risk distinctive to Petitioner's employment. Petitioner testified that she fell when her left foot caught on the draped garbage bags. In either scenario, I believe it is indisputable that Petitioner's fall and right shoulder injury are the direct result of a risk particular to her employment as a fruit chunker.

For the forgoing reasons, I would reverse the Decision of the Arbitrator and find that Petitioner's right shoulder injury arose out of and in the course of her employment. I would also award any necessary medical treatment and bills and temporary disability benefits.

Thomas J. Tyrrell

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

BINTZ, SANDRA
Employee/Petitioner

Case# **17WC025014**

JEWEL-OSCO
Employer/Respondent

19IWCC0240

On 2/26/2018, 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 1.82% 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:

1505 SLAVIN & SLAVIN LLC
MARK F SALVIN
100 N LASALLE ST SUITE 25TH FL
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
LINDSEY V BEUKEMA
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

19IWCC0240

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)

Sandra Bintz
Employee/Petitioner

v.

Jewel-Osco
Employer/Respondent

Case # **17** WC **25014**

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 **12/18/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

D. [ ] What was the date of the accident?

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

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

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

K. [x] Is Petitioner entitled to any prospective medical care?

L. [ ] What temporary benefits are in dispute?
[x] TPD [ ] Maintenance [x] TTD

M. [x] Should penalties or fees be imposed upon Respondent?

N. [ ] Is Respondent due any credit?

O. [ ] Other ____

FINDINGS

On the date of accident, **8/1/17**, 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 not* sustain an accident that arose out of and in the course of employment.

In the year preceding the injury, Petitioner earned $**27,348.36**; the average weekly wage was $**525.93**.

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

ORDER

Compensation is hereby denied. All other disputed issues have been rendered moot.

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

2-23-2018
Date

ICArbDec19(b)

FEB 2 6 2018

Sandra Bintz v. Jewel-Osco 19 I W C C 0 2 4 0

17 WC 25014

Findings of Fact

Petitioner's Testimony – Direct Examination

Petitioner testified that she has been employed with Jewel for three years. She was also concurrently employed as a bartender at the Elks Lodge. Her job at Jewel was to chop fruit and put it in containers and onto the sales floor. She worked overnight from 10:00 pm to 6:00 am. At the time of the accident, she was working four nights a week. Petitioner testified that when she arrived at work at 10:00 pm, she would go onto the sales floor and check the inventory to see what she needed to make to refill the fruit wall and the refrigerator. T. 14-15. She would then go back into the "big cooler" and get the fruit that she needed, bring that fruit into the "prep room" and sanitize it. At about midnight, petitioner would put on warm clothes and begin cutting.

The prep room, according to petitioner's testimony, is a refrigerated kitchen that contains sinks and is where the fruit is cut. Petitioner testified that she worked in the prep room alone overnight and would wear long underwear, pants, a turtleneck, Jewel shirt, fleece jacket, hat, and gloves. T. 15.

Petitioner testified on direct examination that on August 1, 2017 she performed her usual duties of cutting fruit. She stated that at about 5:00 a.m. she stopped to clean up and price all the fruit that she put in the bowls and containers. Petitioner stated that she was on the last round of cantaloupes and had them in her arms - - she got them out of the shopping cart - - and as she was going past the garbage can, got her foot caught in the garbage bag that hangs down, and she fell. Petitioner said she struck her right side on the ground. T. 17.

Petitioner presented a photograph purporting to contain a picture of the garbage can that she tripped over - Petitioner's Exhibit 6D. T. 19.

Petitioner testified that you can only put so much weight in each garbage bag, because they have to be taken out and put in the compactor and they cannot be too heavy. So you put that in a bag, tie it up and then put in another bag. So as more bags are layered on, it gets higher and higher and the bag gets longer and longer. T. 20. She testified that her foot got caught in the bag that was hanging down on the ground. T. 20.

Petitioner testified that after she fell, she felt that something was wrong with her right arm and shoulder. She got up and left the prep room to out onto the sales floor where she

found Clarence "Sonny" Wendling stocking shelves. T. 25. This was approximately 4:45 am. Petitioner testified that she told Sonny she thought she broke her arm and felt that she needed to go to the hospital. After Sonny told Jim O'Connor, the shift manager, Sonny drove petitioner to Northwest Community Hospital. T. 25-26.

Petitioner testified that upon return to the store after the hospital, she saw Carmen, the produce manager and petitioner's boss, and she told Carmen about the accident. T. 28.

Petitioner testified that she came under the care of Dr. Brian Moss who recommended physical therapy. T. 31.

Petitioner testified that she was off of work at both jobs from the date of accident through September 9, 2017. At that time, she returned to work as a bartender. T. 32. She testified that she has earned $817.51 in gross wages as a bartender since her return to work there until the date of trial. T. 33. She testified that the week before Thanksgiving she returned to work light duty at Jewel. Her job duties included taking tomatoes off the counters and wiping down counters and stacking and tidying up and cleaning. Since her return, she has been working Monday through Thursday, five- hour shifts from 10:00 pm to 3:00 am. T. 33.

Petitioner testified that she has not received any workers' compensation benefits since the accident. T. 37. At the time of trial, Dr. Moss was recommending ongoing physical therapy.

Petitioner's Testimony – Cross-Examination

Petitioner testified that she was wearing winter boots on both feet the night of the accident. T. 38. She further testified that she was wearing those boots all night including the time of the accident and nothing else on her feet at any time that night. T. 38-39. Petitioner denied that there are guidelines for the type of footwear that she was required to wear to work in produce. T. 39.

Petitioner testified that Petitioner's Exhibit 6D does not show the area where petitioner fell. T. 40. The area where petitioner fell is also not depicted in Petitioner's Exhibit 6C. T. 40. Petitioner testified that she fell in front of the sinks. When looking at P. Ex. 6C - - that would be off of the top left of the photo horizontally to the left. T. 40. She said the work table was in front of her and the garbage can is "right to my left of my leg." T. 41. According to petitioner, to the left of that is the shopping cart where she kept the fruit that she was going to cut. She had to go over to the basket and get her last round of cantaloupes, which she had in her arms. As she walked past the garbage can, her foot got caught in the bag and she went down to the right. T. 42.

Petitioner testified that she fell at approximately 4:45 am. Petitioner denied that she did anything prior to going to get help on the sales floor. T. 42.

Petitioner agreed that Carmen did not fill out an accident report when petitioner spoke with her upon returning to the store from the hospital. Petitioner agreed that she spoke with Brent Smith, the assistant store director, later that day. T. 43.

Petitioner testified that despite having health insurance through Jewel, she had not submitted her medical bills to her group carrier because "it was supposed to be workmen's comp." T. 44.

Petitioner's Testimony – Re-direct Examination

On re-direct examination, petitioner testified that she uses more than one garbage can during her shift. T. 47. She testified that while she is working the liners are on the floor next to her. T. 48.

Testimony of Clarence Wendling

Mr. "Sonny" Wendling testified that in July of 2017, he worked at the same Jewel store as petitioner, also working the overnight shift from 10:00 pm to 6:00 am. Mr. Wendling testified that petitioner had normal shoes on the night of the accident. T. 53. He testified that he took petitioner to Northwest Community Hospital and stayed with her until she was released. He did not know why petitioner fell. T. 55.

Testimony of James O'Connor

Mr. O'Connor testified that he also worked at the same Jewel store as petitioner and was working at the time of the accident. His shift is from 10:30 pm to 7:00 am. He explained that he is the night crew clerk, not the shift manager, but the regular shift manager, Kathy Howell, was off the night of the accident. As she was off that night, Mr. O'Connor was technically in charge. T. 59-60. Mr. O'Connor testified that petitioner came to him after she fell and he authorized Sonny to take her to the hospital. Mr. O'Connor did not investigate the area where petitioner fell. T. 62.

Mr. O'Connor testified that he did not fill out an accident report that morning. However, he left a note for the manager. T. 64. He also recalled that the accident occurred around 4:00 am, or sometime before the store opened at 5:00 am. T. 64-65.

Testimony of Brent Smith – Direct Examination

Respondent called witness Brent Smith. Mr. Smith testified that he is the assistant store director at the Jewel store in Arlington Heights where petitioner was working at the time of the accident. He has been employed with Jewel for 16 years total and at this location for almost three years. T. 69-70. Mr. Smith testified that as an assistant store director, he is responsible for the total store operations. This includes going around the store to make sure that all of the departments are doing their jobs and processing and getting product out for the customers to buy. T. 71. Mr. Smith further testified that he is familiar with jobs in all departments. As part of his store director training, he has to go through and spend at least a week in every department of the store. T. 71. Mr. Smith testified that he had knowledge of petitioner's job duties, which included cutting up fruit into bite sized pieces and putting them in bowls and containers for customers to buy. T. 72.

Mr. Smith testified that when he came in to work on the morning of August 1, 2017, there was a note left for him that an accident had happened on the night shift. T. 72. He testified as to the protocol he follows as the assistant store director when an accident takes place. First, there is a form that is printed out from the company website portal with various questions that need to be answered. T. 73-74. Mr. Smith testified that he filled out the form - R. Ex. 1 - while speaking with petitioner on the phone on August 1, 2017. T. 74. The handwriting on R. Ex. 1 is Mr. Smith's. Per the report, Mr. Smith asked petitioner whether she was wearing slip-resistant shoes at the time of the accident and petitioner answered affirmatively. T. 75. Mr. Smith also noted "Produce cooler. Tripped on a bag. Fell on right shoulder." Mr. Smith testified that based on petitioner's responses to his questions, he did not question the validity of the incident. T. 75. He noted this on the form. R. Ex. 1.

Mr. Smith testified that after speaking with petitioner and obtaining the information he needed to complete R. Ex. 1, he called the Call Center and provided the information, which was then forwarded to Sedgwick. T. 75. He then received a response back – R. Ex. 1-A – which is a confirmation of what he had called in. These forms were then stored in a file cabinet in the store director's office. T. 77.

Mr. Smith testified that at the time he completed R. Ex. 1, he had not checked to see if there was video of the accident. T. 77. He later did so at the request of Sedgwick, Jewel's insurance administrator. T. 78. Mr. Smith testified that as part of his job as the assistant store director, he regularly reviews in-store video. T. 78 Mr. Smith testified he reviews video on the occasions of theft, customer slips and falls, parking lot vehicle accident, as well as employee incidents. T. 79. Mr. Smith testified that there are 48 cameras located throughout the store and a machine to review the cameras is in the store director's office. The videos are recorded onto

the hard drive and the length of video depends on the amount recorded. The cameras only record if there is movement. T. 79.

After Sedgwick requested that Mr. Smith look for video of petitioner's accident, he viewed footage from the cameras that record in the produce back room as petitioner told him the accident occurred in the produce cooler. After viewing the video, Mr. Smith burned it onto a CD and sent it to Sedgwick. T. 80.

Mr. Smith testified to the video that was recorded the night of the accident. He pointed out the date and time stamp indicating July 31st at 10:00 p.m. Mr. Smith testified that he started the video at that time because that is when petitioner's shift started. T. 81. Mr. Smith explained that the video records the produce warm room, which is the supply room. He pointed out that the boxes on the right side of the frame are supplies and the door that is seen leads into the cooler, also called the cutting room or the prep room. T. 82.

Mr. Smith identified the woman seen in the video at 10:07:57 as petitioner. T. 82. He testified that as seen on the video at 10:08:31, petitioner is wearing what appears to be a boot on her right foot. T. 83. At 12:20:33, Mr. Smith testified that petitioner was wearing a garbage bag over the boot on her right foot. T. 87. At 4:35:03, petitioner was seen uninjured, reaching with both arms. T. 89.

Mr. Smith testified that at 4:36:02 in the video, there was no movement seen. At 4:37:03, Mr. Smith visualized the petitioner behind the doors - - as seen through the right window. Mr. Smith observed petitioner bending over at 4:37:39. T. 90-91. At 4:38:09 on the video, Mr. Smith testified, he saw white through the windows on the doors and at 4:38:13, petitioner is seen walking out of the prep room with no bag on her foot. T. 91.

Mr. Smith testified that P. Ex. 6C represents the area of the produce cooler/prep room looking through the doors, approximately eight to ten feet down on the right side looking to the left. T. 94. He explained that you walk through the doors into the prep room from the warm supply room and when you walk in on the right-hand, side there is a row of tables up against the wall and this photo is probably eight to ten feet down that row of tables looking to the left side of the room. T. 95. Based on petitioner's testimony as to where she fell, Mr. Smith testified that would be through the doors seen in the video to the left. T. 95.

Mr. Smith testified that petitioner's fruit-chopping duties are called "chunking" and that means she cuts fruit into bite sized pieces and places them in bowls. The chunking process takes place in the prep room. There are two rows of tables in the prep room. Petitioner would wash the fruit in a solution to sanitize it and then throw the fruit rinds into the garbage can. The garbage cans, according to Mr. Smith in the prep room are 55 gallons. He testified that the "chunker," the person prepping the fruit, uses multiple bags. They will put a bag in the can.

They will throw the rinds from several pieces of fruit into the bag and then fold the bag down, put it in there, and put a new bag on top and continue the process. T. 97.

Mr. Smith testified that he took the photograph identified as R. Ex. 3, which a photo of a garbage can that is used in the cutting room to dispose of the rinds of the fruit. Mr. Smith took the photograph a few weeks prior to the trial. T. 98 He testified that after putting about three or four bags in the garbage can, the bags start to get really tight on the can and so they would never overflow over the top of the garbage can. He said they are not big enough to fit on a 55-gallon can and go all the way to the ground. T. 99. Mr. Smith testified that R. Ex. 3-A shows a garbage can with a bag in it with the rinds of a fruit, which shows the process. Mr. Smith testified that P. Ex. 6D is a picture of the same type of garbage can and bag. T. 100.

Mr. Smith testified that there are guidelines for people working in the produce department as to what type of footwear they are required to wear. Mr. Smith testified that any employee working in a "fresh shop" which includes the produce department, is required to wear slip resistant shoes. T. 101. He further testified that even if someone had the need to wear special footwear due to a medical condition, the medical accommodation department would not allow the employee to do so in a "fresh shop." T. 101.

Testimony of Brent Smith – Cross-Examination

Mr. Smith testified that he and the store director are the only ones with keys to the compactor and so he has unlocked it and thrown the garbage bags away several times. Mr. Smith testified that there are two kinds of garbage bags used, 32 gallon and 55 gallon. T. 104-105. Mr. Smith testified that the 32-gallon garbage can liner would not fit the garbage cans that the petitioner would use to perform her job duties. T. 106.

Mr. Smith does not work overnights and has not observed the petitioner chopping fruit. T. 109. Mr. Smith was shown a photograph (P. Ex. 11) that exhibited the garbage bag hanging over the side of the can significantly more than those in R. Ex 3, 3-A. Mr. Smith explained that was because there were not the layers of bags on top of the one in petitioner's exhibit. T. 113. Mr. Smith testified that his understanding of the way the job is done is that one does not push the air out of the garbage bags and that they are tight around the top of the garbage can. T. 117.

Testimony of Brent Smith – Re-direct Examination

Mr. Smith testified that the blue garbage can in P. Ex. 11 is a smaller garbage can than the cans in P. Ex. 6D and R. Ex. 3 and 3A. T. 119.

Mr. Smith testified that while the petitioner told him that she was wearing slip-resistant shoes at the time of the accident, the video showed otherwise. T.119. In addition, after viewing the video his opinion as to the validity of petitioner's claim changed. T. 120. After viewing the video, he believed that petitioner tripped over the garbage bag around her foot. T. 120.

Mr. Smith testified that he has never seen a garbage bag overflowing so that the liner reaches the floor. T. 122.

Testimony of Brent Smith – Re-cross Examination

When Mr. Smith comes into work in the morning, there are typically 10-15 bags piled up to be taken to the compactor. T. 122.

Petitioner's Testimony – Re-direct Examination

Petitioner testified that she took the photograph identified as P. Ex. 11 "a couple of weeks" before the trial. T. 124. She testified that she never had the bag that was tight around the garbage can like that showed in Respondent's exhibit. T. 128.

Petitioner testified that in July she had a broken toe on her right foot and had an orthotic shoe with Velcro straps on it with an open toe. T. 128. She testified that "everyone knew she had it." T. 128 She testified that her immediate manager, Carmen, knew that she wore the boot and that Cathy Tiske in HR knew that she wore it. T. 129. Petitioner further testified that she wrapped a small bag around it and taped it to her leg so that it was in a solid position all night and never got in her way. T. 129-130. Petitioner testified that her left foot got caught in the garbage bag hanging down. T. 131.

Re-cross of Petitioner

Petitioner testified that P. Ex. 11 shows the area where she fell, near where the blue garbage can is located. T. 137.

Re-direct of Petitioner

Petitioner testified as to where she fell in the photograph. T. 139-141.

Video – R. Ex. 2

Surveillance video from the night of the accident was admitted into evidence as Respondent's Exhibit 2. Of note, petitioner is seen working uninjured using both arms as late as 4:35:01. She is seen behind the doors, with the bag on her right foot, as late as 4:35:58 walking to the left of the screen. There is no movement seen behind the doors from 4:36:00 – 4:37:03, at which time she is seen again behind the doors. At 4:38:08, petitioner is seen behind the

doors bending over, removing the garbage can. At 4:38:13 she walks back into the warm room/supply room and at 4:37:39 is seen holding her arm.

Conclusions of Law

In support of his decision regarding issue (C) "Did an accident occur that arose out of and in the course of her employment by Respondent?", the arbitrator finds as follows:

The arbitrator finds that petitioner did not sustain an accident that arose out of and in the course of her employment by Respondent.

A claimant bears the burden of proving by a preponderance of the evidence that his accident arose out of and in the course of his employment. *First Cash Financial Services v. Industrial Comm'n*, 367 Ill. App. 3d 102, 105, 853 N.E.2d 799, 304 Ill. Dec. 722 (2006). The arbitrator finds that petitioner was not credible and therefore gives no weight to her testimony. In addition, the arbitrator finds that petitioner's injury arose of a personal risk, not related to her employment.

The arbitrator had the opportunity to observe the Petitioner when she testified and the arbitrator reviewed all of the evidence submitted. The arbitrator finds that petitioner was not credible and therefore gives no weight to her testimony. The arbitrator has considered (1) the witness' demeanor, (2) the interest or motivation of the witness, 3) the probability or improbability of the witness' version, 4) the internal inconsistencies in the witness' testimony and conduct, and 5) the external inconsistencies when the witness' testimony as compared with other evidence. After considering each of these, the arbitrator concludes that petitioner was not credible.

The arbitrator finds direct contradictions between petitioner's testimony and that of the video evidence and other witness testimony. Mr. Smith, the assistant store director and a 16-year Jewel employee, testified that petitioner told him just hours after the accident that she was wearing slip-resistant shoes. Mr. Smith contemporaneously made notes of this conversation, reflecting what petitioner told him. R. Ex. 1. Based on petitioner's statement, Mr. Smith initially did not question the validity of petitioner's claim. However, video evidence clearly contradicted what petitioner told Mr. Smith. The arbitrator finds that, based on the video, petitioner fell between 4:36:00 and 4:37:03 a.m. It is clear from the video that petitioner was *not* wearing slip resistant shoes at the time of the accident. R. Ex. 2. The arbitrator finds that petitioner was not truthful to Mr. Smith when reporting her accident.

At trial, petitioner also did not admit to her unauthorized footwear until confronted with video evidence. On cross-examination, petitioner was given an opportunity to be truthful about her footwear. Instead, petitioner testified that she was wearing normal winter boots at the time of the accident. She testified that she was wearing those boots on both feet, throughout the whole night, including at the time of the accident. When confronted with the video evidence to the contrary, petitioner claimed that she "forgot" that she was wearing the walking boot and garbage bag at the time of the accident. The petitioner's "forgetfulness" at the time of trial does not explain her failure to tell Mr. Smith the truth about her footwear *just hours after the accident*.

Moreover, Mr. Smith credibly testified, based on his experience and knowledge as a 16-year Jewel employee, assistant store director, and store director-in-training, that the way petitioner described the accident as having occurred could not have happened. T. 99-100. Mr. Smith's testimony remained consistent throughout direct and cross examination. He clearly testified that the garbage can shown in P. Ex. 11 is a 32-gallon can, and those seen in the other photos are 55-gallon cans. T. 119. He testified that the cans used to chop fruit are 55-gallon cans and that the garbage bags do not hang over the side to the floor.

Petitioner's testimony changed over the course of trial, after she heard Mr. Smith's testimony. At first, petitioner testified that the garbage can that is shown in P. Ex 6D was the same type of can that she was working with at the time of the accident. T. 19. However, she later testified that the can in P. Ex. 11 was the type of can she was working with at the time of the accident. T. 125-126. The arbitrator also notes that petitioner did not testify as to which foot got caught in the garbage bag until *after* seeing the video evidence.

In taking into account the varying accounts of how petitioner's fall may have occurred, the arbitrator again must consider the credibility of the witnesses. The arbitrator finds petitioner's testimony to be inconsistent and has already found that petitioner had been untruthful in her testimony.

Even assuming petitioner's version of how she used the garbage bags to be true, the arbitrator still finds that petitioner's injury was due to a personal risk and thus, not compensable. An employee's injury is compensable under the Illinois Workers' Compensation Act only it if it arises out of and in the course of the employment. An accident arises out of one's employment if its origin is in some risk connected with or incidental to the employment so as to create a causal connection between the employment and the accidental injury. *Sisbro, Inc. v. Indus. Comm'n,* 207 Ill. 2d 193, 203 (2003). There are three categories of risk to which an employee may be exposed: 1) risks distinctly associated with her employment; 2) personal

risks; and 3) neutral risks which have no particular employment or personal characteristics. *Illinois Institute of Technology Research Institute v. Indus. Comm'n*, 314 Ill. App. 3d 149, 162 (1st Dist. 2000). In the course of employment refers to the time, place and circumstances surrounding the injury. *Sisbro* (supra).

Employment risks are "inherent in one's employment" and "include the obvious kinds of industrial injuries and occupational disease that are universally compensated." *Meierdirks v. Ill. Workers' Comp. Comm'n*, 2014 IL App (1st) 130749WC-U, P16. Employment risks also include hazards or defects at the employer's premises. Personal risks include exposure to elements that cause non-occupational diseases, personal defects or weaknesses, and confrontations with personal enemies. Finally, neutral risks are those which have no particular employment or personal characteristics. Injuries from a neutral risk generally are only compensable where the employee was exposed to the risk to a greater degree than the general public.

Due to the fact that petitioner was wearing an open-toed walking boot with a large plastic bag tied around it, petitioner's footwear exposed her to a personal risk - - not an employment risk. Petitioner was not told to wear her walking boot and garbage bag as part of her employment. In fact, Mr. Smith testified that that type of footwear was prohibited. The arbitrator finds that even if petitioner's testimony were to be given weight, her injury was due to a personal risk caused by her choice of footwear on the night of the accident and, thus, is not compensable under the Act.

Compensation is hereby denied. All other disputed issues have been rendered moot.

2-23-18

Brian T. Cronin

Arbitrator

Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Krista Kane-Boop,

Petitioner,

vs. NO: 12 WC 43695

19IWCC0241

State of IL / Dixon Correctional Center,

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 medical bills, temporary total disability (TTD), and nature and extent, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Findings of Fact

As an initial matter, a December 30, 2013, §19(b) Decision of the Arbitrator addresses the issues of accident, causal connection, medical benefits, and temporary total disability benefits through April 4, 2013 (the date of the hearing). The Commission affirmed and adopted the Arbitration Decision on December 9, 2014 in case number 14 IWCC 1056. The Commission takes official notice of these earlier decisions and in the interest of efficiency primarily relies on the detailed recitation of relevant facts therein.

On September 9, 2012, Petitioner was working as a nurse in Respondent's prison facility. Petitioner injured her low back when she fell while trying to avoid a heavy door that "came flying" at her. Petitioner was 12 weeks pregnant at the time of the accident. She gave birth on March 18, 2013. Following the April 4, 2013 hearing, Petitioner had continued complaints of low back pain and continued to treat with Nurse Practitioner Dittmar. An April 19, 2013, lumbar MRI was normal. On April 23, 2013, Petitioner reported a pain level of 4/10. Nurse Dittmar noted the recent normal lumbar MRI. Petitioner complained of continued low back pain and intermittent radiculopathy. The nurse prescribed physical therapy. At her initial therapy session on April 29, 2013, the therapist wrote that Petitioner was currently off work due to recently giving birth and that she was unable to work secondary to dysfunction. One of the goals of physical therapy was to

return Petitioner to her pre-accident work capabilities.

The therapist provided monthly assessments to Nurse Dittmar. The physical therapy records reveal that except for some temporary exacerbations, Petitioner consistently rated her low back pain level as 4-5/10. Nurse Dittmar's office visit notes also reveal that while Petitioner made small functional improvements during her treatment, Petitioner's baseline pain remained generally unchanged. On September 30, 2013, in the physical therapy discharge records, the therapist wrote that Petitioner reported fairly constant low back pain of 4-5/10 and stated the sharp episodes of severe pain had resolved.

Following her release from physical therapy, Petitioner continued to follow up with Nurse Dittmar each month. On November 18, 2013, Petitioner reported increased pain after standing for a long period at a wake. The nurse practitioner noted steady improvement in pain and told Petitioner to avoid lifting anything over 30 lbs. On December 24, 2013, Petitioner's exam was positive for back pain but negative for tingling, weakness, and numbness. Petitioner reported an increased level of stress and discomfort. Petitioner also began to complain of numbness in her feet. On February 19, 2014, Petitioner complained of back pain at level 6/10. Nurse Dittmar noted that Petitioner was 13 weeks pregnant. The nurse practitioner noted Petitioner's exam was positive for joint pain and stiffness and back pain as well as left leg radiculopathy. She continued a 30 lb. lifting restriction for work. Petitioner was to return to the office in a month; however, there are no further treatment records in evidence.

Conclusions of Law

It is axiomatic that Petitioner bears the burden of proving each element of her case by a preponderance of the evidence. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). After carefully considering the totality of the evidence, the Commission modifies the Arbitrator's denial of temporary total disability benefits and medical treatment after April 23, 2013. The Commission affirms and adopts the remainder of the Decision of the Arbitrator.

The Arbitrator awarded TTD from April 5, 2013 through April 23, 2013. He concluded that Petitioner reached MMI on April 23, 2013, and therefore was not entitled to any additional TTD. This finding was based primarily on his interpretation of the April 23, 2013, office visit note's reference to a work release effective on that day. The Commission interprets the evidence differently. The Commission finds that the April 23, 2013, office visit note does not release Petitioner to return to work in any capacity. While the Arbitrator correctly stated that Nurse Dittmar included "misc: Work Release 4/23/13" in the office visit note, the nurse practitioner also clarified that Petitioner was not yet ready to return to work. In the follow-up plan, the nurse practitioner wrote, "Return to work in not yet." The April 29, 2013, initial physical therapy assessment further supports a finding that no medical provider released Petitioner to return to work on April 23, 2013. The therapist wrote that Petitioner was off work secondary to dysfunction and listed returning Petitioner to work as one of the goals of the prescribed therapy.

The Commission finds that Petitioner met her burden of proving an entitlement to TTD from April 5, 2013, through June 20, 2013, or 11 weeks. "A claimant is temporarily totally disabled from the time an injury incapacitates him from work until such time as he is as far recovered or

restored as the permanent character or his injury will permit." *Westin Hotel v. Indus. Comm'n*, 372 Ill. App. 3d 527, 542 (2007). When considering the issue of TTD benefits, the dispositive inquiry is whether the claimant has reached MMI. *See Interstate Scaffolding, Inc. v. Ill. Workers' Comp. Comm'n*, 236 Ill. 2d 132, 142 (2010). Nurse Dittmar never placed Petitioner at MMI. Thus, the Commission must carefully weigh the evidence to determine when Petitioner's condition stabilized to the extent that further improvement was unlikely. Throughout Petitioner's treatment with Nurse Dittmar and the physical therapist, she consistently reported similar pain and symptoms. Generally, Petitioner rated her pain at 4-5/10 during her visits with Nurse Dittmar, with the exceptions being times when Petitioner suffered temporary aggravations that resulted in temporarily worsened symptoms. Her complaints changed very little even when she decreased her use of pain medication. Petitioner returned to Nurse Dittmar on June 20, 2013, with generally the same complaints she had throughout her entire period of treatment. A thorough review of the medical records reveals that Petitioner's condition stabilized by the June 20, 2013, office visit. Given the consistency of Petitioner's complaints following the June 20, 2013, office visit, the Commission finds Petitioner reached MMI by June 20, 2013. For the forgoing reasons, the Commission finds Respondent shall pay TTD to Petitioner from April 5, 2013, through June 20, 2013, or 11 weeks. Therefore, the Commission modifies the Arbitrator's award of TTD.

While Petitioner reached MMI, on June 20, 2013, the Commission finds her continued treatment after achieving MMI is causally related to the work injury through November 18, 2013. Pursuant to Section 8(a) of the Act, Respondent must pay for all necessary medical, surgical, and hospital services reasonably required to cure or relieve the effects of the work injury. The Illinois Appellate Court has held that an employer's liability pursuant to Section 8(a) is continuous as long as the medical services are necessary to alleviate the effects of the claimant's injury. *See Elmhurst Mem'l Hosp. v. Indus. Comm'n*, 323 Ill. App. 758, 765 (2001). In the present case, while Petitioner's condition stabilized by June 20, 2013, the Commission sees no evidence that Petitioner's ongoing conservative treatment through November 18, 2013, was not meant to help alleviate Petitioner of the discomfort associated with her chronic low back complaints. However, the Commission denies any entitlement to medical services Petitioner received after November 18, 2013. It is clear from the evidence that while Petitioner continued to report generally unchanged chronic symptoms up to November 18, 2013, her condition noticeably began to deteriorate from November 18, 2013, to February 19, 2014 (her last date of treatment). Petitioner became pregnant in November 2013 and immediately began to complain of worsening symptoms. By December 2013 Petitioner complained of additional stress and reported changing symptoms. By January 2014, Petitioner complained of increased back pain as well as numbness in her feet. For the foregoing reasons, the Commission finds Petitioner met her burden of proving the medical services she received through November 18, 2013, are reasonable, necessary, and causally related to the work injury. Therefore, the Commission modifies the Arbitrator's award of medical bills.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 8, 2018, is modified as stated herein.

IT IS FURTHER ORDERED that Respondent shall pay to Petitioner temporary total disability benefits of $**704.61**/week for **11** weeks, commencing **April 5, 2013** through **June 20,**

2013, as provided in Section 8(b) of the Act. Respondent shall be given a credit in the amount of $20,956.66 for temporary total disability benefits previously paid to Petitioner.

IT IS FURTHER ORDERED that Respondent shall pay reasonable, necessary, and related medical charges incurred by Petitioner through November 18, 2013, as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED that Respondent shall pay Petitioner permanent partial disability benefits of **$634.15**/week for **25** weeks, because the injuries sustained caused the 5% loss of use of the whole person, as provided in Section 8(d)2 of the Act.

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

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

DATED: MAY 17 2019

o: 4/9/19
TJT/jds
51

Thomas J. Tyrrell

Maria E. Portela

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KANE-BOOP, KRISTA
Employee/Petitioner

Case# **12WC043695**

SOI/DIXON CORRECTRIONAL CENTER
Employer/Respondent

19IWCC0241

On 1/8/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.57% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2028 RIDGE & DOWNES LLC
JOHN E MITCHELL
415 N E JEFFERSON AVE
PEORIA, IL 61603

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

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH P BLEWITT
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

JAN 8 - 2018

19 I W CC0241

STATE OF ILLINOIS)

)SS.

COUNTY OF LaSalle)

- [ ] 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

Krista Kane-Boop
Employee/Petitioner

Case # **12 WC 43695**

v.

State of Illinois / Department of Corrections
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 **Ottawa**, on **11/29/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [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 **9/9/2012** Respondent *was* operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On 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 first injury, Petitioner earned $**54,960**; the average weekly wage was $**1,056.92.**

On the first date of accident, Petitioner was **29** years of age, ***Married*** with **2** dependent children.

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$20,956.66** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$20,956.66.** Respondent shall be given credit for all other amounts it has paid to or on behalf of Petitioner in this claim.

Respondent is entitled to a credit for payment of all reasonably related group medical under Section 8(j).

ORDER

Respondent shall pay Petitioner temporary total disability benefits under Section 8(b) of the Act of $704.61 per week for a period of 19 days, or 2-5/7 weeks, commencing on April 5, 2013 and ending on April 23, 2013 inclusive. Respondent shall receive credit for all periods of TTD paid.

Respondent shall pay reasonable and necessary medical services which Petitioner has incurred through date of service of April 23, 2013 and as provided under Section 8.2 of the Act pursuant to the medical fee schedule. Respondent shall receive credit pursuant to Section 8(j) of the Act for any medical services that have been paid through April 23, 2013, and Respondent shall hold Petitioner safe and harmless from any claim for reimbursement by providers of the service for which Respondent shall receive credit.

Respondent shall pay Petitioner benefits for permanent partial disability of $634.15 per week for an additional period of 25 weeks, as Petitioner sustained the permanent partial loss of use to the person as whole to the extent of 5% 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.

Robert M. Harris

Signature of Arbitrator

January 8, 2018
Date

JAN 8 - 2018

FINDINGS OF FACT

This matter was previously heard pursuant to Section 19(b) on 4/4/2013 and Arbitrator Mathis rendered his Arbitration Decision on 12/20/13. In this previous Decision, Arbitrator Mathis found a causal connection exists between the accident and Petitioner's condition of ill-being as of 4/4/2013. Arbitrator Mathis awarded TTD benefits of 20-5/7 weeks through and including the date of hearing, 4/4/2013. Arbitrator Mathis, however, did not award payment of medical bills, ordering that medical bills and group liens will be submitted at a subsequent hearing. Respondent filed a Petition for Review, and the Commission issued its Decision and Opinion on Review on December 9, 2014, wherein it affirmed and adopted the Decision of the Arbitrator,

Petitioner Krista Boop testified that she was a registered nurse employed at Respondent's Dixon Correctional Center. She said that while she was at the Center opening a heavy steel door, an inmate on the other side "slapped" it shut. Petitioner said she "turned her head and twisted her body to avoid being struck." She said she immediately felt pain in her low back which radiated down her left leg. She reported the accident, sought medical attention, and was prescribed physical therapy. Accident is not in dispute in the case at bar here.

After the date of the last hearing, Petitioner continued to treat with Margaret Dittmar, a nurse practitioner and not a medical doctor or osteopathic physician.

Petitioner underwent a lumbar MRI on 4/19/2013 (see, PX 4). The lumbar MRI was normal in all regards ("The lumbar discs all maintain normal height and signal intensity without degeneration, bulging or herniation. No central canal or foraminal stenosis at any level. Conus resides normally at the T12-L1 level. No areas of abnormal marrow signal.).

Petitioner discussed these MRI results with Nurse Dittmar at her visit on 4/23/13, who acknowledged that the MRI results were normal. (See, PX 3). Also as of this date, she was morbidly obese, 1 month post-partum, and was referred to physical therapy. Physical examination indicated normal gait, no gross motor deficits and no gross sensory deficits. Under the "Procedure" section of this note, there is an entry that indicates, "WORK RELEASE 4/23/13." This ties in with the "Physical Therapy and Exercise Prescription" dated 4/23/13 signed by Dittmar which indicates, ""Precautions/Limitations NONE" (capitalizations in original).

On 4/29/13, Petitioner initially presented to Rock Valley for physical therapy. The therapist recorded in her seven page record of "Initial Evaluation": "She is a nurse for the Dixon Correctional Center, and is currently not working due to recently giving birth." The physical therapist repeated this entry in all of her subsequent notes, for 51 total physical therapy sessions, until September 30, 2014.

On 4/29/13, the physical therapist recorded that Petitioner was morbidly obese. On Physical examination, Petitioner's subjective complaints and symptoms were different from those she gave Nurse Dittmar the prior week; that is, on this 4/19/13 visit, Petitioner showed some muscle weakness, reported a decrease in right thigh sensation and "pins and needles" at the bilateral ankles and feet, and demonstrated "moderate-to-severe increase in the normal lumbar lordosis" and "significant musculoskeletal imbalances with adaptive postural abnormalities" – none of which was previously reported to Dittmar.

In the 5/3/13 notes, the therapist indicates, "Bending over, such as to pick up her baby, is still extremely painful." is still very aggravating to her low back." On May 6, the therapist again indicates, "Pt. states that bending forward to pick up her baby is still very aggravating to her low back." On 5/20, the therapist indicates that, "Pt reports that her pain and tightness is still worse since the incident last Friday…when she leaned over to pick up her baby and had severe muscle spasms."

On 5/15/13, Petitioner reported that "…she is finding that her functional status has noticeably improved since beginning therapy." However, on 5/17, the therapist recorded that, "Pt reports that she was doing reasonably well this morning—then, she was reached [sic] down to pick up her baby from his swing and had a sudden, severe muscle spasm in the right lower back. States that the pain/muscle spasm has persisted and has prevented her from moving around and doing activities as she normally would."

On 6/17, Petitioner showed some improvement, reporting, "Now able to lift and carry her baby without the severe muscle spasms that she initially had.."

On 7/10, the therapist recorded, "Pt reports an aggravation of her back pain due to an incident yesterday. She was at home and taking a shower upstairs, her smoke alarm went off, and in her haste to get downstairs to her baby, she slipped down 4 or 5 steps (caught herself with her

arm on a railing)." At the next session on 7/12, Petitioner reported an increase in pain intensity since that slip. On 7/22, Petitioner "reports a new sore spot at the right low thoracic/upper lumbar region. She first noticed this painful region the 2nd week of June (recalls that it occurred during my vacation from work), it seemed to resolve, but has recently returned. Additionally, she had a new c/o bilateral lower extremity numbness which she long-sits on the floor..."

The later notes indicate that Petitioner's overall condition gradually improved, e.g,, 8/12, "Overall condition is: Improving."

However, on 9/30, the therapist said Petitioner made "very good ROM, strength, and functional gains…no further treatment is indicated." She was discharged from physical therapy.

Petitioner saw Nurse Dittmar with complaints of back pain on 5/21, 6/20, 7/26, 8/3, 10/1, 11/8, 12/24. On 1/24/2014 Petitioner again saw Nurse Dittmar, who noted Petitioner was 10 weeks pregnant. Petitioner returned again on 2/9/14 and Nurse Dittmar recommended weight loss and a home exercise program.

There are no medical records prepared or signed by an actual doctor of medicine or osteopathic physician. All medical records indicate that only Petitioner's nurse practitioner Dittmar examined her and prepared all of her treating records and notes.

Petitioner testified that she did not return to work with Respondent, nor did she attempt to return to work. Petitioner testified she started working as a school nurse for West Carroll school district in approximately March 2014. She said she left that position due to low pay and took a position with Freeport Health Network as a nurse in approximately August 2015. She said she makes $1,400 per pay period at her new position. Petitioner has not seen any medical provider for her low back since 2015.

Conclusions of Law

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

Arbitrator Mathis found a causal connection between Petitioner's accident and her condition of ill-being as of 4/4/2013. Based on the record in this proceeding, this Arbitrator finds no persuasive basis or reason to disturb that conclusion establishing causation.

On 4/19/2013, Petitioner underwent a lumbar MRI that was normal and on 4/23/2013 Petitioner obtained a work release from her treating nurse practitioner. However, she sustained several subsequent incidents accidents and aggravations to her how lack that caused her back pain to flare or increase while remaining off-work. These subsequent aggravations, while clearly causing at times an increase in symptoms, do not, either considered individually or in the aggregate, rise to the level necessary to act to sever the chain of causal connection.

Significantly, there is no medical opinion in the record from any source concluding that there was a break in established causation at any time. Petitioner's aggravations are noted above and as found in the records. Additionally, at the time of the normal MRI, she was morbidly obese and 1 month post-partum, which also contributed to her aggravating symptoms. Petitioner's subsequent pregnancy also contributed and/or caused her symptomatic aggravations. The Arbitrator notes that inexplicably no follow-up MRI was performed after the 4/19/2013 MRI.

Therefore, no diagnostic imaging study is available to show evidence that Petitioner's spinal anatomy had changed (become worsened) after the 4/1/9/2013 MRI and after her multiple aggravations which only were shown to have increased her symptoms. Petitioner continued treatment with the same providers, undergoing repeated treatment, mostly physical therapy.

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

As Petitioner suffered a work-related injury on 9/9/2012, Respondent is liable for reasonable and necessary medical expenses resulting from that injury up to and including Petitioner's 4/23/2013 visit with Nurse Dittmar where she reviewed the results of the MRI with Petitioner and provided her with a work release. Petitioner's ongoing multiple physical therapy visits (51) and

her continuing visits to nurse Dittmar are not proven to be reasonable and necessary. Respondent is not liable for payment of any bills (or reimbursement) for medical treatment incurred after Petitioner reached MMI on April 23, 2013. There is no expert medical opinion explaining Petitioner's alleged continuing subjective symptoms (and therefore the claimed need for continuing treatment) when confronted by a completely normal MRI.

K. What temporary benefits are in dispute? TTD

"It is a well-settled principle that when a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized, i.e., whether the claimant has reached maximum medical improvement." *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Comm'n*, 236 Ill.2d 132, 142, 337 Ill.Dec. 707, 923 N.E.2d 266, 271 (2010). Once an injured employee's physical condition stabilizes, she is no longer eligible for TTD benefits. *Sunny Hill of Will Cty. v. Illinois Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC, ¶ 23, 14 N.E.3d 16, 22. Here, the evidence indicates that Petitioner had a normal MRI on 04/19/2013 and was issued a work release as of 4/23/2013. A few days later, her physical therapist indicated Petitioner is remaining off work because she just gave birth.

The Arbitrator finds and concludes that Petitioner's work-related condition had stabilized, reaching MMI as of April 23, 2013. Therefore, TTD ends on that date upon reaching MMI. After Petitioner was subsequently off-work due to the recent birth and physical therapy continued due only to this and the numerous unrelated aggravations of her lumbar spine.

Although Petitioner did not return to work for Respondent, there is no evidence that she attempted to return to work for Respondent. There is no evidence that Respondent refused to return Petitioner to her pre-accident position. If Respondent could not take Petitioner back, maintenance might be appropriate, but Petitioner did not claim entitlement to maintenance on the Request for Hearing, so the issue is moot. Therefore, no TTD benefits are due after 4/23/2013.

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

Pursuant to Section 8.1b of the Act, the level of permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. Regarding these factors, the Arbitrator notes the following evidence:

1. Neither party submitted an AMA rating; therefore, the Arbitrator did not receive for review and consideration this objective measurement of a reported level of impairment. The Arbitrator gives this factor moderate weight.
2. The Petitioner was a registered nurse. This is clearly not a heavy manual labor job. The Arbitrator gives this factor moderate weight.
3. Petitioner was 29 years old at the time of the accident. There was no evidence presented as to how Petitioner's age affects her potential disability either positively or negatively. But clearly she is young and she can move on with her career. The Arbitrator gives this factor minimal weight.
4. The Petitioner provided minimal evidence indicating how her injury has or will potentially affect her future earning capacity. Petitioner had no work restrictions after reaching MMI on 4/23/2013. She did not attempt to return to work for Respondent, although she did work for two other employers before the time of the hearing. However, she did testify that she makes $1,400 per pay period, whereas she made $2,113 per pay period pre-accident. There is no evidence, however, that Petitioner earns less now as a direct and sole consequence of her 2012 injury. The Arbitrator gives this factor moderate weight.
5. The most recent significant objective evidence of the nature and extent of Petitioner's permanent disability is based on the 4/19/2013 MRI, which the Arbitrator emphasizes was normal. Further, the most recent objective evidence related to disability is the physical therapy discharge note, which recorded "very good ROM, strength, and functional gains." The Arbitrator gives these factors the most significant weight and credibility regarding the issue of permanency. Lastly, the Arbitrator notes with great emphasis to significantly discount the weight and credibility of the medical records in this case. The fact that Petitioner was apparently examined only by her nurse practitioner, and not a medical doctor or osteopathic physician, greatly diminishes the value, weight and credibility of the medical

records as a whole and the "opinions" noted therein. Further, Petitioner apparently never even completed her course of treatment, as the records from nurse Dittmar dated February 19, 2014 indicate that the plan was for Petitioner was to return again in one month, but there is no record in evidence that she did. Further, there was never even a straightforward diagnosis, the non-specific assessment being "lumbago" ("low back pain") and radiculopathy (radiating symptoms, which were never corroborated by any diagnostic imaging or other study). Therefore, all comments, opinions, "work restrictions" and the like given by nurse Ditrmar and the physical therapist are afforded little, if any, weight or credibility.

Based on the above, the Arbitrator finds that Petitioner suffered a 5% loss of her person as a whole pursuant to Section 8(d)2 of the Act (25 weeks X $634.15 per week).

M. Should penalties or fees be imposed upon Respondent?

Petitioner requests penalties pursuant to Sections 19(k) and (l), as well as attorney fees pursuant to Section 16 of the Act. The Arbitrator denies this request.

Relating to Section 19(l) penalties, the Act states, "If the employee has made written demand for payment 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 the reason for delay." Here, there is no evidence in the record that the employee made such a demand. With no written demand, Respondent has nothing to respond to, and no way of knowing what benefits the employee is seeking. Therefore, Petitioner's claims for Section 19(l) penalties must fail.

Alternatively, even if such a demand was made, the employer has the burden of justifying its good-faith belief that a claim is invalid or that an award is not supported. *R.D. Masonry, Inc. v. Indus. Comm'n*, 215 Ill. 2d 397, 409, 830 N.E.2d 584, 592 (2005). The employer's belief is justified only if the facts which a reasonable person in the employer's position would have would justify it. *Id.* Here, it's not unreasonable for Respondent to rely on the statements of Petitioner's physical therapist where she notes dozens of times that Petitioner "is currently not working due to recently giving birth" and not once that Petitioner was not working due to the 9/9/2012 accident.

Additionally, it was not unreasonable for Respondent to believe that Petitioner had suffered new and perhaps multiple injuries/aggravations to her back and that her current need for treatment was due to one of the many non-work-related aggravations found contained in the therapist's notes. Lastly, it was not unreasonable for Respondent to believe that Petitioner had reached MMI for her work-related accident on 4/19/2013 when her lumbar MRI was normal.

In regards to Section 19(k) penalties and Section 16 attorney fees, these remedies address situations where there is not only delay, but the delay is deliberate or the result of bad faith or improper purpose. *Zitzka v. Industrial Comm'n*, 328 Ill.App.3d at 849, 262 Ill.Dec. 945, 767 N.E.2d at 408. Section 19(k) penalties and Section 16 attorney fees, therefore, require a higher standard than section 19(l) penalties. Penalties under these sections require more than inadvertence, neglect, or a lack of good and just cause in denying benefits. *McMahan v. Industrial Comm'n*, 289 Ill.App.3d 1090, 1093, 225 Ill.Dec. 292, 683 N.E.2d 460, 463 (1997), aff'd, 183 Ill.2d 499, 234 Ill.Dec. 205, 702 N.E.2d 545 (1998).

Here, as the Petitioner has not met her burden proving entitlement to Section 19(l) penalties, she did not and could not prove entitlement to 19(k) or 16 penalties and fees, as they require a higher standard of vexatious conduct by the Respondent.

Further, there was no evidence that Respondent denied payment of benefits improperly and the record fails to show evidence that Respondent engaged in "bad faith or improper purpose."

Robert M. Harris

Arbitrator

January 8, 2018

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Corina Shaw,

Petitioner,

vs. NO: 11 WC 3365

Illinois State University,

19IWCC0242

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 30, 2108, 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: MAY 17 2019
TJT:yl
o 5/7/19
51

Thomas J. Tyrrell

Maria E. Portela

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SHAW, CORINA
Employee/Petitioner

Case# **11WC003365**

ILLINOIS STATE UNIVERSITY
Employer/Respondent

19IWCC0242

On 1/30/2018, 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 1.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

JAN 30 2018

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

19IWCC0242

STATE OF ILLINOIS)
)SS.
COUNTY OF MC LEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Corina Shaw
Employee/Petitioner

v.

Illinois State University
Employer/Respondent

Case # 11 WC 03365

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Bloomington, on December 28 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [ ] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [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 _____

19IWCC0242

FINDINGS

On December 11, 2010, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $20,357.78; the average weekly wage was $407.16.

On the date of accident, Petitioner was 44 years of age, single with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $27,416.52 for TTD, $0.00 for TPD, $17,527.97 for maintenance, and $0.00 for other benefits, for a total credit of $44,944.49.

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 15, 17 and 28 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner permanent partial disability benefits of $244.30 per week for 200 weeks because the injuries sustained caused the 40% loss of use of person as a whole, as provided in Section 8(d)2 of the Act.

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

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

William R. Gallagher, Arbitrator

January 26, 2018
Date

JAN 3 0 2018

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment for Respondent on December 11, 2010. According to the Application, "Petitioner while working for Respondent sustained injuries to Petitioner's left lower extremities and other parts of the body" (Arbitrator's Exhibit 2). At trial, the primary disputed issue was the nature and extent of disability. Petitioner alleged that she was permanently and totally disabled. Respondent also stipulated that it was liable for payment of Petitioner's medical expenses (Arbitrator's Exhibit 1).

This case was previously tried before Arbitrator Pulia on October 8, 2012, in a 19(b) proceeding in which Petitioner sought payment of temporary total disability benefits and medical bills. Arbitrator Pulia ruled in favor of Petitioner and her Decision was subsequently affirmed by the Commission on April 24, 2013 (Petitioner's Exhibit 29).

When the case was tried on December 28, 2017, Petitioner claimed that she was entitled to temporary total disability and maintenance benefits for periods of time subsequent to the Decision of the Commission. Petitioner claimed she was entitled to payment of temporary total disability benefits of 100 6/7 weeks, commencing June 9, 2014, through May 15, 2016; and payment of maintenance benefits of 64 3/7 weeks commencing May 16, 2016, through August 9, 2017. Respondent stipulated Petitioner was entitled to said benefits. Petitioner also claimed she was permanently and totally disabled as of August 10, 2017, and entitled to permanent total disability benefits commencing on that date (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a building services worker, cashier and cafeteria service worker. On December 11, 2010, Petitioner was stacking some food in the cooler and she slipped and fell injuring her left leg.

Subsequent to the accident Petitioner was treated at the ER of Bromenn Medical Center. X-rays of the left leg were taken which revealed a slightly displaced oblique fracture of the distal tibia (Petitioner's Exhibits 3, 4 and 5).

Petitioner was then treated at Orthopedic & Sports Enhancement Center by a Physician Assistant, Jeff Williamson. PA Williamson confirmed that Petitioner sustained a fracture of the left tibia and a long leg cast was applied. PA Williamson treated Petitioner through August 23, 2011 (Petitioner's Exhibit 9).

On August 31, 2011, Petitioner was seen by Dr. Lawrence Li, an orthopedic surgeon. At that time, Petitioner continued to complain of left leg pain. Dr. Li ordered a CT scan which was performed on September 1, 2011. The scan revealed a nonunion of the fracture of the tibia. Dr. Li referred Petitioner to Dr. D. Gordon Allan, an orthopedic surgeon (Petitioner's Exhibits 6 and 10).

Dr. Allan saw Petitioner on September 16, 2011, and agreed there was a nonunion of the fractured tibia. Dr. Allan performed surgery on October 13, 2011, which consisted of an osteotomy of the fibula and tibia with intramedullary nailing. When Dr. Allan saw Petitioner on December 16, 2011, he authorized her return to work for sedentary duties only on January 2, 2012 (Petitioner's Exhibit 11).

When Dr. Allan evaluated Petitioner on April 12, 2012, Petitioner continued to complain of left leg symptoms. Dr. Allan ordered a TENS unit and work hardening (Petitioner's Exhibit 11).

Rhonda Harms, a Nurse Practitioner associated with Dr. Allan, saw Petitioner on March 4, 2013. At that time, Petitioner advised that she could not stand for more than two to three hours per day because of her left leg symptoms. When Dr. Allan saw Petitioner on September 27, 2013, he recommended that the surgical screws used in the prior surgery be removed because they were irritating Petitioner's left leg condition and causing her to have increased pain symptoms. Dr. Allan performed that surgery on June 9, 2014 (Petitioner's Exhibit 24).

Dr. Allan authorized Petitioner to return to work on July 12, 2014. However, Dr. Allan imposed work restrictions of no standing more than two to three hours at a time, then sedentary duties for two hours before resuming standing duties for two to three hours (Petitioner's Exhibit 24).

At the direction of Respondent, Petitioner was examined by Dr. Bernard Bach, an orthopedic surgeon, on July 17, 2015. In connection with his examination of Petitioner, Dr. Bach reviewed medical records provided to him by Respondent. Dr. Bach opined Petitioner had sustained a fracture of the tibia which was subsequently determined to be a nonunion that required surgery. He agreed that all of the medical treatment Petitioner had received was appropriate. Dr. Bach opined Petitioner was at MMI; however, he did not specifically note any work/activity restrictions, but specifically stated that Petitioner had difficulties kneeling, squatting and climbing stairs (Petitioner's Exhibit 22).

Petitioner was later seen by Dr. Li on March 31, 2016. Dr. Li ordered a functional capacity evaluation (FCE) to determine Petitioner's permanent restrictions (Petitioner's Exhibit 27).

The FCE was performed on May 4, 2016. The examiner initially noted that Petitioner gave maximal effort during the testing. The FCE examiner found Petitioner had work/activity restrictions on bending, standing, crawling, kneeling, climbing stairs, walking and lifting. The FCE examiner opined Petitioner was limited to working in a "light" physical demand level (Petitioner's Exhibit 23).

At trial, Petitioner testified she started working for Respondent in 1995 as a building service worker. From 2001 through 2008, Petitioner worked for Respondent as a cashier in one of the dining halls. This position was eliminated by Respondent sometime in 2008, but Petitioner continued to work for Respondent as a cafeteria service worker. Petitioner was working as a cafeteria service worker at the time she sustained the accident on December 11, 2010.

Petitioner stated she graduated from high school in 1985, but, because of a learning disability she was in classes for "slow learners." The exact nature of Petitioner's learning disability was not stated. From 1985 to 1992, Petitioner worked primarily in home care and in two nursing homes. From 1992 to 1995, Petitioner worked for Jumer's Hotel as a housekeeper/supervisor. Petitioner stated that all of the jobs she previously had, including those she had with Respondent, required her to be on her feet for long hours. She said she was unable to return to work to any of those positions because their physical demands were inconsistent with her work/activity restrictions.

Petitioner's job search logs from May, 2015, through November, 2017, were tendered into evidence at trial. Virtually all of the contacts/applications with prospective employers were conducted online. Petitioner made approximately 1,500 contacts with potential employers (Petitioner's Exhibits 31, 33, 34 and 35).

At the direction of Respondent, Amy Portz, a vocational rehabilitation expert, met with Petitioner on October 25, 2016. Portz reviewed Petitioner's educational and employment history as well as the FCE report. Portz opined that there were jobs for which Petitioner was qualified and were within her work restrictions. They were caregiver/companion, front desk attendant, driver, cashier and receptionist/switchboard. The annual salaries ranged from approximately $19,000.00 to $27,000.00 (Petitioner's Exhibit 30).

Again, at the direction of Respondent, Petitioner was interviewed by Melanie Kamen, a vocational rehabilitation expert, on January 10, 2017. Kamen provided vocational services to Petitioner from that time through July 27, 2017. Kamen met with Petitioner on a regular basis during that period of time and her reports were received into evidence at trial.

When Kamen initially met with Petitioner on January 10, 2017, she opined Petitioner had transferable skills and was employable even though Petitioner's restrictions limited her to the light physical demand level. Kamen also noted that Petitioner needed to be fully committed to the process and make a good faith effort (Petitioner's Exhibit 30).

Kamen prepared numerous reports from January 23, 2017, through July 27, 2017, regarding Petitioner's efforts to secure employment. For the most part, Petitioner was compliant with the rehabilitation plan from January, 2017, through May, 2017. Petitioner completed the job search activities, made the required number of employer contacts, applied for jobs for which she received leads, etc. (Petitioner's Exhibit 30).

In Kamen's report of June 5, 2017, she noted Petitioner had been noncompliant with the job search process because she did not follow up with an employer who had requested additional information. In her subsequent report of June 15, 2017, Kamen noted Petitioner was compliant (Petitioner's Exhibit 30).

In Kamen's report of July 1, 2017, she noted Petitioner had again been noncompliant with the vocational rehabilitation plan. The primary issue with Petitioner was her not following up with prospective employers from prior applications or employers who had contacted her for additional information (Petitioner's Exhibit 30).

When Kamen subsequently saw Petitioner on July 11, 2017, she noted that, among other things, Petitioner failed to attend a hiring event held at the Holiday Inn in Decatur. She also noted it had been recommended Petitioner enroll in a computer class but that Petitioner was reluctant to do so. At that time, Kamen noted "Client does not wish to enhance her computer skills, vital to today's workforce; nor does she attend hiring events where she can be seen by employers. She does not respond to requests from employers by email, makes no in person contacts, and sabotages interviews by discussing her worker's compensation case. Client submits applications, but does not respond to requests from employers who notice her application and want further communication. Consequently, the application submissions are useless." (Petitioner's Exhibit 30).

In Kamen's last report of July 27, 2017, she reaffirmed the opinions she had stated in her prior report of July 13, 2017 (Petitioner's Exhibit 30). Subsequent to that report, Respondent discontinued providing vocational services to Petitioner and terminated payment of maintenance.

At the direction of Petitioner's counsel, Petitioner was evaluated by Dennis Gustafson, a vocational expert, on September 19, 2016. Gustafson reviewed Petitioner's educational and work history as well as the medical records, including the FCE of May 4, 2016. He noted Petitioner had significant work/activity restrictions. Because of Petitioner's work/activity restrictions and a narrow range of vocational options, he opined Petitioner's chances of obtaining and sustaining employment were poor. He opined that if Petitioner was, in fact, able to return to work, the starting wages would be in the range of $8.50 to $9.50 per hour (Petitioner's Exhibit 20).

Melanie Kamen was deposed on December 13, 2017, and her deposition testimony was received into evidence at trial. On direct examination, Kamen's testimony was consistent with her reports and she reaffirmed the opinions contained therein. She opined Petitioner had transferable skills, but that there were periods of time in which Petitioner was noncompliant, in particular, in June/July, 2017. She stated that one of the ways she would monitor a client's progress was to check their emails to make certain applications were being completed, interviews were conducted, emails were responded to, etc. However, Kamen noted that Petitioner deleted all of the emails generated during the time that they had worked together. Kamen also testified Petitioner was sabotaging the process by her behavior. Specifically, she noted Petitioner would disclose her work/activity restrictions and discuss the status of her workers' compensation case (Respondent's Exhibit 2; pp 12-15, 21-26).

On cross-examination, Kamen agreed Petitioner could not return to any of her prior jobs because of the work/activity restrictions. She also agreed that Petitioner was compliant with the rehabilitation plan on various occasions (Respondent's Exhibit 2; pp 30-36, 40-60).

Dennis Gustafson was deposed on December 22, 2017, and his deposition testimony was received into evidence at trial. On direct examination, Gustafson's testimony was consistent with his report of September 19, 2016, and he reaffirmed the opinions contained therein. He noted Petitioner did have some personal service work, but that it was low skill and not transferable to anything else. While he agreed Petitioner had worked as a cashier, he also noted that Petitioner usually did nothing more than scan cards or meal tickets, not take money and make change (Petitioner's Exhibit 36; pp 12-16).

On cross-examination, Gustafson conceded he had no knowledge of Petitioner's job search activities. Further, he had no specific information or knowledge of exactly what Petitioner's learning disability was (Petitioner's Exhibit 36; pp 19- 21).

Conclusions of Law

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

Pursuant to the stipulation entered into at trial, the Arbitrator concludes Respondent is liable for the medical expenses incurred by Petitioner as a result of the accident of December 11, 2010.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibits 15, 17 and 28 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

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

The Arbitrator concludes Petitioner has sustained 40% loss of use of the person as a whole as a result of the accident of December 11, 2010.

In support of this conclusion the Arbitrator notes the following:

Petitioner sustained a serious injury to her left lower leg which caused a fracture of the tibia which was subsequently determined to have resulted in a nonunion. Two surgeries were required, the first involving the insertion of metal hardware and the second involving the partial removal of metal hardware.

Petitioner was subject to significant work/activity restrictions and was limited to working in a light physical demand level.

There was no question that, because of her work/activity restrictions, Petitioner could not return to work to the job she had at the time she sustained the accident on December 11, 2010, or any of the jobs Petitioner previously held.

Petitioner was a high school graduate, but testified she had a learning disability and took classes for what she described as "slow learners." The exact nature of Petitioner's learning disability was not identified.

Petitioner claimed that she was permanently and totally disabled as result of the injury she sustained; however, the Arbitrator concludes that Petitioner did not prove that she was permanently and totally disabled.

While Petitioner was drawing weekly benefits, she performed a self-directed job search.

Petitioner also utilized the services of Melanie Kamen, a vocational rehabilitation expert hired by Respondent, from January 10, 2017, through July 27, 2017. During the majority of time Petitioner was receiving these services, she was compliant with the rehabilitation plan. However, Petitioner's noncompliance became an issue in June/July, 2017. According to the testimony tendered at trial, Petitioner did not follow up with prospective employers, did not attend a hiring event, did not make in person contacts, did not enroll in a computer class and sabotaged the process by discussing her restrictions and workers' compensation case.

Petitioner's vocational expert, Dennis Gustafson, met with Petitioner on one occasion and opined that Petitioner's chances of obtaining and sustaining employment were poor. Gustafson only met with Petitioner on that one occasion and did not provide any vocational services. Further, he did not review any of the reports prepared by Kamen.

Based upon the preceding, the Arbitrator finds the opinion of Kamen to be more persuasive than that of Gustafson.

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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BARBARA MILLER,

Petitioner,

vs. NO: 13 WC 17936

CITY OF CHICAGO,

19IWCC0243

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, and permanent disability, and being advised of the facts and law, affirms the Decision of the Arbitrator. We write separately to address Petitioner's arguments on review.

Findings of Fact

Petitioner filed an Application for Adjustment of Claim alleging a lower back injury arising out of and in the course of her employment on August 17, 2012. RX1. The matter proceeded to hearing before Arbitrator David Kane on January 26, 2018. The signed Request for Hearing confirms the date of the alleged accidental injury is August 17, 2012. ArbX1.

Petitioner was the sole witness at trial. Petitioner testified she worked in Respondent's Department of Law as assistant to the Deputy Corporation Counsel. 1/26/2018 Trans., p. 8-9.

Questioning then turned to Petitioner's alleged accident. Petitioner's Counsel directed Petitioner's attention to August 10, 2012 and asked her to describe her duties that day. Petitioner responded as follows:

> On that particular day, we had a new senior attorney starting; and I was asked by my deputy to prepare the office, which required me to remove quite a lot of files from

> the credenza, inside the office and out, and a lot of bending, and taking the files from the credenza, packing them into file boxes and labeling the boxes, preparing the boxes for the warehouse and carrying them over to the warehouse site for processing…
> I noticed that my back injury - - there was a lot of pain in my back that went down to my right side, and I told my boss right away that I think I hurt my back. 1/26/2018 Trans., p. 9-10.

Petitioner testified her boss directed her to contact Sherry Brydon, the administrative assistant for employment in the Law Department. 1/26/2018 Trans., p. 10.

Later in her testimony, Petitioner confirmed she had testified she was injured on August 10, 2012. 1/26/2018 Trans., p. 31. Asked to describe the pain she experienced on August 10, 2012, Petitioner stated it was significant and like nothing she had felt before. 1/26/2018 Trans., p. 32. She agreed she had a prior history of back pain and explained she had back problems dating back to July 2009 when there was a six-month move at work. 1/26/2018 Trans., p. 33.

Petitioner testified she contacted Ms. Brydon who forwarded a form the Monday after the Friday injury. 1/26/2018 Trans., p. 10. She completed the form and which her boss signed upon his return from vacation. 1/26/2018 Trans., p. 10. Petitioner explained she was advised Respondent would send her to a physician once her form was approved. 1/26/2018 Trans., p. 12.

Petitioner continued to work after the injury but no longer lifted boxes. 1/26/2018 Trans., p. 11, 36. While working, she experienced pain radiating from the right side of her buttocks to the left side as well as down her right leg to her foot. 1/26/2018 Trans., p. 11.

Petitioner stated she consulted with her primary care physician, Dr. Allgeier, in August or September of 2012. Dr. Allgeier's treatment records were not offered into evidence, however Petitioner testified Dr. Allgeier applied heat treatments and provided a therapeutic exercise program. 1/26/2018 Trans., p. 13-14. Petitioner testified she did not follow up with Dr. Allgeier immediately thereafter as she was waiting to see Respondent's doctor. 1/26/2018 Trans., p. 19. On questioning by the Arbitrator, Petitioner explained Ms. Brydon directed her to see Dr. Hartsock at Respondent's company clinic, Advanced Occupational Medicine. 1/26/2018 Trans., p. 39-40. Petitioner agreed she saw Dr. Hartsock on September 14, 2012, and Dr. Hartsock diagnosed her with a back strain. 1/26/2018 Trans., p. 34-35.

Directed to November 28, 2012, Petitioner agreed she saw Dr. Allgeier that day and was diagnosed with a herniated disc injury based on an MRI. 1/26/2018 Trans., p. 20. She testified she underwent intermittent treatment with Dr. Allgeier over the next few years. 1/26/2018 Trans., p. 20.

In December 2014, Petitioner retired. 1/26/2018 Trans., p. 8, RX3.

In July 2016, Petitioner came under the care of Dr. Jeff Louis at West Loop Chiropractic & Sports Injury Center. 1/26/2018 Trans., p. 15, 21. She testified she continues to see Dr. Louis when she has experiences severe episodes of pain; her last appointment prior to arbitration

occurred in October or November 2017. 1/26/2018 Trans., p. 21, 24.

Petitioner testified surgery has been recommended on two occasions, but she has declined it as she does not wish to undergo surgery. 1/26/2018 Trans., p. 26.

Petitioner's current symptoms include pain with lifting objects such as grocery bags, pain with prolonged standing or sitting and walking long distances, as well as difficulty ascending and descending stairs. 1/26/2018 Trans., p. 27-28. She utilizes holistic measures and has made lifestyle changes to ameliorate her symptoms. 1/26/2018 Trans., p. 28-29.

The matter was then continued for close of proofs and submission of documentary evidence. When the hearing reconvened on February 28, 2018, Petitioner offered the following exhibits:

Petitioner's Exhibit 1 – October 4, 2010 Report of Occupational Injury or Illness detailing injury dates of August 4, 2009 and April 2010 (1 page);

Petitioner's Exhibit 2 – Cover Letter/Accommodation Request Medical Questionnaire (4 pages);

Petitioner's Exhibit 3 – incomplete copy of Dr. Avi Bernstein's May 11, 2015 Section 12 examination report (1 page);

Petitioner's Exhibit 4 – Dr. Chris Edginton's February 18, 2016 office note (2 pages);

Petitioner's Exhibit 5 – Dr. Robert Strugala, Midland Orthopedic Associates at Wabash (2 pages);

Petitioner's Exhibit 6 – November 12, 2016 lumbar spine MRI (1 page);

Petitioner's Exhibit 7 – NorthShore University HealthSystem (5 pages); and

Petitioner's Exhibit 8 – Dr. Jeff Louis' October 18, 2016 re-examination report (1 page).

The Commission observes five of Petitioner's exhibits are not presented in their unadulterated form but instead contain handwritten comments not original to the document. While Respondent stated for the record it did not wish to be bound by any of the extraneous notations, formal objection was waived in the interest of judicial economy. The Commission further observes Petitioner's medical record Exhibits do not include either a Section 16 certification or subpoena and therefore lack the requisite indicia the records are true and correct. Through the charity of Respondent's Counsel, Petitioner escaped fatal hearsay and foundational objections. Petitioner's medical care as documented in Petitioner's admitted medical records is detailed in chronological order below.

On November 30, 2012, in response to a request from Petitioner, Dr. Michael Allgeier completed an Accommodation Request Medical Questionnaire. The questionnaire reflects the

condition at issue is a herniated disc injury, and Dr. Allgeier identified the following restrictions: no repetitive bending, no repetitive lifting, proper support during all sitting, and requires ergonomic chair. PX2.

On February 18, 2016, Petitioner was evaluated by Dr. Chris Edginton. Dr. Edginton documented Petitioner's history of injury as follows:

> Ms. Miller reports that in 2009 while working, she had a low back injury. That began a long history of multiple doctor visits and interventions. Briefly, and not in chronological order, Ms. Miller has: visited a Chiropractor, has had physical therapy, has visited her primary care medical doctor, has consulted with an orthopedic surgeon, has had a lumbar spine MRI. To date, Ms. Miller continues to note episodic low back pain and leg pain. She estimates these episodes to last between three days to two weeks at a time, and she has these episodes monthly.

The examination findings include negative straight leg raise; positive Hibb's and Patrick's bilaterally; pain and spasm to palpation in the bilateral lumbar and gluteal muscles, with the gluteal musculature more sensitive on the right; and pain with flexion. Dr. Edginton memorialized Petitioner's request for his review of an October 29, 2012 lumbar spine MRI:

> She is understanding of my credentials as a Chiropractic Physician and not as a radiologist. In viewing the scans, there is multi-level degenerative disc disease through all disc levels visualized. Additionally, there is end-plate abnormality at disc levels L3, L4, and L5, most notable at L3. There is posterior disc bulging at L5, with worsening to the right. There is multi-level facet hypertrophy, consistent with degenerative changes.

Dr. Edginton's diagnostic impression was lumbago, lumbar intervertebral disc degeneration, and lumbosacral intervertebral disc degeneration. PX4.

On February 25, 2016, Petitioner presented to Midland Orthopedic Associates at Wabash where she was evaluated by Dr. Robert Strugala. The records reflect Petitioner complained of low back and right leg pain associated with "an injury at work in 2012 involving repetitive bending and lifting legal files." PX5. She indicated she managed her symptoms with home exercises and chiropractic treatment but was frustrated with her ongoing struggles and sought additional recommendations. Dr. Strugala noted the DVD of the October 2012 lumbar spine MRI he was provided was incomplete; and then referenced the report findings: diffuse lumbar spondylosis with changes most prominent in the lower lumbar region including a grade 1 spondylolisthesis at L5-S1; posterior disc bulging at L5-S1; and moderate spinal stenosis at L4-5 as well as mild to moderate central spinal stenosis at L5-S1. Diagnosing low back pain since 2012 with associated right leg symptoms, Dr. Strugala ordered an updated MRI with further recommendations pending the outcome. Dr. Strugala further noted Petitioner asked him to comment on causation, but he declined: "At this juncture, I conveyed that it would be very difficult for me to address and/or determine causality of the MRI findings..." PX5. A March 11, 2016 chart note reflects Petitioner provided a second copy of the October 2012 MRI; noting the study was over three years old, Dr. Strugala again recommended obtaining a new MRI. PX5.

On March 23, 2016, Petitioner underwent the prescribed lumbar spine MRI. Comparing the images with the October 2012 study, the radiologist's impression was increased size small external synovial cyst at L4-5 level without mass effect; mild increased central canal stenosis L4-5; and similar right foraminal protrusion with very mild stenosis L5-S1. PX7.

On March 29, 2016, Petitioner consulted with Dr. Edward Mkrdichian of NorthShore University HealthSystem. The Commission observes, rather than Dr. Mkrdichian's complete dictated report, only a single-page "After Visit Summary" was submitted into evidence. The summary indicates "Reason for visit: Lumbar Stenosis" and "RECOMMENDATIONS: Surgery for L4-5, L5-S1 decompression, possible Right L5-S1 discectomy and Bony fusion – Skokie Hospital." PX7.

On October 18, 2016, Petitioner was seen by Dr. Jeff Louis at West Loop Chiropractic & Sports Injury Center. Dr. Louis' report reflects Petitioner presented for "established re-examination and continued care" of her lumbar spine disc conditions:

> Initial injury occurred at work in August 2012. It has been 6 weeks since Barbara's last appointment and 11 weeks since her initial examination. Symptoms were originally beginning on the left side of the [lumbar spine] and radiating down the right leg into the foot secondary to a [lumbar spine] protrusion and stenosis as noted on MRI. At this point pain is located across the [lumbar spine] without radiation into the [lower extremities bilaterally].

Dr. Louis indicated Petitioner's prognosis was good, and his treatment plan was continued-manual traction, electrical stimulation, and therapeutic exercises. PX8.

On November 12, 2016, Petitioner underwent a repeat lumbar spine MRI, this ordered by Dr. Louis. The radiologist's impression was: 1) trace anterolisthesis of L5 on S1; 2) at L5-S1, the spondylolisthesis, severe facet arthrosis and ligamentum flavum thickening results in mild narrowing along the lateral aspects of the spinal canal with moderate right and mild left foraminal stenosis, and there is also a small osteophyte related to the right facet joint that is directed towards the right neural foramen; 3) at L4-5, broad-based disc bulging with severe facet arthrosis and ligamentum flavum thickening results in moderate central canal stenosis with mild bilateral foraminal stenosis; and 4) at L3-4, facet arthrosis and ligamentum flavum thickening results in mild central canal stenosis. PX6.

Respondent offered the following exhibits:

Respondent's Exhibit 1 – Application for Adjustment of Claim;

Respondent's Exhibit 2 – Dr. Avi Bernstein's May 11, 2015 Section 12 Report;

Respondent's Exhibit 3 – October 20, 2014 Notice of Forthcoming Retirement; and

Respondent's Exhibit 4 – Wage Statement.

Dr. Bernstein's report reflects Petitioner described an initial low back injury at work in 2009 as well as a reinjury while she was bending and moving files on August 17, 2012. She complained of low back pain radiating down the right leg in a sciatic distribution. Dr. Bernstein documented Petitioner's examination was essentially normal, with full lumbar spine range of motion; ability to heel/toe walk; and normal strength, sensation, and reflexes in the lower extremities. Upon reviewing reports from a September 25, 2009 lumbar x-ray as well as the October 25, 2012 MRI, Dr. Bernstein's assessment was chronic low back pain related to a chronic preexisting degenerative condition of the lumbar spine. Noting Petitioner's medical records document waxing and waning symptoms for a number of years, Dr. Bernstein opined that although certain physical activities may have brought out some of her symptoms, he did not believe the alleged incident resulted in a structural injury to Petitioner's spine as the radiographic study suggested chronic degenerative condition as opposed to an acute injury. Dr. Bernstein concluded, at the most, Petitioner suffered a lumbar strain or temporary aggravation of her degenerative condition. RX2.

Conclusions of Law

The Arbitrator concluded Petitioner failed to prove she sustained an accidental injury on August 17, 2012. In so doing, the Arbitrator emphasized Petitioner repeatedly testified the incident occurred on August 10, 2012, and the medical records, which are noticeably sparse, do not support an accident on either August 10 or August 17, 2012.

Petitioner raises several challenges to the Arbitrator's decision. Before addressing Petitioner's arguments, we feel it prudent to reiterate the statutory constraints which govern our review. "The Commission is an administrative agency, and therefore, it has no general or common law powers. [Citation.] The Commission's powers are limited to those granted by the legislature, so that any action taken by the Commission must be specifically authorized by statute." *Alvarado v. Industrial Commission*, 216 Ill. 2d 547, 553, 837 N.E.2d 909 (2005). Section 19(e) of the Act sets forth the Commission's review power: "If a petition for review and agreed statement of facts or transcript of evidence is filed, as provided herein, the Commission shall promptly review the decision of the Arbitrator and all questions of law or fact which appear from the statement of facts or transcript of evidence." *820 ILCS 305/19(e)*. Significantly, since 1989, "no additional evidence shall be introduced by the parties before the Commission on review of the decision of the Arbitrator." *820 ILCS 305/19(e)*. To be clear, the Commission is statutorily prohibited from considering anything which was not presented to the Arbitrator, and our review of the evidence is restricted to that which is contained within the authenticated transcript of evidence.

Petitioner first directs our attention to an Occupational Injury Report form, signed by her supervisor on September 5, 2012, which reflects Petitioner reported back complaints after lifting boxes. Petitioner did testify Ms. Brydon provided her with an accident report to complete, and this would seemingly be the form she described. Though the Commission does not dispute Petitioner's veracity as to the contents of this form, the only accident report offered into evidence is an October 4, 2010 Report of Occupational Injury which references injuries sustained August 4, 2009 and April 2010. PX1. While a 2012 accident report may very well exist, no such

document is in the authenticated transcript, and as such, we cannot and will not consider Petitioner's allegations as to what is memorialized therein.

Petitioner further notes she created a spreadsheet detailing the approximately 90 medical visits she attended between 2012 and 2017, yet she was "surprised to learn that her former attorney did not submit this." The Commission observes Petitioner testified she underwent an extended course of treatment with both Dr. Allgeier and Dr. Louis over that span, and we do not doubt Petitioner prepared a document chronicling that care. Critically, however, neither a summary spreadsheet nor corresponding treatment records were offered into evidence. Instead, the transcript of evidence contains only three (3) complete physician evaluation notes (Dr. Edginton February 18, 2016; Dr. Strugala February 25, 2016; and Dr. Louis October 18, 2016), and of those three records, only one (Dr. Louis) memorializes a work injury in August, 2012. PX8. In contrast, Dr. Strugala's report describes only an injury in 2012, while Dr. Edginton's note references a history of episodic low back and leg pain dating back to a work injury in 2009. As such, the transcript before us lacks medical documentation corroborating an August 17, 2012 work injury.

Petitioner additionally contends her case was prejudiced because she chose to treat with a chiropractor instead of an orthopedist. In support of her position, Petitioner references The American Chiropractic Association's position that judges often give more weight to orthopedic physicians than chiropractic physicians, and this bias violates a standing cease and desist order set forth in *Wilk, et al v. The American Medical Association, et al.*, 671 F. Supp. 1465 (1987). The Commission notes *Wilk* is a 30-year-old Sherman Act action filed by chiropractors against medical associations which had attempted to eliminate the chiropractic profession by refusing to deal with chiropractors. *Wilk* has no relevance to the present matter.

Petitioner also emphasizes she was evaluated by Dr. Mkrdichian, a neurosurgeon, who recommended surgery. We agree there is evidence of such a consultation, however, the complete evaluation note is not contained in the transcript. Rather, all that was offered into evidence is an "After Visit Summary" which reflects "Reason for Visit: Lumbar Stenosis" and "Recommendation: Surgery for L4-5, L5-S1 decompression, possible Right L5-S1 discectomy and Bony fusion." PX7. While this is consistent with Petitioner's testimony that surgery has been recommended, without a history of injury or physical examination findings, this note does little to establish her condition results from an August 17, 2012 work accident.

Petitioner next notes that her three MRI reports were attached as exhibits to her Proposed Decision, but such evidence was ignored. We first highlight an attachment to a proposed decision does not constitute properly admitted evidence. We nonetheless observe the March 23, 2016 and November 12, 2016 MRI reports are in the transcript, contained within Petitioner's Exhibit 7 and Petitioner's Exhibit 6 respectively, and have been considered.

Petitioner further alleges a violation of Rule of Evidence 103, arguing the Arbitrator made a finding predicated on excluded evidence. It is certainly true that, except when the Act provides otherwise, the Illinois rules of evidence govern proceedings before the Illinois Workers' Compensation Commission. *RG Construction Services v. Illinois Workers' Compensation Commission*, 2014 IL App (1st) 132137WC, ¶35, 24 N.E.3d 923. Illinois Rule of Evidence 103

pertains to a "ruling which admits or excludes evidence". *Ill. R. Evid. 103* (effective Oct. 15, 2015). The Commission finds this rule is inapplicable to matter *sub judice*. The Arbitrator did not rule any evidence was excluded; instead, each of the exhibits offered by both parties was admitted. While the Arbitrator made adverse findings after noting the incomplete medical record, it was not an evidentiary ruling which removed that evidence from consideration. Rather, the documents were never offered and therefore were, in effect, withheld from the Arbitrator's or the Commission's review.

Finally, Petitioner alleges Respondent engaged in bad faith negotiations and has submitted Commission Rule 9040.40 special interrogatories. It is improper under these circumstances for the Commission to comment on negotiations between attorneys. As to the interrogatories, we note Petitioner directed these to Respondent's Counsel personally, however neither the Act nor the Rules provide a mechanism whereby the Commission can require parties or their counsel to respond to interrogatories from their party-opponents.

Having fully considered and analyzed the evidence contained in the transcript, the Commission finds Petitioner failed to prove she sustained an accidental injury arising out of and in the course of her employment on August 17, 2012.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 5, 2018, as modified above, is hereby affirmed and adopted.

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

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

The 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: MAY 17 2019

LEC/mck

O: 5/1/19

43

L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MILLER, BARBARA
Employee/Petitioner

Case# **13WC017936**

CITY OF CHICAGO
Employer/Respondent

19IWCC0243

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:

3029 FICHERA & MILLER PC
HOWARD MILLER
415 N LASALLE ST SUITE 301
CHICAGO, IL 60654

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

STATE OF ILLINOIS)

)SS.

COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Barbara Miller
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # 13 WC 17936

19IWCC0243

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **01/26/2018 and 02/28/2018**. 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. [ ] 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 **08/17/2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 $**67,600.00**; the average weekly wage was $**1,300.00**.

On the date of accident, Petitioner was **64** 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 $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**0.00**.

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

ORDER

The Arbitrator finds that Petitioner lacked credibility and failed to meet her burden of proof on the issues of accident and causal connection. The Arbitrator views the remaining disputed issues as moved. Compensation is denied.

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

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

David A. Kane
Signature of Arbitrator

March 5, 2018
Date

MAR 5 - 2018

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BARBARA MILLER,	)	
	)	
Petitioner,	)	
	)	
v.	)	No. 13 WC 17936
	)	
CITY OF CHICAGO,	)	19IWCC0243
	)	
Respondent.	)	

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The parties agree that on August 17, 2012, Petitioner and Respondent were operating under the Illinois Workers' Compensation or Occupational Diseases Act and their relationship was that of employer and employee. The parties agree that Petitioner provided Respondent notice of the alleged accident within 45 days of its occurrence. The parties agree that Petitioner's average weekly wage is $1,300.00. The parties agree that Respondent is not liable for any bills or TTD benefits.

The disputed issues in this matter include (1) Whether Petitioner sustained an injury that arose out of and in the course of her employment with Respondent on August 17, 2012; (2) whether Petitioner's current condition of ill-being is causally related to an accident at work on August 17, 2012,and (3) the nature and extent of Petitioner's injury.

STATEMENT OF FACTS

Petitioner testified that on August 10, 2012 she was employed by the City of Chicago in the City's Law Department as Administrative Assistant to the Deputy Corporate Counsel. Petitioner testified that she was retired from this position on December 13, 2014. Petitioner voluntarily submitted her resignation on October 20, 2014. (RX3)

Petitioner testified on August 10, 2012 [*sic.*] she was asked to prepare an office for a new attorney that was starting shortly thereafter. Petitioner testified she was carrying files to a warehouse when she began to feel pain down the right side of her leg and low back. Petitioner testified that she continued to work in her regular capacity. Petitioner admitted she was never authorized off work for the alleged injury by any medical professional.

Petitioner testified that sometime in August or September of 2012 she began treatment with Dr. Allgeier, a chiropractor. Petitioner did not submite any medical documentation in support of any treatment in either August 2012 or September of 2012.

Petitioner admitted into evidence a November 28, 2012 "Cover Letter for Employee/Applicant to Provide to Medical Professional." (PX1) This document was addressed to Dr. Allgeier. This documents that Petitioner suffered a herniated disc injury. It is unclear who the author of this document is. There is no further indication as to the mechanism of injury, date of injury, or course of recommended treatment. This document is devoid of any relatedness to an August 2012 accident.

On November 30, 2012, Dr. Allgeier completed in an "Accommodation Request Medical Questionnaire" indicating Petitioner

should avoid repetitive bending and lifting. (PX2) This document fails to describe a mechanism of injury, date of injury, or course of recommended treatment. This document is devoid of any relatedness to an August 2012 accident.

On February 18, 2016, Petitioner retrained chiropractor Chris Eddginton, to draft a narrative report on February 18, 2016 (PX4). According to Dr. Eddginton Petitioner reported a low back injury manifesting in 2009. Dr. Eddginton noted that Petitioner continued to suffer from episodic low back pain and leg pain. Clarifying he was not a radiologist, Dr. Eddginton reviewed an October 29, 2012 lumbar MRI and interpreted it as showing "posterior disc bulging at L5, with worsening to the right." Dr. Eddginton diagnosed Petitioner with lumbago and lumbar intervertebral disc degeneration. Any mention of an August 2012 work accident is noticeably absent from this report.

Petitioner underwent an independent medical examination with Dr. Avi Bernstein on May 11, 2015. Dr. Bernstein diagnosed Petitioner with chronic low back pain related to a chronic pre-existing degenerative condition of the lumbar spine. Dr. Bernstein noted that Petitioner had "waxing and waning symptoms for a number of years based on the medical records." Dr. Bernstein concluded the Petitioner did not suffer any structural injury to her spine as a result of the alleged incident on the job. Dr. Bernstein noted that there was no acute injury on any of Petitioner's diagnostic findings. Dr. Bernstein noted that at most Petitioner sustained a lumbar strain or a temporary aggravation of her degenerative condition.

Petitioner's ongoing course of treatment after November 2012 is unclear. Petitioner testified that in July of 2016 she began treatment with West Loop Chiropractic. Petitioner testified that she began seeing Dr. Luis,

~~a chiropractor. Petitioner testified that the last time she saw Dr. Luis was~~ October or November of 2017. Petitioner testified that Dr. Luis was able to "decompress" her spine without the use of surgery. The Arbitrator notes that the Petitioner did not present any documentation or medical records from October or November of 2017.

Petitioner admitted that she is not taking any pain medications aside from over the counter Tylenol. Petitioner admitted that when requested to complete a drug test following her accident, she refused.

Petitioner admitted to suffering from low back pain dating back to at least 2009. Petitioner admitted that no physician has taken her off of work. Petitioner admitted that she has not returned to Dr. Allgeier since July of 2015. Petitioner testified that she has no plans to return to Dr. Allgeier. Petitioner testified that she has not returned to Dr. Luis since October or November of 2017.

Only July 19, 2017, Dr. Luis drafted a narrative indicating that Petitioner had attained maximum medical improvement. Petitioner was not experiencing any radiating pain or symptoms originating from her lumbar spine. Dr. Luis does not comment on a mechanism of injury or relatedness to the August 2012 incident. (PX3)

CONCLUSIONS OF LAW

In support of the Arbitrator's decision with respect to C (Accident), the Arbitrator finds as follows:

After considering the totality of the evidence, the Arbitrator concludes that the Petitioner failed to meet her burden of proving that she sustained

an accident that arose out of and in the course of her employment on August 17, 2012. In support of this conclusion, the Arbitrator relies on Petitioner's vague testimony, the Application for Adjustment of Claim (RX1), and the scant medical documentation.

First, Petitioner's testimony describing an August 10, 2012 accident is inconsistent with the alleged date of accident stipulated to by the parties on the Request for Hearing Form (AX1), as well as the Application for Adjustment of Claim (RX1). On both the Request for Hearing form and the Application, Petitioner alleges that she suffered a work related injury on August 17, 2012. However, Petitioner testified her injury occurred one week prior on August 10, 2012.

Furthermore, upon a close review of all the medical documentation and Petitioner's own testimony, there is no evidence in the record to support an August 17, 2012 date of accident. The Arbitrator notes that there is not a single piece of evidence in support an August 10, 2012 or even an August 17, 2012 work accident. None of Petitioner's exhibits detail a manifestation date or mechanism of injury.

Perhaps most compelling is the narrative report from Dr. Chris Eddginton diagnosing Petitioner with lumbago and lumbar intervertebral disc degeneration.(PX4) This note documents that Petitioner reported an injury in **2009** that she suffered a low back injury. This record is silent as it pertains to an August 2012 injury.

Additionally, the Arbitrator notes that Petitioner clearly lacks any medical treatment to corroborate her alleged accident. Petitioner submitted into evidence vague and incomplete medical documents providing no outline of Petitioner's course of treatment, her mechanism of injury, or her date of injury.

Finally, Petitioner's own testimony with respect to her alleged injury is vague and unclear. Petitioner testified that she worked for the City of Chicago in the Law Department as an Administrative Assistant. Petitioner testified that sometime in August or September of 2012, though she could not remember when, she began treating with a chiropractor. The Arbitrator notes there is no evidence of any treatment in August or September of 2012. Petitioner's testified she next began treatment with Dr. Luis, a chiropractor in approximately July of 2016. Petitioner provided no details regarding the 4 year period between 2012 and the summer of 2016. Based on the above, the Arbitrator finds petitioner lacked credibility.

Based on Petitioner's inconsistent date of accident, vague and incomplete testimony, and Petitioner's lacking medical documentation, the Arbitrator finds that Petitioner failed to meet her burden of proving by a preponderance of the credible evidence that she sustained an accident that arose out of and in the course of her employment under the act.

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

In light of the Arbitrator's findings that Petitioner failed to prove an accident arising out of her employment, the Arbitrator need not find that Petitioner sustained a condition causally connected to said alleged accident August 17, 2012

Due to the foregoing findings, all other issues are rendered moot. Compensation is hereby denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SHERRI KLOCEK,

Petitioner,

vs. NO: 17 WC 13454

FRESENIUS MEDICAL CARE,

19IWCC0244

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) of the Act having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical, temporary benefits, penalties and attorney's fees, and the weight of evidence, 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. Indus. Comm'n*, 78 Ill. 2d 327 (1980).

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (4th Dist. 1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n*, 51 Ill. 2d 533, 536-37 (1972).

The Commission modifies the Arbitrator's award for prospective medical care. The Commission agrees with the Arbitrator that Petitioner failed to prove that she is entitled to a referral for clinical consultation with a neurologist and/or pain specialist for assessment of Complex Regional Pain Syndrome (CRPS). However, as to the award of the functional capacity evaluation (FCE), the Commission disagrees with the Arbitrator and instead finds that Petitioner is not entitled to the study. The Commission notes, as did the Arbitrator, that Petitioner had refused to attend work conditioning and refused Respondent's offer of a job accommodation that would result in no loss in earnings. While the Commission acknowledges that Petitioner's refusal may have been based in part on the recommendation of her treating physician Dr. Johnny Rossi, the Commission agrees with the Arbitrator that Petitioner's credibility regarding her present complaints were questionable in light of her arbitration testimony and the video received in evidence as Respondent's Exhibit 4. Thus, the Commission agrees with Respondent's Section 12 examiner, Dr. Johnny Lin, that based on Petitioner's refusals, Petitioner had reached maximum medical improvement (MMI) as of November 16, 2017. Therefore, the Commission strikes the Arbitrator's award of the FCE, and instead awards the ASO brace as recommended twice by Dr. Lin. The remainder of the Arbitrator's Decision is affirmed and adopted.

The Commission further writes to correct the following:

1) Page 4 of the Arbitrator's Decision inadvertently states "Respondent's" Findings of Fact. The Commission strikes the word "Respondent's." It is the Arbitrator's Findings of Fact; and,
2) Page 10 of the Arbitrator's Decision contains a duplicative paragraph. The Commission strikes the duplicative paragraph.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on May 30, 2018, is hereby modified as stated above; all else is affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner all reasonable and necessary professional medical bills incurred up to and including November 16, 2017, pursuant to Section 8(a) of the Act and to be adjusted in accord with the medical fee schedule provided in Section 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall receive a credit for any medical bills paid in this claim. The parties agreed that medical bills incurred prior to April 7, 2017 will have been paid directly to the providers.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for the clinical consultation with a neurologist and/or pain specialist for assessment of Complex Regional Pain Syndrome (CRPS) and Petitioner's request for the FCE, are hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to the ankle brace as recommended by Dr. Lin.

ankle sprain; and 2) the disputed complaints of persistent agonizing pain and neurological injury. Following the work accident, Petitioner sought treatment from several providers ultimately coming under the care of Dr. Rossi. At the time of hearing, Dr. Rossi recommended ongoing care specifically a referral to a neurologist/pain physician to address a possible neurological component and/or CRPS. PX7[1]. During the course of her treatment, Dr. Johnny Lin evaluated Petitioner on two occasions at Respondent's request pursuant to Section 12 of the Act. Ultimately, Dr. Lin placed Petitioner at maximum medical improvement (MMI) as of November 16, 2017 and with the exception of suggesting Petitioner be fitted with an ASO brace, recommended no further treatment. PX6C; RX3.

At trial Petitioner testified at length as to her ongoing severe pain complaints which restrict her ability to ambulate and further necessitate the use of a walker and/or cane. T. 43, 47, 50, 52, 57, 58-59, 65. Challenging Petitioner's claimed level of disability, Respondent offered into evidence surveillance video of Petitioner's activities while helping her son move on or about October 23, 2017.

The majority in adopting the Arbitrator's finding that "Petitioner's credibility regarding her present complaints were [*sic*] questionable" appears to want its cake and eat it too. Petitioner is either credible regarding her pain complaints and their *sequela*, or she is not. The majority finds such complaints "questionable" yet still finds Petitioner's current condition of ill-being causally related to her accident. If a causal relationship exists, then it follows that Petitioner is entitled to the treatment recommended by Dr. Rossi. The majority, though, denies the treatment recommended by Dr. Rossi by relying on Dr. Lin's opinion placing Petitioner at MMI as of November 16, 2017. With all due respect to the majority, it is confusing MMI with causal relationship. MMI speaks to stabilization of a claimant's medical condition. See *Mech. Devices v. Indus. Comm'n*, 344 Ill. App. 3d 752, 760 (2003) ("The factors to be considered in determining whether a claimant has reached maximum medical improvement include: (1) a release to return to work; (2) the medical testimony concerning the claimant's injury; (3) the extent of the injury; and (4) 'most importantly,' whether the injury has stabilized"). If, as the majority finds, a causal relationship continues to exist regarding Petitioner's pain complaints, then Petitioner's condition certainly has not stabilized, and she, by definition, has not reached MMI.

I find Petitioner not credible regarding her complaints of ongoing and debilitating pain. At trial Petitioner testified, after seeing Dr. Rossi on September 7, 2017, "I have so much pain…" T. 47. She testified attending physical therapy from September 12 through October 10, 2017 left her in so much pain "I would have to go and lay down most of the day after that. I wasn't able to go out and do anything." T. 50. Petitioner testified she experienced the same pain as of September 28, 2017. T. 52. As of the date of hearing (12/22/17), Petitioner testified she was unable to care for herself and used either a cane or walker to ambulate. T. 58-9. On cross-examination, Petitioner reiterated she needed a cane or a walker to assist her. T. 65.

[1] It should be noted contained in PX7 is the narrative report of Dr. Rossi which the Arbitrator specifically disregarded in arriving at his decision, finding it was prepared in anticipation of litigation. On review, Petitioner took exception to this finding in her brief and at oral argument. The majority opinion fails to directly address this issue in its decision, so I emphasize Petitioner's Exhibit 7 was admitted without objection at trial (T. 121), therefore, the narrative report contained therein constitutes properly-admitted, competent evidence and has been considered.

Respondent offered into evidence surveillance video of Petitioner on or about October 23, 2017. RX4. The video evidences Petitioner walking without any assistive device, cane, walker, or otherwise. In contradiction to her trial testimony, the video evidences Petitioner walking in a normal fashion. She is able to carry boxes and bags without any apparent difficulty. Petitioner is seen walking on uneven ground again without apparent difficulty. Petitioner participated in such activities over an extended period of time. RX4. Additionally, Petitioner testified she appeared in court on December 1, and 4, 2017 in Will County and was able to walk without the use of a cane or walker. T. 75. Petitioner is simply not credible.

An expert's opinion is only as valid as the facts upon which it is based. See *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC, ¶ 36 (quoting *Gross v. Ill. Workers' Comp. Comm'n*, 2011 IL App (4th) 100615WC ("Expert opinions must be supported by facts and are only as valid as the facts underlying them")). Given Dr. Rossi's opinions are predicated on Petitioner's incredible subjective complaints of pain, I afford little weight to Dr. Rossi's opinions. I further note Dr. Rossi seemingly acknowledged Petitioner's complaints were dubious in his narrative report of December 11, 2017 stating an FCE may be warranted "to objectively ascertain whether there is validity in her subjective complaints of paresthesia, pain and functional ankle stability given the differences in physical exam findings among Dr. Lin, Dr. Toolan, myself and the physical therapist." PX7.

Thus, I afford greater weight to the opinions of Dr. Lin who opined that based on Petitioner's refusals regarding participation in work conditioning as well as his review of the diagnostic studies (x-rays and MRI), and physical examination findings, Petitioner reached maximum medical improvement (MMI) as of November 16, 2017, and no further treatment was warranted. Dr. Lin's opinions are supported by Dr. Toolan who on May 8, 2017 found Petitioner neurologically intact without injury to the arch of her foot and no abnormalities warranting further intervention beyond physical therapy to stretch her Achilles tendon.

Consistent with the parties' arguments and the medical evidence, Petitioner's diagnoses of 1) left foot contusion; 2) left foot first toe distal phalanx fracture, healed; and 3) left ankle sprain remain causally related. However, I find Petitioner's current condition of ill-being, specifically her unsupported subjective complaints of incapacitating pain and an alleged neurologic component including but not limited to CRPS, is not causally related to her accident of December 2, 2016. Therefore, I concur with the majority's decision denying the FCE but awarding the ASO brace, as this was recommended twice by Dr. Lin prior to his finding of MMI. I find Petitioner's medical care rendered through November 16, 2017 to be reasonable and necessary as found by the Arbitrator on page 2 of his Decision. As such finding is contradicted by the finding of the Arbitrator made on page 16, paragraph 5, I would strike this paragraph.

For the reasons set forth above, I concur with the outcome reached by the majority.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is not entitled to temporary total disability benefits (TTD) or temporary partial disability (TPD) benefits after January 26, 2017.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $6,261.85 for TTD previously paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for penalties and attorney's fees pursuant to Sections 16, 19(k), and 19(l) 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 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 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.

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

DATED: MAY 17 2019

D. Douglas McCarthy

DDM/pm
O: 5-1-19
052

Stephen Mathis

SPECIAL CONCURRENCE

I agree with the ultimate result reached by the majority. I write separately as I arrived at my decision utilizing a different analysis.

Petitioner sustained an undisputed injury to her left foot/ankle when an electric wheelchair ran over her foot. T. 20. To be clear, there are two components to the condition of ill-being Petitioner alleges results therefrom: 1) the left foot contusion, first toe distal phalanx fracture, and

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

KLOCEK, SHERRI
Employee/Petitioner

Case# **17WC013454**

FRESINIUS MEDICAL CARE
Employer/Respondent

19IWCC0244

On 5/30/2018, 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:

0850 CIFELLI SCREMENTI & DOE
DAVID CIFELLI
423 ASHLAND AVE
CHICAGO HTS, IL 60411

0766 HENNESSY & ROACH PC
LAUREN A SERAFIN
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

STATE OF ILLINOIS)

)SS.

COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Sherri Klocek
Employee/Petitioner

Case # **17** WC **13454**

v.

Consolidated cases: **N/A**

Fresenius Medical Care
Employer/Respondent

19IWCC0244

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **December 22, 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 ______

ICArbDec19(b) 2/10 100 W. Randolph Street #8-200 Chicago, IL 60601 312/814-6611 Toll-free 866/352-3033 Web site: www.iwcc.il.gov
Downstate offices: Collinsville 618/346-3450 Peoria 309/671-3019 Rockford 815/987-7292 Springfield 217/785-7084

FINDINGS

On the date of accident, **12/2/2016**, 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 $**42,482.96**; the average weekly wage was $**816.98**.

On the date of accident, Petitioner was **45** years of age, ***married*** with **3** dependent children.

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

Respondent shall be given a credit of $**6,261.85** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**6,215.85**.

ORDER

Respondent shall pay to Petitioner all reasonable and necessary professional medical bills incurred up to and including November 16, 2017, to be adjusted in accord with the medical fee schedule provided in §8.2 of the Act.

Respondent shall authorize and pay for the Functional Capacity Evaluation recommended by Drs. Rossi and Lin.

Respondent will receive a credit for $6261.85 for benefits paid by Respondent previously.

Penalties and fees are denied.

Respondent shall receive a credit for any medical bills paid in this claim. The parties agree that medical bills incurred prior to April 7, 2017 will have been paid directly to the providers.

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.

19IWCC0244

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 29, 2018
Date

MAY 30 2018

Sherri Klocek v. Fresenius Medical Care
17 WC 13454

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** Is Petitioner entitled to prospective medical care and services?; ***L:*** What temporary benefits are in dispute? TTD, TPD; ***M:*** Should penalties be imposed upon Respondent?

Respondent's FINDINGS OF FACT

Petitioner Sherri Klocek testified that she works for Respondent Fresenius Medical Center, as a registered nurse. Her job duties included patient assessment taking patients' weights, getting patients into chairs, setting up machines, and cannulation.

On December 2, 2016, Petitioner began work at 4:30 a.m. While helping a patient in a motorized wheelchair put on her coat from behind, the patient put the wheelchair in reverse and ran over Petitioner's foot, great toe, ankle, and up her leg. A co-worker came to her aid. As the wheelchair was reversed it ran over Petitioner's foot again. The patient and the wheelchair together weighed 424 pounds.

Petitioner testified that she sustained a "big gash" down her leg that was bleeding, her toe "didn't look right." Her foot was red and bruised. Petitioner testified that she felt awful and could not walk. She testified that her pain was from her toes to her brain, through her back, side, and arms.

Petitioner testified that she asked a coworker nurse for help but the other nurse said she was too busy. Petitioner then called for relief from Tess, the charge nurse, but Tess said she was too busy and that Petitioner would have to continue working. Petitioner then continued to work through the remainder of her shift even though she was in tears and a lot of pain. She had to hop around to perform her regular duties until she was relieved by Desiree Porter.

Petitioner was told to go to Occupational Health at St. James Hospital, WorkingWell (PX #1). Petitioner was seen December 2, 2016 and gave a history of being run over and pinned beneath an electric wheelchair. She complained of pain over her entire left leg but mostly the left great toe. Bruises and superficial abrasions over

the left shin were noted. Left foot x-rays were equivocal, showing a questionable cortical irregularity in the distal aspect of the first digit phalanx. There was no dislocation. Petitioner was diagnosed with a non-displaced fracture of the left great toe and contusions and abrasions over her left leg from foot to hip. She was discharged with an Ace wrap, crutches, and a referral to an orthopedist. She was taken off work. Petitioner testified she was given only one crutch because a second was not available.

Petitioner testified that she was sent to Dr. (William) Payne to assess her foot, leg, and hip. She saw Dr. Payne December 8, 2016 (PX #2). Petitioner complained of pain in her left foot, the left groin area, and the left side of her back. Petitioner gave a long list of drug allergies. On exam Dr. Payne noted tenderness but normal motion in the left hip, as well as tenderness, reduced motion, and reduced strength in the left foot and ankle. There was also bruising on the left great toe. He diagnosed a non-displaced fracture of the left great toe, left ankle sprain, low back pain, and left hip strain. Dr. Payne prescribed a tall CAM boot, two crutches, physical therapy for the hip and low back, and Tramadol. Dr. Payne took Petitioner off work.

Petitioner received physical therapy for her foot, ankle, leg, and left hip at New Life Physical Therapy & Rehabilitation from December 9, 2016 through March 2, 2017 (PX #3).

Petitioner saw Dr. Payne again on December 22, 2016. Her clinical presentation and complaints were essentially the same as before. Petitioner reported no improvement from therapy, rating her pain 4–5/10. Petitioner complained of continued numbness and tingling in the left foot and that she developed right leg pain compensating for the left leg pain. She complained of numbness and tingling in the left leg. She stated that left leg pain radiated into her groin. There were no significant changes during the clinical examination. Dr. Payne planned to wean Petitioner off the CAM boot over the following 2 weeks and then wean off crutches. He continued physical therapy and ordered an EMG/NCV.

Petitioner returned to Dr. Payne January 24, 2017 with continuing complaints of pain and swelling in he left great toe. There was normal left ankle strength but left foot leg and thigh strength was reduced. She had not had the recommended EMG. Petitioner requested a return to light duty work. Dr. Payne authorized work restricted to 20 pounds lifting or push/pull and no standing for more than 4 hours, with periodic sitting. He also continued therapy and the recommendation for an EMG.

Petitioner had an EMG/NVC February 15, 2017 at Suburban Pain Center, which was within normal limits (PX #4).

Petitioner last saw Dr. Payne March 2, 2017. She reported that she had a normal EMG. Petitioner complained of continued paresthesia in the dorsal and plantar of her left foot, radiating into the lateral/anterior/posterior leg. She also complained of continued numbness in the distal left great toe. Petitioner had returned to work but reported she was working on her feet for extended hours. Dr. Payne added the diagnosis of Baxter nerve entrapment syndrome. Dr. Payne discharged Petitioner with 20-pound lifting/pulling/pushing work restrictions and also a 4 hour limit on standing. Dr. Payne referred her to a foot and ankle specialist for evaluation of possible Baxter nerve entrapment and continued fracture pain.

On Dr. Payne's referral Petitioner began physical therapy at New Life Physical Therapy and Rehabilitation [New Life] December 9, 2016 (PX #3). Petitioner reported her current pain in her left great toe and left foot and ankle at 4/10, but the worst was 8/10. The last progress note at New Life is dated March 6, 2017. At that time Petitioner reported left great toe left ankle and foot pain at 2/10, the worst at 5/10. Petitioner still had some deficits in range of motion and strength but showed good overall improvement. The therapist was unsure of the cause of continued complaints of pain. There was a recommendation of continued therapy 3 times a week for 4 weeks of physician authorization was required for continued therapy.

Petitioner testified that Dr. Payne refused to continue to treat her for her toe injury. She said Dr. Payne told her he had not been authorized to treat her for anything else.

Petitioner testified that she continues to have pain, numbness, and tingling in her foot. Her pain was shooting up and down her leg. She testified that there was bluishness in her toes. Petitioner also testified that she had bleeding at her toenail.

Petitioner testified she saw Dr. Lin on April 7, 2017 for her first IME. She testified that Dr. Lin only spent about 3 minutes with her, which upset her. She was not able to talk about her complaints. Dr. Lin recommended an ASO brace. Petitioner did not remember if Dr. Lin recommended additional physical therapy.

Petitioner testified that she continued working but it was "horrible." She had to stand for longer than 4 hours and "run around." Because of work demands Petitioner could not sit as needed. She developed pain and swelling at the end of a work-day. She testified that by the time she got home she could not stand and had to crawl to the bathroom.

Petitioner consulted orthopedist Dr. Brian Toolan at The University of Chicago Medicine May 4, 2017 (PX #5). She testified that Dr. Toolan refused to see her as a

patient and discharged her. The records note that Petitioner complained of her left foot, ankle, leg, and hip. She also complained about injury to her right foot. Her primary complaints were with her left foot and ankle. Petitioner reported that her foot had been run over by an inpatient resident that she was treating in a nursing home. She reported that electric wheelchair and rolled over her foot and pinned her foot underneath the tires for approximately 5 minutes. She had treated with Dr. Payne but was not "forthcoming with much detail" of Dr. Payne's treatment plan other than she had not improved

Dr. Toolan noted no acute distress. Petitioner's left foot was normal in appearance with no swelling or inflammation. He noted she had a normal plantigrade-appearing foot. She had normal strength and motion. Dr. Toolan found no sign of a fracture on x-rays.

Dr. Toolan explained that Petitioner did not have a crush injury that would be destructive of the arch of the foot. He did note that something had run over her foot but found no neurologic deficits. He did find in an equinus contracture of the ankle and an inability to dorsiflex past neutral, which was different from her right foot. Dr. Toolan recommended Petitioner return to Dr. Payne and continue physical therapy for the Achilles tendon. He found no other abnormalities and told Petitioner that he would not assume her care and that she should follow up with Dr. Payne.

Petitioner then saw podiatrist Dr. Johnny Rossi on referral from her attorney. Petitioner first consulted Dr. Rossi August 9, 2017 (PX #7). She said she was seeking a third opinion for the injury to her left foot. She gave a history of being run over by a motorized scooter we 400 pounds in December 2016. Petitioner reported that her ankle was twisted and her shin was trapped between the tire and the battery pack of the scooter. She reported fractures in two places of her left great toe, both noted as healed by a prayer physician. Petitioner reported that she had not had an MRI of the foot or ankle since her injury. She complained of foot ankle and leg pain since the injury and also on the right side due to compensation. She reported she was working within restrictions but that she had severe pain despite those restrictions. Petitioner reported that two bouts of physical therapy were not helpful.

On examination of the left foot and ankle Dr. Rossi noted a normal temperature gradient. Petitioner had a left-sided antalgic gait. Range of motion of the left ankle was limited by pain but was normal in the right ankle. Specifically, Petitioner had pain on motion along the lateral gutter, anterior talofibular ligament, and subtalar joint. In addition, she had pain along the peroneal tendons and along the plantar fascia as well as the plantar heel. Pain radiated proximately to the mid-leg and distally to the mid-foot

with plantarflexion. Dr. Rossi also noted reduced muscle strength, except for 5/5 pronation with pain. Sensation was within normal limits.

Dr. Rossi diagnosed left foot neuritis, pain in the left foot and ankle, "other" sprain of the left foot, and sprain of other left ankle ligament. He recommended an MRI to assess possible peroneal tendon tear or osteochondral lesion. He prescribed Gabapentin for neuropathic symptoms and Meloxicam for inflammation. He also recommended an articulated AFO.

Included in Dr. Rossi's records is Petitioner's attorney's August 17, 2017 letter requesting a narrative report.

Petitioner had MRIs of her left foot and left ankle August 30, 2017 at Homer Glen Imaging (PX #8). The foot MRI demonstrated no evidence of osteochondral lesion within the first metatarsal head or at the base of the proximal phalanx of the left hallux. There was a hallux valgus deformity with evidence of degenerative osteoarthropathy but the at the first metatarsophalangeal joint. There was also marrow edema within the distal phalanx of the hallux but no acute fracture. The ankle MRI showed a possible focal tear of the peroneus longus tendon with associated tenosynovitis. There was evidence of tenosynovitis of the posterior tibial tendon. A focal tear of the flexor hallucis longus tendon could not be ruled out. Also, mild tenosynovitis of the flexor digitorum longus tendon could not be ruled out.

Petitioner returned to Dr. Rossi September 7, 2017, following her MRI. Dr. Rossi noted Petitioner was working full-time but that she reported she limps by the end of the day due to excruciating pain. She was described pain around her ankle and into the top and bottom of her foot as well as her heel. Petitioner's presentation on clinical exam findings were essentially unchanged from August 9. Dr. Rossi noted that the left foot was warm to touch. Sensation was again intact. Dr. Rossi's diagnoses were then pain in the left foot and ankle joint, other sprain of left foot, sprain of other left ankle ligament, strain of muscle and tendon of long flexor muscles of toe at the ankle and foot, and neuritis of left foot. Dr. Rossi ordered therapy 3 times a week for 4 to 6 weeks. He continued to recommend an articulated AFO, but noted a BK cast application might be possible if no improvement.

Petitioner began therapy September 12, 2017 at Athletico on referral from Dr. Rossi (PX #9). Petitioner complained that her left foot pain disrupts her sleep. She reported difficulty with stairs and had fallen several times using while using stairs. She reported that she limps the whole day and can tolerate standing for less than an hour for developing pain. Petitioner stated that she returned to full duty work she would be unable to do much walking, pivoting, patient transfers, or heavy lifting. Petitioner had

12 sessions of therapy at Athletico through October 10, 2017. She still had complaints of being unable to be on her feet for more than an hour before pain increased significantly and had to rest. Petitioner reported some improvement with therapy but had continuing difficulty with prolonged walking and standing. Therapy was discontinued October 10 pending further orders from her podiatrist. It was noted that Petitioner referred to a neurologist for assessment of apparent nerve pain.

Petitioner returned September 28, 2017 with continuing complaints. She did report some improvement with therapy but also describes shooting pain all over her foot she complained of her ankle getting out at times and that she had been unable to obtain Meloxicam because it was not approved. Petitioner's presentation on clinical examination was essentially unchanged from prior examinations. She still had pain on range of motion testing. Muscle strength, except on pronation, was diminished. He noted that Petitioner's left foot was warm to touch. Sensation was again intact. Dr. Rossi added causalgia of left lower to his prior diagnoses. He advised Petitioner to finish her therapy. He added Lyrica to her prescriptions. He recommended a referral to Dr. "Lubinow" [*sic*] at Rush Medical Center for evaluation of CRPS (complex regional pain syndrome). He also continued his recommendation for an articulated AFO, but advised in the meantime use of an OTC ankle brace. Dr. Rossi took Petitioner off work.

Petitioner saw Dr. Rossi again November 2, 2017. She reported minimal improvement with therapy but had no change in her pain level. Petitioner reported that she could not tolerate Gabapentin or Lyrica due to alterations in her mental status. She reported that Dr. Lin advised that she could return to light duty work. Petitioner's clinical presentation was essentially unchanged, although Dr. Rossi described her antalgic gait has "shuffling." He again noted normal temperature gradient. Range of motion remained limited and painful. Muscle strength, except for pronation, was still diminished. Dr. Rossi's diagnoses remained unchanged. He opined that Petitioner would benefit from work hardening which he felt Petitioner was unable to tolerate given her symptoms. He recommended she be off work until she was evaluated by a neurologist. He again referred Petitioner for an FCE. He noted that if those accommodations could not be met he did not know what more he could do for Petitioner. He further recommended a third opinion from a physician of equal qualifications as Dr. Lin.

Petitioner last saw Dr. Rossi November 30, 2017. Petitioner reported that 2 weeks before she injured her ankle again when she was going downstairs and felt her ankle give out. She still noted shooting pain the entire foot which had not changed. Petitioner's clinical presentation on examination was essentially unchanged from prior encounters: temperature gradient normal, range of motion reduced by pain sensation intact bilaterally, and muscle strength diminished. Dr. Rossi did note that Petitioner

exhibited hypersensitivity on sensation testing. His diagnoses remain the same. He noted Petitioner's report that she could not afford an OTC ankle brace. Petitioner had reduced activity. Dr. Rossi again recommended a neurology consultation to assess why the ankle continues to give out though she was structurally sound per the MRI and collateral ankle ligaments.

Petitioner testified that "every day all the time" she feels intense pain in her foot, ankle, legs, hips and low back. Further, she testified that she cannot perform her daily activities of normal living. Petitioner testified that she cannot walk or travel without her cane or walker. She uses her cane around the home for short distances, and her walker for long stretches.

On cross-examination, Petitioner testified that she uses a cane around the house or when she needs to go short distances. She uses her walker for longer distances or when walking over uneven surfaces.

Further, Petitioner testified that on the previously set trial date for her Workers' Compensation claim, November 21, 2017, she was in too much pain to attend. On further cross-examination Petitioner did not remember attending at divorce proceedings in Will County on November 13, December 1 and December 4, 2017. After review of Respondent's Exhibits #9 and #10 Petitioner recalled that she appeared for those proceedings on December 1 and December 4, 2017. Further, Petitioner admitted that she appeared in court for those proceedings without using a cane or a walker.

Further, Petitioner testified that on the previously set trial date for her Workers' Compensation claim, November 21, 2017, she was in too much pain to attend. On further cross-examination Petitioner did not remember attending at divorce proceedings in Will County on November 13, December 1 and December 4, 2017. After review of Respondent's Exhibits #9 and #10 Petitioner recalled that she appeared for those proceedings on December 1 and December 4, 2017. Further, Petitioner admitted that she appeared in court for those proceedings without using a cane or a walker.

Respondent called Aona Anderson, the clinic manager, to testify. She created Petitioner's work schedule and managed Petitioner's job duties. Ms. Anderson testified that Petitioner's job duties included drawing medications, making sure patient charting is done, and handling medical equipment. A typical day for Petitioner included intermittent periods of sitting and standing while working, on her feet from 5:00 a.m. to 7:00 a.m., and then sitting from 7:00 a.m. to 9:00 a.m. Petitioner would be back on her feet from 9:00 a.m. to 11:00 a.m. and then patient turnover begins. Ms. Anderson testified that if Petitioner needed to, she would be able to sit, just as any other nurse would.

Ms. Anderson testified that after Petitioner was released to return to work, she offered Petitioner days to return to work that would total her regular work week. She testified that Petitioner refused some of the work days due to personal reasons. Had Petitioner accepted all hours offered, she would have earned the same amount as she did before her injury.

Ms. Anderson further testified that Petitioner worked until September 7, 2017. On October 31, 2017, Ms. Anderson received Petitioner's new work restrictions. She testified that she called Petitioner to offer her 4 hours a day, followed by a 10-minute rest period, and the Petitioner refused. Ms. Anderson then stated that she contacted the insurance adjuster, Mary LoParco, who requested she accommodate Petitioner's request for 100% seated work. Ms. Anderson testified that she told Ms. LoParco that Petitioner could be accommodated with 2 hours a day, for 10 hours a week. When that offer was made, Petitioner said it was not "worth her time." Ms. Anderson further testified that after that phone call she attempted to contact Petitioner again to return to work, Petitioner did not answer. She could not leave a voicemail because the mailbox was full.

Video Surveillance (RX #4)

Respondent offered its Exhibit #4, a video recording of surveillance of Petitioner on October 23, 2017. The parties stipulated that Petitioner was recorded after the work accident at issue. Petitioner was depicted variously walking and carrying boxes and bags which did not appear particularly heavy. Petitioner was observed stooping and at times bending to place boxes and items into the back seat and trunk of a car. She was observed moving items from the trunk of the car into the back seat and rearranging those items in the back seat of the car. Last, Petitioner was observed driving the loaded car away.

Rebuttal

On rebuttal Petitioner acknowledged that the activity portrayed on surveillance video occurred around October 23, 2017. Petitioner testified that she was carrying "just some papers" out of the house to help her son, Devin, move. Petitioner testified that she walked only on flat surfaces, and anything she was carrying that was "considerable" was done with the assistance of her son.

Devin Klocek, Petitioner's son, was also called to testify on behalf of Petitioner. He installed the cameras in his father's home. He testified that the video was an "accelerating of pictures" and that the video sped up the footage so she appeared to move faster than she really did. Mr. Klocek testified that his mother was only there helping him for 45 minutes to an hour.

Dr. Payne narrative report

Dr. William Payne wrote a narrative report September 21, 2017 addressed "To Whom It May Concern" (PX #2). Dr. Payne recounted his course of care beginning with the first encounter with Petitioner on December 8, 2016. He noted that Petitioner presented with 4/10 pain. On physical examination he found tenderness in the greater trochanter area. Left hip motion was reduced. There was tenderness over the ankle. Foot strength was diminished in all muscle groups. Dr. Payne diagnosed a left great toe nondisplaced distal phalanx fracture, left lower leg soft tissue injury, left ankle sprain, low back pain, and left hip strain. Dr. Payne noted he ordered a tall boot and physical therapy 3 times a week for 4 weeks for the lumbar spine and left hip. He took Petitioner off work.

Dr. Payne noted that on December 20, 2016. Petitioner reported no improvement from therapy, rating her pain 4–5/10. Petitioner complained of continued numbness and tingling in the left foot and that she developed right leg pain compensating for the left leg pain. There were no significant changes during the clinical examination. Dr. Payne planned to wean Petitioner off the CAM boot over the following two weeks and then wean off crutches. Petitioner returned January 24, 2017 with continuing left great toe pain. Petitioner stated she wanted to return to light duty work. There was normal left ankle strength but left foot leg and thigh strength was reduced.

Petitioner last saw Dr. Payne on March 2, 2017. She reported that she had returned to work with restrictions but that work involved extended periods of time on her feet. She had increased pain and tingling which rest alleviated. Examination of the right and left ankles were normal, although there was left ankle swelling. Dr. Payne referred Petitioner to a foot and ankle surgeon for assessment of possible Baxter nerve entrapment and post fracture pain. He discharged Petitioner from his care. Dr. Payne went on to opine that the injuries were associated with Petitioner's work-related accident and that she may require surgery in the future if her persistent pain continued.

Dr. Rossi narrative report

On December 11, 2017 Dr. Rossi wrote a lengthy narrative report address "to whom it may concern." Dr. Rossi reiterated Petitioner's course up through his consultations, the last on November 30. In his narrative report Dr. Rossi opined that, objectively and subjectively, the December 2, 2016 incident was causally related to petitioner's current diagnoses in the left foot and left ankle. Dr. Rossi made reference to Dr. Lin's April 7, 2007 IME, noting Dr. Lin's recommendation for light duty work 4 hours standing with a 20-pound carry limit and for physical therapy.

Petitioner reported that she attended therapy, but Dr. Rossi noted those records were unavailable to him. Dr. Rossi also noted Dr. Toolan's benign findings, but noted Dr. Toolan did not note palpable pain or a positive Tinel's sign. He did note Dr. Toolan's recommendation that Petitioner return to Dr. Payne for further physical therapy.

In summary Dr. Rossi now advised Petitioner to refrain from work hardening until she has been evaluated by neurology or a pain specialist in order to assess for possible underlying neurological conditions such as a lumbar disc herniation or CRPS. He felt these evaluations could identify why Petitioner's symptoms persisted and to ultimately treat their underlying cause so she could return to work. Dr. Rossi also recommended an FCE to assess the validity of Petitioner's subjective complaints of paresthesia, pain, and ankle instability given the differences in her presentation on exams by himself, Dr. Lin, Dr. Toolan, and the physical therapist.

IMEs (PX #6, RX #1, RX #2, & RX #3)

Petitioner was examined by orthopedic surgeon Dr. Johnny Lin of Midwest Orthopedics at RUSH Respondent's request pursuant to §12 of the Act April 7, 2017 (PX #6a & RX #1). In addition to the clinical exam Dr. Lin reviewed Dr. Payne's records, a January 24, 2017 x-ray report, and the February 17 EMG report. Petitioner gave a history of her December 2, 2016 work accident when an electric wheelchair over her left foot, entrapping the foot 15 to 20 seconds. Petitioner had immediate pain and swelling and was unable to bear weight. She was immobilized and made nonweightbearing with crutches.

On exam Petitioner walked with reciprocal heel/toe gait. She had left-sided antalgic gait. Light touch sensation was intact. She demonstrated mild hypersensitivity on the plantar aspect of her foot and over the dorsal aspect of the midfoot. Motor strength was 4/5 in dorsiflexion, plantar flexion, eversion, and inversion. Dr. Lynn noted mild swelling in the left ankle (noting right ankle circumference was 28 cm and left ankle circumference was 21 cm: an apparent scrivener's error). Left ankle range of motion was diminished when compared to the right.

Dr. Lin diagnosed left foot contusion, left foot first toe distal phalanx fracture, healed, and left ankle sprain. He noted Petitioner's prognosis was good. Dr. Lin opined that Petitioner was able to work for 4 hours standing with 10 minutes of seated rest and that she should limit lifting to 30 pounds. Dr. Lin recommended a course of physical therapy at 2 times a week for 6 weeks followed by two weeks of work conditioning. He believed that would be adequate to achieve appropriate range of motion and strength to

where Petitioner would be able to return to work. He also recommended an ASO brace and compression stockings. Dr. Lin did not recommend further imaging or surgery. Finally, Dr. Lin opined that Petitioner's condition was related to her work accident.

Dr. Lin examined Petitioner for a second §12 IME on October 20, 2007 (PX #6b & RX #2). Dr. Lin repeated the history given by petitioner at the initial IME on April 7. In addition to prior records he reviewed Dr. Lin reviewed Dr. Toolan's opinion letter dated May 4, 2017, Dr. Rossi's records, and a "March 30, 2017" [*sic*] MRI (the MRI was done August 30, 2017). In addition, Dr. Lin reviewed updated Dr. Payne records.

On exam muscle strength with dorsiflexion, plantarflexion, eversion, and inversion was slightly improved. Neurologically Petitioner was essentially the same. Right and left ankle circumferences were the same, 23 cm. Right foot and left foot circumferences were the same, 19 cm. Petitioner was tender to palpation over her sinus tar site and the dorsal aspect of the midfoot. She had a little pain over the proximal phalanx of the MTP joint, both medially and laterally as well as dorsally. Ankle and foot ranges of motion were equal, except for diminished range of the left great toe on dorsiflexion.

Dr. Lin continued with his diagnoses of left foot contusion, healed left foot first toe distal phalanx fracture, and left ankle sprain. He again noted Petitioner's prognosis was good and that she was able to work for 4 hours standing with 10 minutes of seated rest. At that time he noted no limit for lifting. The only objective sign Dr. Lin noted was dorsiflexion contracture and minimal deficit in the left calf circumference, which was also present on the April 7 exam. Dr. Lin recommended 4 weeks of work conditioning to obtain adequate strength and ability to work full duty without restriction. Dr. Lin noted Petitioner could benefit from an FCE to determine her limitations and potential for her ability to return to full duty work. He further recommended that Petitioner continue with an ASO brace and compression stockings. Again, Dr. Lin did not recommend surgery or further imaging.

Dr. Lin prepared an IME addendum November 16, 2017 (PX #6c & RX #3). Dr. Lynn noted the report that Petitioner was refusing to work with the restrictions set forth in his IME report. He further noted the report that Petitioner had refused work conditioning. Based on Petitioner's refusal for further treatment, Dr. Lin opined that Petitioner was at MMI. He continued to recommend work 4 hours of standing with 10 minutes of seated rest during an 8 hour work day with no lifting limit.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner proved that she sustained a work-related injury to her left foot and ankle on December 2, 2016.

Petitioner was provided emergent care on December 2. She was diagnosed with a nondisplaced fracture of the left great toe as well as contusions and abrasions over leg, from foot to hip. She was referred to Dr. William Payne who also diagnosed a nondisplaced fracture of the left great toe, as well as a left ankle sprain and left hip strain.

Petitioner had continuing complaints with her left foot and ankle to the point where she consulted orthopedist Dr. Brian Toolan at The University of Chicago Medical Center. Petitioner consulted podiatrist Dr. Johnny Rossi on referral by her attorney for those continuing claims. Petitioner was examined pursuant to §12 of the Act by Dr. Johnny Lin Midwest Orthopedics at RUSH. Although Dr. Toolan did not diagnose a great toe fracture, Drs. Payne, Lin, and Rossi all diagnosed great toe fractions, as well as foot and ankle contusions and sprains. Later radiology studies confirmed the fracture had healed, despite Petitioner's. On the April 7, 2017, Dr. Lin opined that Petitioner's injury was causally related to her work accident.

The Arbitrator does note that Petitioner's credibility regarding her present complaints is questionable. Petitioner testified clearly that she often had to resort to use of a cane or a walker. Rather, she acknowledged that when attending court hearings relating to her divorce in Will County she did not use a cane or a walker. More compelling, was the surveillance of Petitioner on October 23, 2017. Petitioner was observed exhibiting none of the disability or limitation she testified to at the trial of this cause. Petitioner was observed walking and carrying numerous items without a limp or a facial expression suggesting discomfort.

J: Were 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 parties have agreed that medical care and related bills incurred prior to April 17, 2017, the date of Dr. Lin's first IME, are not disputed. Petitioner continued to receive medical care after April 17 from Drs. Toolan and Rossi. Respondent disputes the reasonableness and necessity of medical care subsequent to April 17, 2017.

The Arbitrator notes that on April 17, 2017 Dr. Lin recommended a course of physical therapy along with an ASO brace and compression stockings. On October 20, 2017, the second IME, Dr. Lin recommended 4 weeks of work conditioning and an FCE to determine Petitioner's limitations and potential for return to full duty work. He continued with his recommendation for an ASO brace and compression stockings. He consistently opined that surgery was not required.

On November 16, 2017, Dr. Lin noted in an addendum report that Petitioner had refused work conditioning. He did not note the refusal was based on Dr. Rossi's recommendation. On November 16, Dr. Lin opined petitioner was at MMI and could return to work with previously stated restrictions.

Both Dr. Rossi and Dr. Lin have recommended an FCE. Neither has retracted that recommendation.

The Arbitrator takes note of the "to whom it may concern" narrative letters drafted by Drs. Payne and Rossi. The letters do not relate to any clinical consultation relating to the dates of those letters. They are summaries of clinical care provided over time but also include opinions on ultimate issues pending in this matter. These letters were clearly prepared for purposes of litigation rather than for diagnosis or treatment, and as such are disregarded by the Arbitrator.

In light of all the evidence, the Arbitrator finds that due to Petitioner's unresolved continuing complaints she proved that the medical care provided up to the date of the hearing was reasonable and necessary to cure or relieve the effects of her injury sustained at work.

K: Is Petitioner entitled to prospective medical care and services?

The Arbitrator finds that Petitioner proved that she is entitled to a Functional Capacity Evaluation, as recommended by Drs. Rossi and Lin. The Arbitrator finds the opinions of these physicians with regard to the wisdom of assessing petitioner's ability to return to work with without restrictions were reasonable and persuasive. As stated above, although not in total agreement, these physicians were in step in recommending an FCE.

On the other hand, the Arbitrator finds that Petitioner failed to prove that she is entitled to a referral for clinical consultation for assessment of Complex Regional Pain Syndrome (CRPS). The Arbitrator did not find in the evidence documenting symptomology, other than chronic pain, normally attributable to CRPS: pain disproportionate to an inciting event, hyperalgesia or allodynia (lack of painful response

to pain-inducing stimuli), temperature asymmetry, skin color changes or asymmetry, trophic changes in hair growth, or edema or sweating changes or sweating asymmetry.

No treating or examining physician suspected CRPS or noted symptoms relatable to CRPS other than Dr. Rossi. The Arbitrator notes that Dr. Rossi is a podiatrist, a medical discipline of limited scope. Medical doctors such as Dr. Payne, Dr. Toolan, and Dr. Lin, who may under the Medical Practice Act may practice medicine without restriction or limit, neither found nor noted symptoms which raised suspicion that Petitioner had CRPS or required consultation for assessment of CRPS. Consequently, the Arbitrator does not find Dr. Rossi's opinion that a neurology or pain management consultation is reasonable or necessary was persuasive.

L: What temporary benefits are in dispute? TTD, TPD

Petitioner claims she is entitled to temporary total disability benefits from December 3, 2016 through February 11, 2017, temporary partial disability benefits from February 11, 2017 through April 13, 2017, and temporary total disability benefits again from September 7, 2017 through December 21, 2017. Respondent paid benefits from December 3, 2016 through January 26, 2017.

Petitioner was released to return to work with restrictions by Dr. Payne on January 24, 2017. Aona Anderson testified that after Dr. Payne's release she contacted the Petitioner to return to work. Ms. Anderson's testimony that she called Petitioner to offer her a job accommodation that would have resulted in no loss in earnings, but the Petitioner did not accept various dates of work she was offered was unrebutted. Therefore, Petitioner failed to prove that she was entitled to any disability benefits rafter January 26, 2017, based on her refusal to work within her restrictions.

The Arbitrator finds Petitioner's work schedule printouts (PX #11) irrelevant due to the fact that any reduction in hours was a result of her refusal to work the hours offered. In fact, Petitioner's Exhibit #11 shows that Petitioner worked an average of 14 days per pay period through August in 2017. The Arbitrator notes Petitioner did not present evidence of her normal work schedule before she was injured on December 2, 2016 or any specific date or period of time when she was so incapacitated that she was prevented from doing any work whatever.

The Arbitrator notes that Ms. Anderson testified credibly to efforts to allow Petitioner to work within the restrictions recommended by Dr. Payne and endorsed by Dr. Lin. Ms. Anderson was credible in her testimony that she offered Petitioner work within her restrictions as late as October 31, 2017.

Therefore, for want of proof by the preponderance of evidence, the Arbitrator finds that Petitioner failed to prove that she is entitled to temporary total disability benefits or temporary partial disability benefits after January 26, 2017.

M: Should penalties be imposed upon Respondent?

The evidence clearly showed that Petitioner sustained an injury to her left foot and ankle which limited her ability to perform full duty work without restrictions. Petitioner's treating physician, Dr. Payne, and Respondent's examining physician, Dr. Lin, both opined that Petitioner could return to work with a schedule which accommodated 4 hours on her feet with 10-minute rest periods each hour for an 8-hour shift. Respondent's witness Aona Anderson testified credibly that responded made good faith efforts to accommodate Petitioner's restrictions. Ms. Anderson also testified credibly that in her final effort to accommodate Petitioner on October 31, 2017, Petitioner refused those work accommodations. At the §19(b) hearing petitioner acknowledged her refusal of the offer of those accommodations.

Further, while the Arbitrator does not find Dr. Lin's opinion stated November 16, 2017 that Petitioner was at MMI persuasive, it was reasonable for Respondent to rely on that opinion as a basis for terminating benefits. It is neither frivolous nor vexatious to rely on the opinion of a qualified physician who had examined Petitioner when a Respondent terminates benefits and reliance on that opinion.

Steven J. Fruth, Arbitrator

May 29, 2018

STATE OF ILLINOIS)		
) SS.	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
COUNTY OF SANGAMON)	☐ 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

DANIEL OSTREM,

Petitioner,

vs. NO: 16 WC 13518

RUBY ELECTRIC, INC.,

Respondent.

19IWCC0245

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, nature and extent and §19(l) penalties, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission affirms and adopts the decision of the Arbitrator as to causation, nature and extent, and §19(l) penalties. However, the Commission modifies the decision of the Arbitrator and awards the unpaid bill of Dr. Romanelli from December 23, 2016. The Commission further strikes the language of the Award being pursuant to §8(j). Respondent is entitled to a credit of $2,000.00, but such credit does not fall within the purview of §8(j).

Petitioner's current condition of ill-being is causally connected to the work accident of May 21, 2015. The testimony and medical records support that an undisputed twisting accident occurred on May 21, 2015 (T. 8, Px2 and Px3). Petitioner first reported to the emergency room complaining of swelling and pain in his leg. (Px2) He was subsequently sent for an MRI wherein the diagnosis of a torn meniscus was confirmed. (Px6) Petitioner underwent surgical repair of his left knee on June 16, 2015. (Px3) Petitioner subsequently went through several months of physical therapy and follow-up appointments. During such time, he continued to report continued swelling and pain that was not resolving. (T. 11-18, Px3) Petitioner was released at maximum medical improvement by Dr. Herrin on December 10, 2015, but noted Petitioner does have some generalized swelling along anterior medial and anterolateral portions of the knee,

some mild tenderness along the patellofemoral joint as well as along the medial joint line. (Px3 12/10/15 visit).

The Commission finds that the Respondent's argument that the varus malalignment is a separate condition unrelated to the May 21, 2015 accident is not supported by the evidence. On May 22, 2015, Dr. Senica noted that Petitioner seems stable to varus and valgus stresses. (Px3 5/22/15 visit). Additionally, in his post-operative notes, Dr. Herrin confirmed that the meniscus could not be completely repaired. Dr. Herrin additionally noted that Petitioner had a displaced bucket-handle tear of the meniscus. (Px3 6/22/15 visit) Given the extent of the Petitioner's injury, the fact that the meniscus could not be fully repaired, the ongoing complaints of swelling, increased pain, and the interference of the condition as to the activities of daily living of Petitioner, the evidence supports that Petitioner's visit to Dr. Romanelli regarding his unresolved knee pain was causally connected to the May 21, 2015 work accident. The Commission therefore awards the unpaid bill of December 23, 2016 for $434.00.

The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $509.54 per week for a period of 53.75 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 25% loss of use of the left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $434.00 in relation to the outstanding bill of December 23, 2016, 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 penalties are denied.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $28,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 17 2019

Marc Parker

Stephen J. Mathis

L. Elizabeth Coppoletti

MP/dmm
O:040819
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OSTREM, DANIEL
Employee/Petitioner

Case# **16WC013518**

19IWCC0245

RUBY ELECTRIC INC
Employer/Respondent

On 5/23/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5041 ACKERMAN LAW OFFICE PC
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SPRINGFIELD, IL 62704

0265 HEYL ROYSTER VOELKER & ALLEN
DANIEL R SIMMONS
PO BOX 9678
SPRINGFIELD, IL 62791-9678

STATE OF ILLINOIS	)	G Injured Workers' Benefit Fund (§4(d))
	)SS.	G Rate Adjustment Fund (§8(g))
COUNTY OF **Sangamon**	)	G Second Injury Fund (§8(e)18)
		Y None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Daniel Ostrem
Employee/Petitioner

v.

Ruby Electric, Inc.
Employer/Respondent

Case # **16** WC **13518**

Consolidated cases: **N/A**

19IWCC0245

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **04/24/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. G Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. G Was there an employee-employer relationship?
C. G Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. G What was the date of the accident?
E. G Was timely notice of the accident given to Respondent?
F. 3 Is Petitioner's current condition of ill-being causally related to the injury?
G. G What were Petitioner's earnings?
H. G What was Petitioner's age at the time of the accident?
I. G What was Petitioner's marital status at the time of the accident?
J. 3 Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. G What temporary benefits are in dispute?
G TPD G Maintenance G TTD
L. 3What is the nature and extent of the injury?
M. 3Should penalties or fees be imposed upon Respondent?
N. G Is Respondent due any credit?
O. G Other

FINDINGS

On **05/21/15**, Respondent ***did*** operating under and subject 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 ***was*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**44,159.83**; the average weekly

wage was $**849.23**.

On the date of accident, Petitioner was **37** years of age, married with **2** dependent children.

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

Respondent ***did not*** pay all appropriate charges for all reasonable and necessary medical services.

Respondent paid all TTD and **all medical has been paid except 12/23/2016 OCI bill.**

Respondent is entitled to a credit of $**2,000.00 (PPD advance)** under Section 8(j) of the Act, but this is

subject to an adjustment for TTD as a result of a miscalculation in the average weekly wage.

ORDER

RESPONDENT SHALL PAY TO THE PETITIONER THE SUM OF $509.54/WEEK FOR 53.75 WEEKS, REPRESENTING 25 % LOSS OF USE OF THE LEFT LEG.

PENALTIES 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.

19IWCC0245

[signature]

5/16/2017

Signature of Arbitrator

Date

ICArbDec p. 2

MAY 2 3 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Daniel Ostrem
Employee/Petitioner

v.

Ruby Electric, Inc.
Employer/Respondent

Case # **16** WC **13518**

Consolidated cases: **N/A**

EXHIBIT A

The parties agreed that, based on the average weekly wage, that there was a slight underpayment of TTD, which the Respondent agreed to pay. (Tr. Pg. 7).

Petitioner, at 38 year of age, is a service electrician. He troubleshoots, determines electrical problems, and repairs them, whether it be residential, commercial, or industrial; it could involve power lines coming in underground or inside wiring. He has been an electrician for his working career of about twenty years, and worked for the Respondent for almost seven years. He had never had problems with this knee before the accident. (Pet # 2)

His job duties include being on his feet all day, climbing ladders, climbing in and out of attics, crawl spaces, underground holes, manholes, pretty much anything that has got electric. He either kneels, crawls or squats 50% of the day. He uses knee pads when possible, but there are situations where knee pads are not safe to use.

On May 21, 2015, Petitioner injured his knee at work. Petitioner went to Memorial Medical Center the same day complaining of a twisting and popping from an injury at work. The doctors noted he had no prior problems with his knee. While working in an attic, he felt a popping sensation. An x-ray was negative for a fracture.

On May 22, 2015, Petitioner saw Dr. Senica, who noted he had immediate pain following the incident and she found swelling. Petitioner had never had any prior problems with this knee before, although he had prior problems on the right. Petitioner told his doctor he wanted to return to work, so she let him the next day, but she told him not to work in attics, climb, and crawl or kneel.

Petitioner had an MRI on May 28, 2015, which showed a complex tear of the medial meniscus.

On June 03, 2015, Petitioner followed up with Dr. Herrin, who diagnosed a torn meniscus and recommended surgery for it.

Dr. Herrin performed surgery on June 16, 2015. He found a complex, unstable bucket handle tear, which was not repairable. He found horizontal cleavage to the tear and cut away the medial portion of the meniscus. He also found chondromalacia in the trochlear groove of the

femur. He took out a fragment of the meniscus and contoured what he could, trying to leave two stable flaps.

Petitioner met with Dr. Herrin on June 22, 2015. Dr. Herrin kept Petitioner off work and recommended physical therapy. Petitioner attended 26 sessions of physical therapy from June 20, 2015 to December 04, 2015. He missed numerous sessions, but he testified that he made up all the sessions he missed. All of the appointments he missed he missed for his employer's benefit. If he was in the middle of doing a repair, he would not want to leave the customer without an electrician while he went to physical therapy. (Tr. Pg. 12).

During physical therapy the therapist noted an antalgic gait, pain when he rolls over, and the inability to bend as much as it should. He had trouble with uneven surfaces, calf burning, and trouble with ladders, swelling, and trouble bending the knee. Petitioner repeatedly said he had trouble squatting, kneeling, and trouble sitting down.

On July 06, 2015 Dr. Herrin let him return to full duty work as of July 20, 2015.

On August 27, 2015, he described his knee as a fat man's knee, complaining that he could not see his kneecap. The therapist noted he still had decreased flexion and extension. On September 3, 2015, like he testified at trial, he told the therapist his knee swells by the end of the day. He told the therapist that working as an electrician is not helping his knee. The therapist thought his current problems are at least partly sub-patellar, along the patellar tendon and bursa, again confirming that this is more than just a torn meniscus. The therapist noted significant swelling.

On September 14, 2015, Dr. Herrin noted that he continues to have pain and swelling, consistent to the Petitioner's testimony. He found tenderness along the medial joint line.

On October 01, 2015, the therapist noted swelling. The edema was below the patella, consistent with later findings, including those of Dr. Romanelli, who finds varus malalignment in his later report.

On October 05, 2015, because the petitioner was still having so many problems, Dr. Herrin drained the knee of synovial fluid and injected a steroid. He also viewed the knee through an ultrasound to help with guidance of the needles. He noted that he was having pain on the medial part of the knee, having swelling, and troubles with stairs. He thought an inflammatory component may be part of the issue, as opposed to just the meniscal tear. He assessed the synovial fluid and the work he did that day as "injury caused by twisting with sudden strenuous movement" and called it a "work related injury," in the assessment section of his report, relating the synovial fluid issue and the "inflammatory component" to the injury.

Dr. Herrin found that petitioner was still having significant problems on October 21, 2015, which he felt may be more patellofemoral joint issues as opposed to medial compartment problems, but called it post injury and subsequent treatment, relating the patellofemoral issues to the work injury. He thought it might be partly related to his continued work activities and inadequate rehab, and that Petitioner's continued activity level may be contributing too. Dr.

Herrin wanted Petitioner to take a break from his work activities, so once his work schedule allows, he should be off work for a couple of weeks. (Petitioner's #3).

Dr. Herrin still felt the patellofemal joint problem was related to the work injury. Dr. Herrin again wrote that this was caused by an injury caused from twisting with sudden strenuous movement, and "work related injury" in his assessment. Dr. Herrin took Petitioner off work starting October 26, 2015 for two weeks to give his knee a respite from work duties. (Petitioner's #3).

In therapy on October 29, 2015, the therapist noted that the knee still bothers him significantly, especially when going sit to stand, and working ladders or steps at work. The therapist found sub patellar crepitus. She recommended he modify activities at home.

On November 06, 2015, Herrin took Petitioner off work until November 12, 2015.

On November 11, 2015, in physical therapy Petitioner noted that he may have to climb slower in the future. He was using knee pads at work, as he testified at trial. He said that when he goes back to work he does not plan on going all out like he did before. He is concerned about kneeling, squatting and bending at work.

Petitioner saw Dr. Herrin on November 12, 2015. Dr. Herrin believed Petitioner seems to have patellofemal joint issues, as well as the meniscus tear. He called the entire injury, not just the meniscal tear, an injury caused by twisting with a sudden strenuous movement and a work injury. He noted swelling per the therapist. Dr. Herrin told Petitioner to be more careful with his knee. He recommended that Petitioner return to work on November 16, 2015 with minimal kneeling, squatting or crawling. (Petitioner's Exhibit #3).

On December 10, 2015, Dr. Herrin saw Petitioner again. He saw him for his torn meniscus, patellofemoral problems which he described as problems that "go with" the injury. He found good range of motion and no significant effusion. He did note generalized swelling along the anterior medial and anterolateral parts of the knee. However, Petitioner was tender at the patellofemoral joint and medial joint line. Dr. Herrin thought he was at MMI. (Pet. #3).

On January 13, 2016, Dr. Brewer, at Springfield Clinic, performed an impairment rating. He noted that the Petitioner still has an antalgic gait, a loss of some extension and flexion, mild to moderate swelling and decreased strength. He gave an impairment rating of 2% of a leg or 1% MAW. (PX 4)

Petitioner, however, was still concerned about why he had so much pain, so, on December 23, 2016, Petitioner saw Dr. Romanelli, a partner of Dr. Herrin, for a second opinion. Dr. Romanelli said Petitioner is concerned because they are going to have attrition soon and wants a prognosis. He still has pain and swelling while working. Dr. Romanelli wrote that he lost about 50 – 75% of his meniscus in surgery according to Dr. Herrin's records.. On exam, he found Grade 3 effusion. Dr. Romanelli noted that petitioner has an antalgic gait in that he walks with lateral thrust. He found a varus malalignment of the leg. There was mild laxity from degeneration and from meniscus loss.

Dr. Romanelli took x-rays. He said the radiology report shows increased problems in the knee, which used to be mild. He has decreased joint space which has progressed from one year ago. Dr. Romanelli said since he lost 50 – 75% of the meniscus, he will have degenerative changes over time. He believes the current pain is from varus malalignment. He felt the Petitioner should, in the short term, use a brace and medicine for pain. Long term he wanted Petitioner to lose weight, swim, bike or treadmill. Dr. Romanelli felt that the petitioner will need a partial knee replacement. He may need a high tibial osteotomy or partial knee replacement.

. Petitioner explains what happens to his knee every day. Petitioner stated in the mornings, it may be a little stiff, but the pain is not horrible in the mornings. As he gets moving throughout the day and get to work it starts throb, and he gets shooting pain through the inside of that joint, which starts to swell.

Petitioner has a ritual he goes through every night with his knee. By the end of the day he has to ice his knee. He has his daughter trained to bring an ice pack. After she brings him the ice packs, he ices it, and takes pain medication for it at night. (Tr. Pg.13). When asked if the knee swells every single day, the Petitioner responded "absolutely." (Tr. 13).

Petitioner showed the judge his knee at trial, which occurred in the morning, the knee was slightly larger than the other one. Petitioner testified it gets about 50% bigger by the end of the day. (Tr. 16).

Petitioner cannot crawl on the floor with his children like he would like any more. He has a horse business, but he can no longer ride. He has difficulty with the horse work. He bought a tractor to help moving hay and manure. He has some trouble with intimacy with his wife.

Petitioner takes ibuprofen daily, and a narcotic "not quite every day." (Tr. 18).

Petitioner testified that if the arthritis continues to get worse, as Dr. Romanelli says it will, that he will not be able to continue in his job as an electrician. The crawling and squatting will be an issue for future employment. (Tr. 20-21).

His employer helps accommodate his problems now. They send others to help him with attics, crawling in trusses, in situations where he cannot wear knee pads, or in situations where there is deep digging. This typically occurs once a week for Petitioner. (Tr. 21-22).

Petitioner said his group health had to pay Dr. Romanelli's bill because Respondent refused.

Causation of Knee Issues

The Respondent claims on the Request for Hearing form that only the meniscal tear is related. This position is unsupported by any evidence.

All the evidence shows the current problems with Petitioner's knee are related to the injury. Dr. Herrin and Dr. Romanelli also find, in addition to the meniscal tear,

- varus malalignment
- patellofemoral
- synovial joint effusion
- "an inflammatory component, as opposed to just the meniscal tear" (10/5/15 visit to Herrin)

Dr. Herrin said the knee is all related to the incident repeatedly, except for the varus malalignment, which he never diagnosed. That is a diagnosis only Dr. Romanelli made, which is discussed below.

Dr. Romanelli's treatment is clearly related. Petitioner never had any knee problems with this knee before the incident. He has struggled with significant knee issues ever since. This is documented on the November 15, 2016 visit, but Dr. Herrin relates it up repeatedly. Dr. Romanelli wrote he is here for a final evaluation status post arthroscopic surgery from Dr. Herrin. He discusses the loss of 50% - 75% of his meniscus. He says he later had recurrent effusions, aspiration, and injections.

He found "a little bit of laxity secondary to degeneration and loss the meniscus (sic) the medical compartment," leaving no question that Dr. Romanelli believes the laxity in the knee is related to the meniscal tear. He continues "he does still have problems but more related to post meniscectomy syndrome. Clearly, if this patient's loss (sic) 50-70% of the medial meniscus, he is going to get some degenerative changes in this knee over time. Currently, I think he is still having pain and discomfort of the knee because of varus malalignment.....It is very possible in the future he will get worsening of his arthritis and his symptoms that would require either a high tibial osteotomy or a partial knee replacement. He is way too young for that, so therefore, I do recommend conservative management including a brace and anti inflammatories". Dr. Romanelli describes this in the active problems section of his report, as

- Injury caused by twisting with sudden strenuous movement, initial encounter
- Injury caused by twisting with sudden strenuous movement, subsequent encounter
- Left knee pain
- Work related injury
- History of complex tear of medical meniscus, initial encounter
- History of complex tear of medical meniscus, subsequent encounter

Petitioner had no prior problems before the work injury. If he had a varus malalignment, i.e. bowlegged, prior to his accident, it was asymptomatic. The obvious change in the Petitioner's knee joint, specifically the increasing progressive medial joint line narrowing, would likely result in pain, particularly to one who is bowlegged. It is axiomatic that the employer takes the employee as it finds him. The Arbitrator finds the treatment by Dr. Romanelli causally related to the Petitioner's accident.

Penalties

Petitioner sent a Dr. Romanelli's bill to respondent asking that it be paid on January 23, 2017. The bill was for his visit dated December 23, 2016 and is in the amount of $434.00. His insurance paid $155.03, along with an adjustment, leaving a balance due for Petitioner of $60.00.

Respondent contends that it did not pay the bill because Dr. Romanelli found that the Petitioner's symptoms at that time were due to his bow leggedness. While the Arbitrator disagrees, he does not find the Respondent to have been unreasonable in not paying the bill. Penalties are denied.

Nature and Extent

AMA Rating

The impairment rating is 2% of a leg or 1% MAW. This factor is neutral.

Occupation

The Petitioner is an electrician, which he has done all his adult life. He squats, climbs ladders, works on his feet all day long, digs manholes, underground holes, installs and repairs wires, which may be installed in tight quarters, necessitating his twisting, kneeling, crawling or squatting 50% of the workday. The notes from Both Dr. Romanelli and Midwest Physical Therapy post surgery clearly show that the Petitioner had to climb, dig and work on his knees as part of his job. This factor favors the Petitioner.

Age

Petitioner was 37 at the time of the injury. This factor favors the Petitioner in that he will likely experience knee problems which Dr. Romanelli opined could increase over time.

Future Earning Capacity

Petitioner testified that if his knee gets any worse he will not be able to work as an electrician any more. His employer accommodates his current problems by allowing other workers to help him, but other employers may not be so forgiving. Dr. Romanelli wrote that he will need a future surgery including a partial knee replacement. He will continue to develop arthritis, which will only limit his ability to work in his trade in the future. This factor favors the Petitioner.

Evidence of Disability Corroborated by Medical Reports

The Petitioner underwent a serious injury to the knee involving a loss of 50 to 70% of the meniscus. He has swelling, noted repeatedly in the medical reports, he has an antalgic gait, and Dr. Romanelli said he will continue to develop arthritis until he needs a partial knee replacement.

His exam findings on December 23, 2016, a year and a half after the accident, certainly corroborate the Petitioner's disability. His complaints are generally consistent with such a serious injury. The Petitioner was credible about his limitations. The Petitioner has an antalgic gait. His leg swells significantly daily. He must ice it every night. It has affected his ability to work with horses, crawl with his daughter, work in tight spaces like attics, requiring assistance of other workers when he used to do the work himself.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOHN JEFFERS,

Petitioner,

vs. NO: 16 WC 37611

CHESTER MENTAL HEALTH CTR,

19IWCC0246

Respondent.

DECISION AND OPINION ON REVIEW

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

In determining Petitioner's permanent partial disability, the Commission weighs the five factors listed in §8.1b of the Act differently than the Arbitrator, as explained below:

1) No A.M.A impairment rating was submitted into evidence so this is given no weight.

2) We give the occupation factor little weight. Petitioner testified that he was an "STA-I" at Respondent. *T.14*. The Form 45 indicates that this is a "security therapy aide." *Rx2*. However, the evidence is not clear regarding the nature of Petitioner's primary job duties and physical requirements or how his left knee condition might impact those duties. The Arbitrator wrote, Petitioner "may spend a significant time sitting" (*Dec. at 2*) but the basis for this is not even clear from the record. Apparently, Petitioner must respond to "code reds" occasionally, which is how he hurt his knee. However, Petitioner never testified how often these "code red" situations happen. He did testify that he "ran into a code red a few weeks ago" and his knee "felt like just bone on bone." *T.17*. There is some evidence that a small portion of his job might be affected by his left knee condition. Petitioner returned to work full duty and also works some double-shifts. *T.21*. As Dr. Lehman's April 26, 2018, note states, "he is back to work more than full time (approximately 75 hours a week)." Petitioner testified that at the end of his 8-hour shift, his knee is "really painful compared to the beginning" of the shift and that after 16

hours, "it really throbs pretty good, and it takes a couple days" for the throbbing to not be constant. *T.22.* He testified that he has a lot of grinding in his knee, it is stiff in the morning, it gets stiff and swells up "if I over-work it," and he constantly has pain in it. *T.17.* Nevertheless, the evidence does not indicate how Petitioner's occupation is a factor in these symptoms or how these symptoms impact his occupation other than perhaps occasionally having to "run" to a code red.

Petitioner appears to have a mostly sedentary job and he has failed to introduce sufficient evidence to prove that his occupation is a significant factor for a finding of increased disability related to his knee condition.

3) Petitioner was 60 years of age at time of his accident. We find that he did not introduce any evidence to show how his age is a factor in his disability and therefore give this factor no weight.

4) There is no evidence that Petitioner's injury had any effect on his future earning capacity so we give this factor no weight.

5) Regarding "evidence of disability corroborated by the treating medical records," we give significant weight to this factor. Petitioner's testimony about his symptoms and complaints are consistent with Dr. Lehman's records. However, we also note that Petitioner's most recent records include a diagnosis of arthritis. While it is possible that Petitioner's work injury may have contributed to this diagnosis, there is no medical opinion that affirmatively states that causal relationship.

Based on the above analysis, the Commission finds that Petitioner is entitled to permanent partial disability benefits of 20% of the left leg, as provided in §8(e) of the Act.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $501.15 per week for a period of 43 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 20% of the left leg.

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

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

Pursuant to §19(f)(1) of the Act, this decision is not subject to judicial review.

DATED: MAY 1 7 2019

Maria E. Portela

Thomas J. Tyrrell

Deborah L. Simpson

SE/
O: 5/7/19
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JEFFERS, JOHN
Employee/Petitioner

Case# **16WC037611**

CHESTER MENTAL HEALTH
Employer/Respondent

19IWCC0246

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:

1580 BECKER SCHROADER & CHAPMAN
TODD J SCHROADER
3673 HWY 111 P O BOX 488
GRANITE CITY, IL 62040

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

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

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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

NOV 13 2018

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

John Jeffers
Employee/Petitioner

v.

Chester Mental Health
Employer/Respondent

Case # 16 WC 37611

Consolidated cases: n/a

19IWCC0246

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on October 12, 2018. By stipulation, the parties agree:

On the date of accident, September 5, 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 $43,433.44; the average weekly wage was $835.25.

At the time of injury, Petitioner was 60 years of age, married, with 0 dependent child(ren).

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00. At trial, the parties stipulated TTD benefits had been paid in full.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $501.15 per week for 59.125 weeks because the injuries sustained caused the 27 1/2% loss of use of the left 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.

William R. Gallagher, Arbitrator

November 3, 2018
Date

NOV 13 2018

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on September 5, 2016. According to the Application, Petitioner sustained an injury to his left knee while running to a "Code" (Arbitrator's Exhibit 2). At trial, counsel for Petitioner and Respondent stipulated that all temporary total disability benefits and medical had been paid and the only disputed issue was the nature and extent of disability (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a security therapist aide. On September 5, 2016, Petitioner responded to a "Code Red" and ran to assist a coworker. When he did so, Petitioner felt a "pop" and an immediate onset of pain in his left knee.

Subsequent to the accident, Petitioner was seen in the ER of Sparta Community Hospital. Petitioner was diagnosed with a muscular strain of the left hamstrings and was discharged (Petitioner's Exhibit 1).

Petitioner was subsequently seen by Dr. Mark Pruess, his family physician. Dr. Pruess ordered x-rays of Petitioner's left knee which were performed on October 6, 2016. The x-rays were negative for fracture, but revealed early degenerative arthritis (Petitioner's Exhibit 1).

Dr. Pruess ordered an MRI scan which was performed on October 13, 2016. According to the radiologist, the MRI revealed an impacted osteochondral fracture of the medial femoral condyle, a partial tear of the anterior cruciate ligament (ACL) and tears of both the medial and lateral meniscus (Petitioner's Exhibit 1).

At the direction of Respondent, Petitioner was examined by Dr. Richard Lehman, an orthopedic surgeon, on November 17, 2016. In connection with his examination of Petitioner, Dr. Lehman reviewed Petitioner's medical records and the MRI scan. On examination, Dr. Lehman noted Petitioner had swelling and pain over the medial and lateral joint lines as well as pain/discomfort on flexion and extension (Petitioner's Exhibit 3).

Dr. Lehman reviewed the MRI and his interpretation of it was consistent with that of the radiologist. Dr. Lehman opined Petitioner had a torn ACL, torn medial and lateral meniscus and a medial femoral condyle osteochondral defect. He recommended Petitioner undergo arthroscopic surgery (Petitioner's Exhibit 3).

Dr. Lehman subsequently provided medical treatment to Petitioner. He performed arthroscopic surgery on Petitioner's left knee on April 26, 2017. The surgical procedure consisted of a partial medial and lateral meniscectomy, debridement of the medial femur and intercondylar notch, debride chondrocalcinosis and removal of particles/loose bodies, posterior capsular release, debridement of the ACL and internal fixation of insufficiency fracture of the medial femoral condyle (Petitioner's Exhibit 7).

Following surgery, Dr. Lehman continued to treat Petitioner and ordered physical therapy. Petitioner received physical therapy from May 1, 2017, through September 26, 2017. When evaluated on September 26, 2017, Petitioner stated that while at work he is sitting the majority of the time, but he needs to be ready to go at any time to break up fights or assist other guards. Petitioner noted his knee felt stronger, but it would get sore if he was on it for an extended period of time (Petitioner's Exhibit 8).

When Dr. Lehman saw Petitioner on October 5, 2017, Petitioner had returned to work on light duty one week prior. Petitioner stated he had pain underneath the kneecap with motion. Petitioner's symptoms were exacerbated with activities such as running and cycling (Petitioner's Exhibit 3).

Dr. Lehman again saw Petitioner on November 21, 2017, and Petitioner continued to complain of left knee pain. However, Dr. Lehman was pleased with Petitioner's progress and released him to return to work without restrictions on December 4, 2017 (Petitioner's Exhibit 3).

Dr. Lehman last saw Petitioner on April 26, 2018. At that time, Petitioner advised he had returned to work more than full time which he indicated to be approximately 75 hours per week. Petitioner continued to complain of left knee pain which he attributed to working long hours. Dr. Lehman observed that, ideally, Petitioner would not have to work 75 hours a week so he could rest his knee. However, he opined Petitioner was at MMI and discharged him from care. He recommended Petitioner continue with home and gym strengthening exercises (Petitioner's Exhibit 3).

At trial, Petitioner testified he had returned to work at full duty. Petitioner stated he continued to experience pain and grinding in the knee, stiffness in the morning, and swelling and a limited range of motion. Petitioner's knee symptoms were intensified after working an eight hour shift and even more intense after working a double shift. Petitioner denied any prior left knee injuries or symptoms.

Conclusions of Law

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 27 1/2% loss of use of the left leg.

In support of this conclusion the Arbitrator notes the following:

Neither Petitioner nor Respondent tendered an AMA impairment rating. The Arbitrator gives this factor no weight.

Petitioner worked for Respondent as a security therapy aide. While Petitioner may spend a significant amount of time at work sitting, Petitioner needs to be ready to respond quickly to render assistance when needed as was the circumstance in this case. The Arbitrator gives this factor moderate weight.

Petitioner was 60 years old at the time of the accident. While Petitioner will have to live with the effects of this injury for the remainder of his working and natural life, Petitioner is approaching normal retirement age. The Arbitrator gives this factor moderate weight.

There was no evidence the injury had any effect on Petitioner's future earning capacity. The Arbitrator gives this factor no weight.

The medical treatment records, in particular, the surgical report, clearly indicated Petitioner sustained a significant injury to his left knee which required extensive surgery. As was noted in the surgical report, Petitioner underwent medial and lateral meniscectomy, debridement of the medial femur and intercondylar notch, debridement of chondrocalcinosis and removal of particles/loose bodies, posterior capsular release, debridement of the ACL and internal fixation of insufficiency fracture of the medial femoral condyle. While Petitioner was able to return to work at full duty, he continues to have complaints consistent with the injury he sustained and the surgical procedure he underwent thereafter. The Arbitrator gives this factor significant weight.

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Timothy Koeneman,
Petitioner,

vs. NO: 18 WC 01212

19IWCC0247

State of Illinois,
Chester Mental Health Center.
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that, other than as stated above, the Decision of the Arbitrator filed November 14, 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.

19IWCC0247

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: MAY 17 2019

Marc Parker

o-05/09/19
mp-wj
68

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KOENEMAN, TIMOTHY
Employee/Petitioner

Case# **18WC001212**

SOI/CHESTER MENTAL HEALTH CTR
Employer/Respondent

19IWCC0247

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:

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

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

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

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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

NOV 14 2018

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

TIMOTHY KOENEMAN
Employee/Petitioner

v.

STATE OF ILLINOIS/CHESTER MENTAL HEALTH CTR.
Employer/Respondent

Case # 18 WC 01212

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 **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **September 20, 2018**. By stipulation, the parties agree:

On the date of accident, **August 29, 2017**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$63,675.49**, and the average weekly wage was **$1,224.52**.

At the time of injury, Petitioner was **57** years of age, ***married*** with **1** dependent child.

Necessary medical services and temporary compensation benefits have been or will be provided by Respondent. Respondent has stipulated that it will pay the causally related medical bills contained in PX 1, subject to the Medical Fee Schedule, and the parties agreed that Respondent should receive credit for any medical bills previously paid, including any that may have been paid by Respondent's group medical plan for which credit is allowed under Section 8(j) of the Act.

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

19IWCC0247

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 **$734.71**/week for a further period of **37.5** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused the **7.5% loss of the body as a whole.**

Respondent shall pay Petitioner compensation that has accrued from **June 28, 2018,** through **September 20, 2018,** and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

November 11, 2018
Date

NOV 14 2018

FINDINGS OF FACT AND CONCLUSIONS OF LAW REGARDING THE NATURE AND EXTENT OF PETITIONER'S INJURY

The Arbitrator finds:

Petitioner has worked for Respondent 19 years and 4 months as a Security Therapy Aide I. The parties stipulated that on August 29, 2017, Petitioner sustained accidental injuries at work when a violent patient/resident came out and attacked staff, and Petitioner assisted in the physical hold. During the physical hold, the staff was moving the resident/patient down the hallway and they all fell to the floor. The resident/patient and two other staff members fell on top of Petitioner, and he ended up on the bottom, injuring his right lower back and right side. (RX 1)

On the same day of the accident, Petitioner sought treatment with his family doctor, Dr. Mark Preuss. He was seen by the doctor's nurse practitioner, Karen Chamnes and a consistent history of the accident was given. Petitioner's complaints focused on right lower flank pain. Ms. Chamness' examination showed pain elicited in all direction of range of motion in Petitioner's low back, diminished deep tendon reflexes on the left, positive straight leg raising test on the right, and normal straight leg raising on the left. Petitioner was sent for an x-ray of his lumbar spine at Sparta Community Hospital, which was normal, and he was prescribed Soma, Naproxen, and Tramadol. He was taken off work until seen for re-evaluation on September 5, 2017. (PX 3)

Petitioner returned to see P.A. Chamness on September 5, 2017 and was noted to be taking his Naproxen and Soma, but not the Tramadol. Petitioner's pain was at a 7 out of 10 level, and he was noted to have pain on the right anterior abdomen and a sore spot in the left groin. He was also taking over-the-counter Motrin. Examination again revealed pain elicited in all directions of motion and pain with palpation along the right paraspinous muscle along with moderate spasm. Straight leg raising was questionably positive on the right at 45 degrees. P.A. Chamness' recommendation was to contact the "case worker" for "approval" of physical therapy. (PX 3)

When Petitioner returned to see Ms. Chamness on September 26, 2017, she noted that physical therapy was making his condition worse. Petitioner described pain in his low back, now radiating to his right buttock area. He further reported that the physical therapist had him riding a bicycle, which increased his symptoms. Petitioner was taking over-the-counter medication instead of narcotics. P.A. Chamness decided to discontinue the physical therapy and recommended an MRI. Petitioner was advised to take his narcotic anti-inflammatory pain medication and he remained off work. (PX 3)

Petitioner underwent an MRI of his lumbar spine on October 30, 2017, at Cedar Court Imaging. It showed a small circumferential disc bulge at L3-4 and L4-5 with neural foraminal

narrowing at other levels. It also showed lumbar spine straightening with subtle reversal of the normal lumbar lordosis, suggesting muscle spasm. The rest of the MRI was basically normal. (PX 5)

On November 7, 2017, Petitioner saw P.A. Chamness again. Petitioner reported he was taking Aleve but the Soma had not been beneficial. Tramadol made him "feel weird." Walking short distances was causing his back to spasm and increasing his pain. Petitioner was advised to restart physical therapy at Apex. His caseworker had sent word he would be able to go back on light duty; however, Petitioner declined to do so at this time. Petitioner was advised to stop the Aleve and try Naproxen. He was to hold the Tramadol and return two weeks after he started therapy. (PX 3)

Petitione reported to Apex Physical Therapy on November 14, 2017, with a chief complaint of right lower back pain radiating to his right hip along with numbness and tingling in the right thigh. He described his pain as constant and varying in intensity. The pain would interfere with sleep. He was taking generic Flexeril. Petitioner reported that his MRI revealed a bulging disc but his doctor didn't think it was a cause for concern. Petitioner was trying to rest as much as possible to give his back time to heal. (PX 6)

Petitioner underwent physical therapy from November 14th to December 8, 2017. As of December 8th, Petitioner had attended 11 out of 12 scheduled appoints with one cancellation. He did not feel his symptoms had improved and he was continuing to complain of bilateral lower back pain with right side worse than the left. Prolonged walking was the most painful/restricted activity. The therapist noted that Petitioner had demonstrated good effort. (PX 6)

Petitioner returned to see PA Chamness on December 12, 2017 and advised her that he had finished physical therapy and didn't think it helped. Petitioner had to go home and lay down after taking Aleve. His pain level was now at 7 in his right low back into his buttock. He brought a copy of his MRI with him. It was noted that he was still taking Naproxen and Norflex and having pain rated 8 out of 10 on the pain scale. P.A. Chamness noted Petitioner had scheduled an appointment with Dr. Gornet for the upcoming Saturday. Ms. Chamness agreed to hold his work comp papers until she heard back from Petitioner after his consultation with Dr. Gornet. The Norflex was refilled. (PX 3)

Petitioner saw Dr. Matthew Gornet on December 16, 2017. He took a history of the accident and noted Petitioner's primary complaint was low back pain to the right side, right flank and right buttock. Petitioner tried two courses of physical therapy and a lot of narcotic pain medication but had not been able to return to work. He acknowledged occasional chiropractic care in the past for what he described as "mild symptoms." His current symptoms, in contrast, were constant and very different and made worse with bending, lifting, prolonged sitting or standing. At this point he denied any leg pain or numbness. Dr. Gornet noted limited range of motion on bending, which caused spasms, along with tight hamstrings. Straight leg raising test was positive

for some low back and left leg pain. Deep tendon reflexes, sensation, and motor examination were all normal. Dr. Gornet took x-rays, which showed no significant degenerative changes and no instability. Dr. Gornet did not have the actual MRI disc to review but noted that the MRI report from Cedar Court Imaging showed neural foraminal narrowing bilaterally at L4-5 with some potential spasm being present. Dr. Gornet believed that Petitioner had aggravated an underlying asymptomatic degenerative condition, and also produced a new injury. He wanted an actual view of the previous MRI scan, but given his experiences with Cedar Court Imaging, he recommended a new, higher resolution scan. He gave Petitioner meloxicam and cyclobenzaprine, recommended an expedited MRI, and kept him off work. (PX 7)

Petitioner did not return to see PA Chamness. (PX 3)

Petitioner signed his Application for Adjustment of Claim herein on January 8, 2018. (AX 2)

The new MRI scan was performed on January 13, 2018 at MRI Partners of Chesterfield. The impression was that of "flat back" with little lumbar lordosis, diffuse degenerative changes further described in the report, a central protrusion largest at L4/5 with mild concavity of the dura but extension to the foramina where either L4 root could be affected as well as annular fissures; a small broad-based protrusion at L3/4 with foraminal narrowing but no high grade central stenosis; and more advanced disc space narrowing with central protrusion atL1/2. Clinical correlation was recommended as no high-grade stenosis was noted. (PX 8)

Petitioner returned to see Dr. Gornet on March 1, 2018. Petitioner's main pain was unchanged from his earlier visit although he mentioned intermittent right leg symptoms. His exam was non-focal. Dr. Gornet noted that the high-quality MRI showed more of a right-sided disc herniation and annular tear at L4-5 and he recommended epidural steroid injections at L4-5 on the right as well as transforaminal steroid injections at L4-5 on the right with the same at L3-4. If this did not work, he recommended a discogram from L3 to S1. Petitioner remained temporarily totally disabled. (PX 8)

Petitioner underwent a right L4/5 ILESI on March 13, 2018 and a right L4/5 TFESI on March 27, 2018. Both procedures were done under the guidance of Dr. Blake. (PX 9)

On May 3, 2018, Petitioner returned to see Dr. Gornet. He reported that the injections had helped him significantly, but he still had not returned to baseline. Dr. Gornet thought the best option for Petitioner was a trial of return to work full duty with no restrictions. He noted that Petitioner was definitely not at maximum medical improvement. (PX 8)

Respondent had Petitioner examined by Dr. Chabot on June 6, 2018. Dr. Chabot took a history of the accident and reviewed all the medical records. He noted that during the physical examination, Petitioner was alert and cooperative, and that Petitioner's wife was in the room along with one of Dr. Chabot's assistants. Dr. Chabot's examination was largely normal, with the

exception of some mild hamstring tightness bilaterally and limited range of lumbar extension. Dr. Chabot viewed the MRI of January 13, 2018, and interpreted it as showing desiccation at all levels of the lumbar spine. He agreed with Dr. Gornet that L4-5 had evidence of a bulging disc and increased facet and ligamentum flavum hypertrophy resulting in a mildly diminished central canal area. There was some diffuse bulging and facet degeneration at L3-4 with no neural compression. The rest of the MRI was basically normal. Dr. Chabot's impression was that of a back strain/back pain, and he believed Petitioner's symptoms were caused and related to his work accident of August 29, 2017. He opined that all prior treatment was reasonable and necessary, that Petitioner had reached maximum medical improvement, and that Petitioner could return to work full duty. He felt Petitioner would continue to improve and his physical examination was "devoid" of any objective physical findings to suggest residuals associated with the work injury. (RX 2)

Petitioner saw Dr. Gornet for the last time on June 28, 2018, and he was noted to have some level of pain, but it was tolerable. While he felt Petitioner might need further treatment in the future, Dr. Gornet placed Petitioner at maximum medical improvement and advised Petitioner that his door was open if he needed to see him again. (PX 8)

Petitioner's case proceeded to arbitration on September 20, 2018. Respondent stipulated to liability for any causally related medical bills contained in PX 1 and agreed that it would pay/has paid such bills. (AX 1). The only issue was the nature and extent of Petitioner's injury and Petitioner was the sole witness testifying at the hearing. Respondent did have a representative present for the hearing – Ms. Tamara Linders.

Prior to August 29, 2017, Petitioner sustained no prior injuries, treatment, or diagnostic studies of his low back.

Petitioner testified regarding his accident and treatment as discussed above. He also testified that the injections improved his condition; however, he still has low back symptoms made worse by prolonged periods of standing or walking. He has a two-year-old daughter, and if he carries her for "hardly any length of time" he gets back spasms. While he has diminished pain in his buttocks, he continues to have generally localized low back pain. At the end of a long shift, he takes Aleve, but no prescription narcotic medication. His hobbies of hiking and golfing have been adversely affected. Petitioner's sleep has also been negatively impacted.

On cross-examination Petitioner acknowledged that he is a shotgun hunter and intends to try hunting this Fall. He also agreed that he returned to full duty work in the middle of May and works straight days from 7:00 to 3:00. In all, he underwent three injections. He estimated that he took Aleve two to three times a week.

The Arbitrator concludes:

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

impairment pursuant to subsection (a) 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).

(i) **Level of Impairment**: Neither Party submitted an AMA rating. Therefore, the Arbitrator gives no weight to this factor.

(ii) **Occupation**: Petitioner's job for Respondent is physically demanding. While he returned to work on a full duty basis, Petitioner credibly testified to some ongoing issues related to working. He testified to low back symptoms made worse by prolonged periods of standing and walking, both of which are activities required by his job. Additionally, he testified to taking Aleve at the end of a long shift. Petitioner's testimony regarding issues from work was unrebutted. The Arbitrator places great weight on this factor.

(iii) **Age**: Petitioner was 57 years old at the time of his injury. As such, he may reasonably be expected to work and live with the effects of his injury for a reasonable time into the future. The Arbitrator places some weight on this factor.

(iv) **Earning Capacity**: There is no direct evidence of reduced earning capacity contained in the record. Therefore, the Arbitrator gives no weight to this factor.

(v) **Disability**: As a result of his undisputed accidental injury, Petitioner sustained lumbar disc injuries that required three epidural and transforaminal steroid injections at L4-5 and L3-4. He did not undergo any surgery. Despite the improvement from the injections, he still had low back symptoms made worse by prolonged periods of standing or walking. He has a two-year-old daughter, and his injury makes it more difficult for him to carry her. While he reported diminished pain in his buttock, he continues to report generally localized pain in his low back. His hobbies of hiking and golfing have been adversely affected. Petitioner's sleep has also been negatively impacted.

The Arbitrator finds Petitioner's complaints generally corroborated by the treating records. As of Petitioner's final office visit with Dr. Gornet, he continued to complain of pain, albeit at a tolerable level.

Based upon the foregoing, the Arbitrator places significant weight on this factor and finds that Petitioner sustained serious and permanent injuries that resulted in the 7.5% percent loss of his body as a whole.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tracy Williams,
Petitioner,

vs. NO: 16 WC 30912

19IWCC0248

State of Illinois,
Chester Mental Health Center.
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that, other than as stated above, the Decision of the Arbitrator filed December 7, 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.

19IWCC0248

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: MAY 17 2019

Marc Parker

o-05/09/19
mp-wj
68

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS, TRACY
Employee/Petitioner

Case# **16WC030912**

16WC030913

STATE OF IL/CHESTER MENTAL HEALTH
Employer/Respondent

19IWCC0248

On 12/7/2018, 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 2.49% 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:

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

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
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0558 ASSISTANT ATTORNEY GENERAL
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601 S UNIVERISTY AVE SUITE 102
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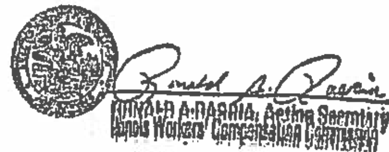
0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

DEC 7 - 2018



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

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

TRACY WILLIAMS
Employee/Petitioner

v.

STATE OF IL/CHESTER MENTAL HEALTH
Employer/Respondent

Case # 16 WC 30912

Consolidated cases: 16 WC 30913

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **October 22, 2018**. By stipulation, the parties agree:

On the date of accident, **July 29, 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 **$44,773.56**, and the average weekly wage was **$861.03**.

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

Necessary medical services and temporary compensation benefits have been or will be provided by Respondent. Respondent has stipulated to payment of the medical bills contained in Petitioner's Exhibit 1 that relate to Petitioner's cervical spine condition. Said bills shall, or have been, paid pursuant to the Medical Fee Schedule. Respondent is to receive credit for any bills previously paid by it or its group medical plan for which credit is allowed under Section 8(j) of the Act and shall hold Petitioner harmless from same.

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

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

ORDER

Petitioner failed to prove that she sustained any permanent, partial disability as a result of the July 29, 2016 accident and no permanent, partial disability benefits are awarded herein.

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.

Nancy Lindsay
Signature of Arbitrator

December 4, 2018
Date

DEC 7 - 2018

Tracy Williams v. SOI/Chester Mental Health, 16 WC 30912

FINDINGS OF FACT and CONCLUSIONS OF LAW

Petitioner has two claims on file against Respondent. Case #16 WC 30912 involves injuries sustained in an accident on July 29, 2016. Case #16 WC 30913 involves injuries sustained in an accident on September 3, 2016. (AX 1, 2, 3, 4). Neither accident is in dispute. At the time of arbitration the attorneys for both parties further stipulated that Petitioner injured her right shoulder in a previous accident, and this incident merely served as an aggravation. Therefore, the parties further stipulated that no shoulder bills or treatment were related to the two accidents in question. Respondent also introduced into evidence an approved settlement contract indicating that all shoulder bills were the responsibility of Respondent for Petitioner's first accident. Respondent further stipulated that it would pay all medical bills for treatment to Petitioner's cervical spine injury. Therefore, the only disputed issue is the nature and extent of Petitioner's injury.

While both cases were consolidated for purposes of the hearing the parties understood that separate decisions would issue.

The Arbitrator finds:

Petitioner is employed by Respondent at its Chester Mental Health facility as a Security Therapy Aide. The parties stipulated that Petitioner sustained an accident on July 29, 2016, while lining up the patients to go down to the dining room, two patients got involved in an altercation, and Petitioner intervened. In the process, she injured her neck and right shoulder. (See RX 1)

Following the accident, Petitioner went to Chester Memorial Hospital on July 30, 2016, where she complained of right shoulder pain and was prescribed Flexeril and Norco, kept off work until Wednesday, August 3, 2016, and advised to follow up with her primary care physician. (PX 3)

Petitioner underwent no further medical care until after another accident on September 3, 2016.

On September 3, 2016, Petitioner and another therapy aide were placing a patient in a physical hold in the restraint room. When they reached the doorway, the patient dropped to the floor and pulled Petitioner with him. He then began kicking and punching Petitioner. After Petitioner and her co-worker managed to get the violent recipient on the restraint bed, Petitioner felt a popping sensation in her neck, broke into a sweat instantly, and had to be seen by the facility physician. (See RX 2) Following that accident, Petitioner again presented again to Chester Memorial Hospital, where a consistent history of the accident was taken. Her primary complaint was neck pain. Petitioner was diagnosed with a neck strain and back pain. Diagnostic studies, including x-rays and CAT scans, were negative except for benign age-related findings in

Petitioner's cervical and thoracic spine. She was discharged with Hydrocodone and Cyclobenzaprine. (PX 3; PX 4)

On September 7, 2016, Petitioner went to see her primary care physician at Quality Healthcare Clinics, Dr. Preuss. There, she saw Karen Chamness, Dr. Preuss's PA. Again, a consistent history of the September accident was taken. Petitioner's complaints included her neck, upper back and right arm. Petitioner's examination showed pain with all ranges of motion, pain with palpation of the thoracic spine, no muscle spasm, and good strength. PA Chamness's assessment was a cervical strain with right radiculopathy and a thoracic strain. Petitioner was instructed to use ice to all the affected areas three times daily, to remain off work, to follow up and to continue the medication. (PX 4)

Petitioner returned to Quality Healthcare Clinics on September 13, 2016, with ongoing cervical symptoms and a burning sensation in her right shoulder. Petitioner explained that she had injured her shoulder in an accident in July and was supposed to undergo an MRI but it had never been approved. Petitioner was scheduled to be seen by Dr. Raskas for her current injury. Treatment and testing for the right shoulder was also discussed. PA Chamness's impression was shoulder and cervical pain. (PX 4)

On September 15, 2016, Petitioner saw Dr. Raskas, a board-certified spine specialist who she had seen before. Petitioner related her two accidents – the first one involving her shoulder; the second, her neck. Petitioner reported she was working. The doctor's physical examination showed limited range of motion in her shoulder, positive impingement sign, and intact cranial nerves. His impression of Petitioner's x-rays was cervical spondylolisthesis with cervical spondylosis and degenerative changes. Dr. Raskas recommended that Petitioner remain off work until such time as she could get her shoulder fixed. (PX 5)

At the request of Dr. Nathan Mall, Petitioner underwent a right shoulder MRI. She also underwent, at his request, an MRI of the cervical spine for which the radiologist's impression was degenerative disc changes with central disc protrusions at C5-6 and C6-7 extending towards the foramina without definite root impingement, though correlation to the C6 and C7 roots were recommended. (PX 6)

Dr. Mall performed right shoulder surgery in October of 2016. (PX 7)

Upon the referral of Dr. Mall, Petitioner presented to Dr. Gornet on January 30, 2017 who recorded a concise history of three events (with one preceding July 30, 2016). Dr. Gornet noted that Petitioner had undergone a C5 injection on July 12, 2016. He also reviewed x-rays which showed some foraminal narrowing, foraminal stenosis, and loss of disc height with a pseudo-translation of C4 on C5. The MRI from September 28, 2016, was reviewed, which he believed showed small central herniations at C5-6 and C6-7 with an acute foraminal herniation at C6-7. Dr. Gornet noted that this best correlated with Petitioner's symptoms. He kept her off work.Dr. Gornet recommended that Petitioner's shoulder condition be allowed to heal first. (PX 7)

When Petitioner returned on May 25, 2017, it was noted that Petitioner was being recommended for steroid injections at C3-4 and C6-7, but these were postponed due to a non-related medical condition. The injections were finally done at C4-5 and C6-7 in February and April of 2017 but provided only temporary relief. (see PX 7; PX 11) Dr. Gornet believed that since the injections had failed, Petitioner would need disc replacement surgery. However, prior to that, he recommended a myelogram. On July 10, 2017, Dr. Gornet reviewed the myelogram results with Petitioner, and it showed facet changes more on the left than on the right at C3-4 and C4-5. He believed that Petitioner also had disc herniations at C5-6 and C6-7. She remained unable to work. (PX 7)

On July 21, 2017 Dr. Gornet performed a two-level disc replacement at C5-6 and C6-7. Intra-operative findings showed a central herniation and a right-sided herniation at C6-7 and at C5-6; however, level C5-6 had more anterior osteophytes. (PX 7; PX 10)

Following surgery, Petitioner returned to see Dr. Gornet. As of September 7, 2017, Petitioner reported that she was doing well, her symptoms had dramatically improved and she felt the surgery had make a remarkable difference for her. A home exercise program was recommended. As of October 30, 2017, Petitioner was released to full duty with no more than 40 hours per week (8 hour days) for three months. (PX 7)

On January 23, 2018 Petitioner settled a workers' compensation claim against Integrity Healthcare of Smithton (16 WC 11045) stemming from a shoulder injury sustained on October 15, 2015. As a result of said accident, Petitioner had sustained a right rotator cuff tear that required surgery and a cervical strain. (RX 3)

Petitioner returned to see Dr. Gornet on January 29, 2018 and told the doctor she was doing well for the most part. Her exam was non-focal. She expressed some concerns about a little lipoma on her neck which the doctor advised her was not his area of expertise. She also told the doctor she had received a diagnosis of carcinoma in situ and was due to see her surgeon in about a month. Clinically, she was described as doing well and she was to return in July with x-rays and a CT. If doing well, she would be placed at maximum medical improvement. (PX 7)

On July 26, 2018, Dr. Gornet placed Petitioner at maximum medical improvement, and stated that clinically Petitioner was doing well. He noted that her radiographs showed some heterotopic bone forming at the C6-7 prosthesis which might play a role down the line in her motion. Dr. Gornet noted that they discussed the "long-term issues" she would have but he did not note them in the office note. (PX 7)

Petitioner's two cases proceeded to arbitration on October 22, 2018. Respondent stipulated to liability for payment of medical bills related to Petitioner's cervical spine. The only disputed issue was the nature and extent of Petitioner's injury. Petitioner was the sole witness.

Petitioner testified that she works as a Security Therapy Aide for Respondent, a job she has held for three years. She acknowledged that she previously injured her right shoulder in an altercation at a previous job as a nurse. She then injured her neck and right shoulder in the two accidents herein; however, she confirmed that she's not claiming any injuries to her right shoulder in connection with these claims.

Petitioner testified to going to Chester Memorial Hospital and seeing her primary care doctor after the July 29, 2016 accident. She was given Norco and Flexeril and had no lost time as a result of the accident.

Petitioner testified that on September 3, 2016 she was involved in another accident and was again seen at Chester Memorial Hospital and eventually referred to Dr. Mall who, in turn, referred her to Dr. Gornet. Petitioner testified that she underwent cervical spine injections and, ultimately, a two-level cervical discectomy and disc replacement procedure. Petitioner testified that the surgery helped, and she was released to return to work full duty as a Security Therapy Aide.

Petitioner testified that both surgery and post-operative home exercises improved her condition significantly. She was released to return to work full-duty back to the same job as a Security Therapy Aide. Petitioner testified that as part of her job she has to restrain combative inmates/patients and that she has been involved in attacks from combative recipients since she's returned to work. She testified that this happens on a daily basis, because she works on the Behavioral Unit. There is a panic button that Petitioner is able to push for assistance and has done so, because her strength isn't what it formerly was. Petitioner testified that when she tries to turn her head she "sees stars." For her symptoms, Petitioner takes over-the-counter medication as needed (usually on days she works). She testified that she takes medication at the end of every shift due to soreness, especially when she is mandated to work overtime. Petitioner also testified that she has gained 50 pounds since the accident since her ability to work out at the gym has been adversely affected.

On cross-examination Petitioner testified that she has worked full duty since January of 2018. She further testified that when she last saw Dr. Gornet, she reported she was doing well. She acknowledged that she is enrolled in Dr. Gornet's long-term study on disc replacements.

Regarding the nature and extent of Petitioner's injury, the Arbitrator concludes:

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

(i) **Level of Impairment**: Neither Party submitted an AMA rating. Therefore, the Arbitrator gives no weight to this factor.

(ii) **Occupation**: Petitioner continues to serve as a Security Therapy Aide for Respondent. She had no lost time from the accident and she testified to no problems performing her job between July 30, 2016 and September 3, 2016 (the date of the second accident which is the subject of a separate claim). The Arbitrator places great weight on this factor as negating against permanency.

(iii) **Age**: Petitioner was 48 years old at the time of her accident. No evidence was presented as to how her age and the accident impacted upon one another, especially as it relates to permanent partial disability. The Arbitrator places no weight on this factor.

(iv) **Earning Capacity**: Petitioner failed to provide any evidence of reduced earning capacity as a result of the accident. Therefore, the Arbitrator gives no weight to this factor.

(v) **Disability**: Petitioner had no lost time and minimal treatment with any treatment relating to her shoulder and not her neck. She testified to no problems with her neck between July 30, 2016 and September 3, 2016, the date of accident in her companion case #16 WC 30913.

The Arbitrator finds that Petitioner failed to prove she sustained any permanent partial disability to her cervical spine as a result of the accident herein and no permanency is awarded. Petitioner's claim for permanent partial disability benefits is denied.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tracy Williams,
Petitioner,

vs. NO: 16 WC 30913

19IWCC0249

State of Illinois,
Chester Mental Health Center.
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that, other than as stated above, the Decision of the Arbitrator filed December 7, 2018, is hereby affirmed and adopted.

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

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

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

DATED: MAY 17 2019

Marc Parker

o-05/09/19
mp-wj
68

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS, TRACY
Employee/Petitioner

Case# **16WC030913**

16WC030912

STATE OF IL/CHESTER MENTAL HEALTH
Employer/Respondent

19IWCC0249

On 12/7/2018, 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 2.49% 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:

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

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

0558 ASSISTANT ATTORNEY GENERAL
KENTON J OWENS
601 S UNIVERSITY AVE
CARBONDALE, IL 62901

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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

DEC 7 - 2018

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
NATURE AND EXTENT ONLY

TRACY WILLIAMS
Employee/Petitioner

Case # 16 WC 30913

v.

Consolidated cases: **16 WC 30912**

STATE OF IL/CHESTER MENTAL HEALTH
Employer/Respondent

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **October 22, 2018**. By stipulation, the parties agree:

On the date of accident, **September 3, 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 **$44,773.56**, and the average weekly wage was **$861.03**.

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

Necessary medical services and temporary compensation benefits have been or will be provided by Respondent. Respondent has stipulated to payment of the medical bills contained in Petitioner's Exhibit 1 that relate to Petitioner's cervical spine condition. Said bills shall, or have been, paid pursuant to the Medical Fee Schedule. Respondent is to receive credit for any bills previously paid by it or its group medical plan for which credit is allowed under Section 8(j) of the Act and shall hold Petitioner harmless from same.

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

19IWCC0249

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

ORDER

Respondent shall pay Petitioner the sum of **$516.62/week** for a further period of **100** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **the 20% loss of the body as a whole**.

Respondent shall pay Petitioner compensation that has accrued from **July 26, 2018,** through **October 22, 2018,** 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.

Nancy Lindsay
Signature of Arbitrator

December 4, 2018
Date

DEC 7 - 2018

Tracy Williams v. SOI/Chester Mental Health, 16 WC 30913

FINDINGS OF FACT and CONCLUSIONS OF LAW

Petitioner has two claims on file against Respondent. Case #16 WC 30912 involves injuries sustained in an accident on July 29, 2016. Case #16 WC 30913 involves injuries sustained in an accident on September 3, 2016. (AX 1, 2, 3, 4). Neither accident is in dispute. At the time of arbitration the attorneys for both parties further stipulated that Petitioner injured her right shoulder in a previous accident, and this incident merely served as an aggravation. Therefore, the parties further stipulated that no shoulder bills or treatment were related to the two accidents in question. Respondent also introduced into evidence an approved settlement contract indicating that all shoulder bills were the responsibility of Respondent for Petitioner's first accident. Respondent further stipulated that it would pay all medical bills for treatment to Petitioner's cervical spine injury. Therefore, the only disputed issue is the nature and extent of Petitioner's injury.

While both cases were consolidated for purposes of the hearing the parties understood that separate decisions would issue.

The Arbitrator finds:

Petitioner is employed by Respondent at its Chester Mental Health facility as a Security Therapy Aide. The parties stipulated that Petitioner sustained an accident on July 29, 2016, while lining up the patients to go down to the dining room, two patients got involved in an altercation, and Petitioner intervened. In the process, she injured her neck and right shoulder. (See RX 1)

Following the accident, Petitioner went to Chester Memorial Hospital on July 30, 2016, where she complained of right shoulder pain and was prescribed Flexeril and Norco, kept off work until Wednesday, August 3, 2016, and advised to follow up with her primary care physician. (PX 3)

Petitioner underwent no further medical care until after another accident on September 3, 2016.

After Petitioner returned to work, she was involved in another accident on September 3, 2016, while she and another therapy aide were placing a patient in a physical hold in the restraint room. When they reached the doorway, the patient dropped to the floor and pulled Petitioner with him. He then began kicking and punching Petitioner. After Petitioner and her co-worker managed to get the violent recipient on the restraint bed, Petitioner felt a popping sensation in her neck, broke into a sweat instantly, and had to be seen by the facility physician. (See RX 2)Following that accident, Petitioner again presented again to Chester Memorial Hospital, where a consistent history of the accident was taken. Her primary complaint was neck pain. Petitioner was diagnosed with a neck strain and back pain. Diagnostic studies, including x-rays and CAT scans, were

negative except for benign age-related findings in Petitioner's cervical and thoracic spine. She was discharged with Hydrocodone and Cyclobenzaprine. (PX 3; PX 4)

On September 7, 2016, Petitioner went to see her primary care physician at Quality Healthcare Clinics, Dr. Preuss. There, she saw Karen Chamness, Dr. Preuss's PA. Again, a consistent history of the September accident was taken. Petitioner's complaints included her neck, upper back and right arm. Petitioner's examination showed pain with all ranges of motion, pain with palpation of the thoracic spine, no muscle spasm, and good strength. PA Chamness's assessment was a cervical strain with right radiculopathy and a thoracic strain. Petitioner was instructed to use ice to all the affected areas three times daily, to remain off work, to follow up and to continue the medication. (PX 4)

Petitioner returned to Quality Healthcare Clinics on September 13, 2016, with ongoing cervical symptoms and a burning sensation in her right shoulder. Petitioner explained that she had injured her shoulder in an accident in July and was supposed to undergo an MRI but it had never been approved. Petitioner was scheduled to be seen by Dr. Raskas for her current injury. Treatment and testing for the right shoulder was also discussed. PA Chamness's impression was shoulder and cervical pain. (PX 4)

On September 15, 2016, Petitioner saw Dr. Raskas, a board-certified spine specialist who she had seen before. Petitioner related her two accidents – the first one involving her shoulder; the second, her neck. Petitioner reported she was working and currently exercising. The doctor's physical examination showed limited range of motion in her shoulder, positive impingement sign, and intact cranial nerves. His impression of Petitioner's x-rays was cervical spondylolisthesis with cervical spondylosis and degenerative changes. Dr. Raskas recommended that Petitioner remain off work until such time as she could get her shoulder fixed. (PX 5)

At the request of Dr. Nathan Mall, Petitioner underwent a right shoulder MRI. She also underwent, at his request, an MRI of the cervical spine for which the radiologist's impression was degenerative disc changes with central disc protrusions at C5-6 and C6-7 extending towards the foramina without definite root impingement, though correlation to the C6 and C7 roots were recommended. (PX 6)

Dr. Mall performed right shoulder surgery in October of 2016. (PX 7)

Upon the referral of Dr. Mall, Petitioner presented to Dr. Gornet on January 30, 2017 who recorded a concise history of three events (with one preceding July 30, 2016). Dr. Gornet noted that Petitioner had undergone a C5 injection on July 12, 2016. He also reviewed x-rays which showed some foraminal narrowing, foraminal stenosis, and loss of disc height with a pseudo-translation of C4 on C5. The MRI from September 28, 2016, was reviewed, which he believed showed small central herniations at C5-6 and C6-7 with an acute foraminal herniation at C6-7. Dr. Gornet noted that this best correlated with Petitioner's symptoms. He kept her off work.Dr. Gornet recommended that Petitioner's shoulder condition be allowed to heal first. (PX 7)

When Petitioner returned on May 25, 2017, it was noted that Petitioner was being recommended for steroid injections at C3-4 and C6-7, but these were postponed due to a non-related medical condition. The injections were finally done at C4-5 and C6-7 in February and April of 2017, but provided only temporary relief. (see PX 7; PX 11) Dr. Gornet believed that since the injections had failed, Petitioner would need disc replacement surgery. However, prior to that, he recommended a myelogram. On July 10, 2017, Dr. Gornet reviewed the myelogram results with Petitioner, and it showed facet changes more on the left than on the right at C3-4 and C4-5. He believed that Petitioner also had disc herniations at C5-6 and C6-7. She remained unable to work. (PX 7)

On July 21, 2017 Dr. Gornet performed a two-level disc replacement at C5-6 and C6-7. Intra-operative findings showed a central herniation and a right-sided herniation at C6-7 and at C5-6; however, level C5-6 had more anterior osteophytes. (PX 7; PX 10)

Following surgery, Petitioner returned to see Dr. Gornet. As of September 7, 2017, Petitioner reported that she was doing well, her symptoms had dramatically improved and she felt the surgery had make a remarkable difference for her. A home exercise program was recommended. As of October 30, 2017, Petitioner was released to full duty with no more than 40 hours per week (8 hour days) for three months. (PX 7)

On January 23, 2018 Petitioner settled a workers' compensation claim against Integrity Healthcare of Smithton (16 WC 11045) stemming from a shoulder injury sustained on October 15, 2015. As a result of said accident, Petitioner had sustained a right rotator cuff tear that required surgery and a cervical strain. (RX 3)

Petitioner returned to see Dr. Gornet on January 29, 2018 and told the doctor she was doing well for the most part. Her exam was non-focal. She expressed some concerns about a little lipoma on her neck which the doctor advised her was not his area of expertise. She also told the doctor she had received a diagnosis of carcinoma in situ and was due to see her surgeon in about a month. Clinically, she was described as doing well and she was to return in July with x-rays and a CT. If doing well, she would be placed at maximum medical improvement. (PX 7)

On July 26, 2018, Dr. Gornet placed Petitioner at maximum medical improvement, and stated that clinically Petitioner was doing well. He noted that her radiographs showed some heterotopic bone forming at the C6-7 prosthesis which might play a role down the line in her motion. Dr. Gornet noted that they discussed the "long-term issues" she would have but he did not note them in the office note. (PX 7)

Petitioner's two cases proceeded to arbitration on October 22, 2018. Respondent stipulated to liability for payment of medical bills related to Petitioner's cervical spine. The only disputed issue was the nature and extent of Petitioner's injury. Petitioner was the sole witness.

Petitioner testified that she works as a Security Therapy Aide for Respondent, a job she has held for three years. She acknowledged that she previously injured her right shoulder in an altercation at a previous job as a nurse. She then injured her neck and right shoulder in the two accidents herein; however, she confirmed that she's not claiming any injuries to her right shoulder in connection with these claims.

Petitioner testified to going to Chester Memorial Hospital and seeing her primary care doctor after the July 29, 2016 accident. She was given Norco and Flexeril and had no lost time as a result of the accident.

Petitioner testified that on September 3, 2016 she was involved in another accident and was again seen at Chester Memorial Hospital and eventually referred to Dr. Mall who, in turn, referred her to Dr. Gornet. Petitioner testified that she underwent cervical spine injections and, ultimately, a two-level cervical discectomy and disc replacement procedure. Petitioner testified that the surgery helped, and she was released to return to work full duty as a Security Therapy Aide.

Petitioner testified that both surgery and post-operative home exercises improved her condition significantly. She was released to return to work full-duty back to the same job as a Security Therapy Aide. Petitioner testified that as part of her job she has to restrain combative inmates/patients and that she has been involved in attacks from combative recipients since she's returned to work. She testified that this happens on a daily basis, because she works on the Behavioral Unit. There is a panic button that Petitioner is able to push for assistance and has done so, because her strength isn't what it formerly was. Petitioner testified that when she tries to turn her head she "sees stars." For her symptoms, Petitioner takes over-the-counter medication as needed (usually on days she works). She testified that she takes medication at the end of every shift due to soreness, especially when she is mandated to work overtime. Petitioner also testified that she has gained 50 pounds since the accident since her ability to work out at the gym has been adversely affected.

On cross-examination Petitioner testified that she has worked full duty since January of 2018. She further testified that when she last saw Dr. Gornet, she reported she was doing well. She acknowledged that she is enrolled in Dr. Gornet's long-term study on disc replacements.

Regarding the nature and extent of Petitioner's injury, the Arbitrator concludes:

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

(i) **Level of Impairment**: Neither Party submitted an AMA rating. Therefore, the Arbitrator gives no weight to this factor.

(ii) **Occupation**: Petitioner continues to serve as a Security Therapy Aide for Respondent. Petitioner testified that she has some diminished strength making it difficult for her to restrain combative recipients. She obtains assistance through the use of a panic button, when needed. While this testimony was unrebutted by any witness, Petitioner did not fully explain the nature of the diminished strength, the Arbitrator noting that Petitioner has also sustained a torn rotator cuff for which she underwent surgery with Dr. Mall. Dr. Mall's office notes were not included as part of the record herein and, therefore, the Arbitrator is unable to determine if Petitioner's diminished strength is due to her shoulder or her neck. She is able to work the mandated overtime but feels sore afterwards.The Arbitrator places some weight on this factor.

(iii) **Age**: Petitioner was 48 years old at the time of her accident. The Arbitrator places some weight on this factor.

(iv) **Earning Capacity**: Petitioner failed to provide any evidence of reduced earning capacity as a result of the accident. Therefore, the Arbitrator gives no weight to this factor.

(v) **Disability**: As a result of her accident, Petitioner sustained C5-6 and C6-7 disc injuries that required two-level disc replacement. Petitioner testified that despite the improvement from surgery she notices her strength isn't what it used to be and when she's not at work and tries to turn her head she "sees stars." She takes Tylenol or Aleve, as needed, but usually on the days she has worked. After working mandated overtime, she is sore. Petitioner also testified that she has gained 50 pounds since the accident because her ability to work out at the gym on a daily basis stopped after the accident. Petitioner's ongoing complaints are not corroborated by Dr. Gornet's medical records. Indeed, his office notes paint a very different picture as they don't identify any ongoing concerns or issues since returning to full duty work in January of 2018. At no time do Dr. Gornet's records indicate Petitioner is "seeing stars" when turning her head. She did not mention problems with interactions/altercations with patients. While Petitioner's ongoing complaints are not corroborated by Dr. Gornet's records the Arbitrator is cognizant that Petitioner has undergone a two-level disc replacement surgery in her cervical spine and she was released with no restrictions. The Arbitrator places some weight on this factor.

(v) Based upon the foregoing, the Arbitrator finds that Petitioner sustained serious and permanent injuries that resulted in the 20% loss of the body as a whole.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christian Bolte,
Petitioner,

vs. NO: 18 WC 05969

19IWCC0250

State of Illinois,
Pontiac Correctional Center.
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that, other than as stated above, the Decision of the Arbitrator filed November 20, 2018, is hereby affirmed and adopted.

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

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

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

DATED: MAY 17 2019

o-05/08/19
mp-wj
68

Marc Parker

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

BOLTE, CHRISTIAN
Employee/Petitioner

Case# **18WC005969**

PONTIAC CORRECTIONAL CENTER
Employer/Respondent

19IWCC0250

On 11/20/2018, 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 2.45% 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:

0190 PETER F FERRACUTI & ASSOCIATES
ALEXIS P FERRACUTI
110 E MAIN ST PO BOX 859
OTTAWA, IL 61350

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

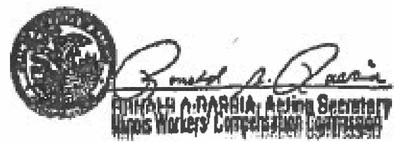
6079 ASSISTANT ATTORNEY GENERAL
BRAD DEFREITAS
55 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

NOV 20 2018



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

19IWCC0250

Christian Bolte
Employee/Petitioner

v.

Pontiac Correctional Center
Employer/Respondent

Case # 18 WC 5969

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 **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Bloomington**, on **October 29, 2018**. By stipulation, the parties agree:

On the date of accident, **January 10, 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, per the stipulation of the parties, Petitioner's earnings in the year preceding the injury were **$48,431.76**; the average weekly wage was **$1,040.39**.

At the time of injury, Petitioner was **25** years of age, ***single,*** with **1** dependent child.

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

Respondent shall be given a credit of **$6,116.06** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$6,116.06.**

Respondent is entitled to a credit for all medical bills paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act.

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 **$624.23/week** for a period of **6.45** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **3% loss of use of the right leg.**

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

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

Melinda M. Rowe-Sullivan
Signature of Arbitrator

11/16/18
Date

NOV 20 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Christian Bolte
Employee/Petitioner

Case # 18 WC 5969

v.

Consolidated cases: N/A

Pontiac Correctional Center
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that on January 10, 2018, he was carrying a laundry bag downstairs when he tripped over two other bags which had been placed on the stairs in front of him, injuring his right knee. He testified that he reported the accident immediately thereafter to Lieutenant McGinnis and Major Brown.

Petitioner testified that he was taken to St. James Medical Center by a fellow correctional officer and that at the emergency room, they took x-rays and gave him an immobilizer and crutches. After having described the medical treatment rendered to his right knee, Petitioner testified that his right knee is more painful when he does more walking. He testified that he has pain 2-3 times per week and that the task of climbing stairs in the towers at work is difficult for him. Petitioner further testified that he is limited in his recreational activities with friends and family based on the associated pain in his knee, and that things such as playing basketball and playing with his 2-year-old child on the floor is difficult. He testified that when his right knee is painful he ices it and takes over-the-counter Aleve, and that he does this 2-3 times per week. Petitioner denied experiencing any instability in the knee.

On cross examination, Petitioner denied having undergone any continued treatment with physical therapy since he was released beyond performing the exercises in his home exercise program.

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1.

The medical records of OSF St. James Occupational Health Clinic were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen on January 12, 2018, at which time it was noted that he stated that he had been treated in the emergency department on January 10, 2018 for right knee pain from a fall down stairs on that date. It was noted that Petitioner was carrying trash bags down the stairs and was nearing the lower steps, that a large bag was leaning up against the lower steps which he did not see and that he tripped on the bag, falling over the bag on the floor and landing on his right knee. It was noted that Petitioner was able to get up and limp to the office, and that he had been seen in the emergency room on January 10th and was given a leg immobilizer and crutches. It was noted that Petitioner reported that the pain was improved while the immobilizer was on, that he took it off at night, that he had pain with any flexion of the knee and also along the right side and that he had no previous knee injury of the right leg. It was also noted that Petitioner had a small abrasion. The assessment was noted to be that of pain in the right knee, contusion of the right knee and other internal derangements of the right knee. It was noted that there was only slight improvement in swelling since the emergency

room visit on January 10th, that the pain continued and that Petitioner may need further imaging as warranted by his condition. Petitioner was given work restrictions and instructed to take NSAIDs. (PX2).

The records of OSF St. James Occupational Health Clinic reflect that Petitioner was seen on January 19, 2018, at which time he was seen for a recheck. It was noted that Petitioner stated that his knee continued to be somewhat swollen and painful with bending and weightbearing activities, that he stated that the knee felt more tight and stiff in the morning but seemed to loosen up a bit throughout the day and that he did try going without the immobilizer the prior weekend and stated that the knee felt better without the brace. It was noted that Petitioner located the knee pain to the upper lateral area of the joint just above the patella and that he also noted tenderness in the area of the LCL from the origin to the insertion. It was noted that Petitioner denied any feelings of weakness or looseness in the knee and that he stated that using the crutches had gone well. The assessment was noted to be that of pain in the right knee, contusion of the right knee and other internal derangements of the right knee. Petitioner was recommended to undergo an MRI of the right knee and was issued work restrictions. The interpretive report for the MRI of the right knee performed on February 1, 2018 noted that the films were interpreted as revealing (1) no evidence of internal derangement or acute osseous abnormality; (2) subcutaneous edema along the anterolateral aspect of the knee is favored to reflect superficial soft tissue contusion given patient's history of recent injury. (PX2).

The records of OSF St. James Occupational Health Clinic reflect that Petitioner was seen on February 6, 2018, at which time it was noted that he stated that he continued to have pain in the right lateral knee. It was noted that the swelling seemed to have decreased a bit, that he noted pain when the knee was touched or bumped in the area and that he had not noticed any weakness or buckling in the right knee. Petitioner was recommended to undergo physical therapy and was issued work restrictions. At the time of the February 20, 2018 visit, it was noted that Petitioner stated that he was doing well, that his pain had decreased a bit, that he began physical therapy on that date and that he stated that physical therapy went well. It was noted that Petitioner had noted some swelling in the knee after riding a stationary bike the week before, that he had iced the knee and that the swelling had gone down. The assessment was noted to be that of pain in the right knee, contusion of the right knee and other internal derangements of the right knee. Petitioner was instructed to use a cold pack and was issued work restrictions. At the time of the March 6, 2018 visit, it was noted that Petitioner stated that his pain level had decreased but that he continued to have weakness in the quad muscles as well as pain along the lateral aspect of the right knee when touched. It was noted that Petitioner stated that walking up and down stairs had gotten better and that he agreed that his strength was still lacking in the quad muscles. The assessment was noted to be that of pain in the right knee, contusion of the right knee and other internal derangements of the right knee. Petitioner was recommended a consultation with an orthopedist and was issued work restrictions. (PX2).

The records of OSF St. James Occupational Health Clinic reflect that Petitioner was seen on March 20, 2018, at which time it was noted that he stated that over the past two weeks he had been doing much better, that he noted occasional soreness after physical therapy and exercising but no real pain and that he stated that he had been able to walk more pain-free as well. It was noted that Petitioner noted very little if any swelling in the knee, that he stated that physical therapy had been going well and that he was doing his home exercise program. The assessment was noted to be that of pain in the right knee, contusion of the right knee and other internal derangements of the right knee. Petitioner was allowed to return to work regular duty. It was noted that they would hold the orthopedic referral at that time due to patient improvement. (PX2).

Included within the records of OSF St. James Occupational Health Clinic were physical therapy notes which documented physical therapy for the timeframe of February 20, 2018 through March 15, 2018. At the time of the initial evaluation on February 20, 2018, it was noted that Petitioner stated that on January 10, 2018 he was walking down stairs at work and tripped over a bag, falling 3-4 stairs. It was noted that Petitioner reported that he fell straight on his knee to a concrete floor and that he went to the emergency

room that day because of immediate swelling. It was noted that Petitioner presented with decreased range of motion, decreased knee and hip strength, edema and tenderness to palpation with signs and symptoms consistent with mechanical knee pain. At the time of the February 22, 2018 visit, it was noted that Petitioner stated that he had to run up a flight of stairs the night before to tend to a work task and that he reported that he had some swelling, but that after icing after his shift the swelling went down. At the time of the February 27, 2018 visit, it was noted that Petitioner reported that he was doing okay and that he was a little sore after the last treatment. At the time of the March 6, 2018 visit, it was noted that Petitioner reported that his home exercises were going okay, that he had been continuing to ride the bike at the gym up to 5 minutes and that he had not noticed much swelling. At the time of the March 13, 2018 visit, it was noted that Petitioner reported that he was doing pretty good, that his pain range was 0-1/10 and that home exercises were going well. At the time of the March 15, 2018 visit, it was noted that Petitioner reported that he was doing okay and that home exercises were going well. (PX2).

The medical records of OSF St. James Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen in the emergency room on August 30, 2016 after having been bitten on the left forearm by a prisoner at work. At the time of the May 20, 2017 visit to the emergency room, Petitioner was seen for a laceration of the right lower leg. At the time of the January 10, 2018 emergency room visit, it was noted that Petitioner presented complaining of right knee pain, that he stated that he was walking and tripped down three stairs landing directly on his right knee and that he reported pain with weightbearing and with movement. It was noted that x-rays of the right knee were interpreted as revealing soft tissue swelling without acute fracture. The clinical impression was noted to be that of right knee injury. It was noted that Petitioner was provided with a knee immobilizer and crutches for non-weightbearing and was encouraged to have close follow-up with his primary care physician. (PX3).

The medical records of OSFMG Orthopedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on April 6, 2018, at which time it was noted that he was seen for an evaluation of right knee pain. It was noted that Petitioner had a history on January 10, 2018 where he was coming down some stairs at his work site, that he was carrying an item and did not see a laundry bag at the bottom of the steps and that he tripped over it and came down on the right knee with a ground-level fall onto cement. It was noted that Petitioner had been seen by Occupational Health and physical therapy and had been released from therapy as he had continued to improve with it. It was noted that at the time that the appointment was made he was having some continued pain but at follow-up on that date, Petitioner related that he continued to get better. It was noted that Petitioner related that he had occasional ache to the lateral aspect of the knee that he pointed to but that he continued to improve, that he denied any numbness/tingling of the lower extremity and that he denied any mechanical symptoms such as catching or locking. The assessment was noted to be that of (1) right knee pain; (2) right knee contusion. It was noted that Petitioner subjectively was improving and that he stated that he was feeling better. It was noted that Petitioner was recommended to continue conservative treatment. It was noted that a discussion was had regarding the use of an over-the-counter knee sleeve for compression and ice as needed. It was noted that Petitioner was advised that it could take 3-4 months to completely resolve but that there was no intraarticular pathology that would warrant further treatment. (PX4).

The Notice of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 1.

CONCLUSIONS OF LAW

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following

criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner was employed as a correctional officer at the time of the accident at issue and that he continued to hold this position with Respondent as of the date of arbitration. The Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 25 years old on his date of accident. Given the younger age of Petitioner and the fact that the medical records lack any reference to Petitioner having been placed under any restrictions, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he continues to be employed by Respondent in the same position that he held prior to his accident. As there was no direct evidence of reduced earning capacity contained in the record, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that his right knee is more painful when he does more walking. Petitioner testified that he has pain 2-3 times per week and that the task of climbing stairs in the towers at work is difficult for him. Petitioner further testified that he is limited in his recreational activities with friends and family based on the associated pain in his knee, and that things such as playing basketball and playing with his 2-year-old child on the floor is difficult. Petitioner testified that when his right knee is painful he ices it and takes over-the-counter Aleve, and that he does this 2-3 times per week. At the time of the most recent office visit on April 6, 2018, it was noted that at the time that the appointment was made Petitioner was having some continued pain but at follow-up on that date, he related that he continued to get better. It was noted that Petitioner related that he had occasional ache to the lateral aspect of the knee that he pointed to but that he continued to improve, that he denied any numbness/tingling of the lower extremity and that he denied any mechanical symptoms such as catching or locking. It was noted that Petitioner subjectively was improving and that he stated that he was feeling better. It was noted that Petitioner was recommended to continue conservative treatment. (PX4). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and limitations, were somewhat corroborated by his treating records. The Arbitrator accordingly places lesser weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of **3% loss of use of the right leg** as provided in Section 8(e) of the Act.

STATE OF ILLINOIS	)	
	) SS.	
COUNTY OF MC LEAN	)	

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Felicitas Sisco,
Petitioner,

vs. NO: 15 WC 21028

Evenglow Lodge, Inc.,
Respondent.

19IWCC0251

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 30, 2017, is hereby affirmed and adopted.

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

DATED: MAY 17 2019

Marc Parker

o-05/09/19
mp-wj
68

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SISCO, FELICITAS
Employee/Petitioner

Case# **15WC021028**

EVENGLOW LODGE INC
Employer/Respondent

19IWCC0251

On 11/30/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
JEAN A SWEE
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

2593 GANAN & SHAPIRO PC
BRET E TAYLOR
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

19IWCC0251

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

FELICITAS SISCO,
Employee/Petitioner

Case # **15** WC **21028**

v.

Consolidated cases: ______

EVENGLOW LODGE, 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 **Maureen Pulia**, Arbitrator of the Commission, in the city of **Bloomington**, on **10/24/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [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 **19IWCC0251**

On **5/14/15**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned $**15,127.67**; the average weekly wage was $**290.92**.

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

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

ORDER

The petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her bilateral hands due to chemical exposure that arose out of and in the course of her employment by respondent on 5/14/15. The petitioner's claim for compensation is denied.

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

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

Maureen H Pulia

Signature of Arbitrator

11/10/17

Date

ICArbDec p. 2

NOV 30 2017

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 61 year old housekeeper, alleges she sustained accidental injuries to her bilateral hands due to a chemical exposure that arose out of and in the course of her employment by respondent on 5/14/15. Petitioner is a diabetic. Petitioner used various chemicals to perform her housekeeping duties. These chemicals included Spic N' Span, window cleaner, bleach and water solutions. Petitioner always wore gloves while performing her duties and would change them every time she did something. Petitioner would fill containers with chemicals from the four wall dispensers. Petitioner testified that the gloves the housekeepers used were different from the gloves the nurse's aides used. She testified that the nurse's aides gloves were thicker and softer.

Prior to 5/14/15 petitioner used the gloves while working with the various chemicals without incident. On 5/14/15 petitioner placed her gloves on and filled her containers as she did every day she worked. After a while of performing her usual duties she noticed something on her left hand between the thumb and her index finger. She showed it to Rich Young, head of housekeeping. Young instructed petitioner to get a different pair of gloves. Petitioner grabbed the thicker gloves that the nursing aides use. After putting on the new gloves petitioner continued working her regular job and later that day was sent with 2 to 3 other housekeepers to clean an isolation room. Cleaning an isolation room required more intensive cleaning and the use of more bleach than the other cleaning products.

While cleaning the isolation room petitioner had her gloves on and used various rags to clean different parts of the furniture. Petitioner sprayed the rags with one hand and cleaned the furniture with both hands. In addition to the furniture, petitioner and the other housekeepers cleaned the walls, floors, and bathroom of the isolation room.

After she finished the isolation room, petitioner continued her regular duties for the remainder of the day. Petitioner testified that by the end of the day her hands were wet inside the gloves. However, she denied any of the chemicals got in her gloves.

After petitioner went home she noticed that her hands were swollen and hurt very bad. She called and told Young that her hands were bad and she would not be at work on 5/15/15. Petitioner remained off work until 6/11/15. During this period petitioner presented to the emergency room at St James with two blisters noted at the base on both thumbs, which petitioner said was from the friction of the spray bottle on her hands. She also had three areas on the back of her hands that were developing blisters. She complained of pain and itching. The blisters appeared to have purulent material inside. She gave a history of working as a housekeeper and wearing gloves. She reported that the spray bottle caused some blistering. The blisters were incised and drained. Petitioner's hands were dressed with antibiotic ointment. She was given Bactrim.

On 5/17/15 petitioner's hands were still in bad shape so she again called in sick. On 5/18/15 petitioner returned to the emergency room at St. James. She presented with large blisters, pain, and erythema to bilateral hands. She also had a couple very small blisters on her lower lip. The etiology of her blisters was unknown. Her culture was negative for bacteria. Petitioner was referred to Dr. Schupbach, a dermatologist, at the request of her husband.

After being discharged from the emergency room on 5/18/15 she presented to Dr. Schupbach. Dr. Schupbach took a biopsy of her hands. No virus was isolated or growth after 24 or 36 hours. Petitioner presented with a rash that was red, painful, blistering, swollen, and severe, that had been present for 1 week. Dr. Schupbach's impression was unspecified rash and edema. She was prescribed Bactrim.

On 5/20/15 petitioner presented to the emergency room at St. Joseph Medical Center. Petitioner reported that she works with cleaning chemicals and on 5/13/15 noted blisters to the dorsum of both hands, that got worse over time. She also reported that she noticed a red streak on her right arm the day before, which was not a day she worked for respondent. Petitioner stated that her problem had been getting progressively worse, despite the fact that she was not working. Petitioner was examined and assessed with cellulitis, infected blister of the right hand, and blister of the left hand. Petitioner was admitted to the hospital for IV antibiotics and further treatment.

On 5/22/15 petitioner was examined by Dr. Jerome Oakey. Petitioner reported substantial improvement with the IV antibiotics. She reported that the pain was a burning pain aggravated by any type of use, and associated with blisters in the dorsal aspect of the hand. She stated that she was a diabetic and there had been no associated elevation of her blood sugars. She rated her pain as moderate to severe, and noted that it was alleviated with pain medication. She stated that she has hypertension. Following an examination, Dr. Oakey diagnosed bilateral hand pain comprised of hand pain potentially due to some infection and inflammation secondary to the chemical injury. He recommended use of anti-inflammatories and Occupational Therapy. Dr. Oakey diagnosed bilateral hand chemical injury with no evidence of suppurative infection.

On 5/22/15 the results of the biopsies of the right ulnar dorsal hand were issued. The biopsies showed that Petitioner had Sweet's Syndrome of the right ulnar dorsal hand.

Petitioner remained in the hospital until 5/25/15 when she was discharged. The discharge report noted that petitioner presented with bilateral hand cellulitis/eczem and chemical burn after spilling some chemicals on her hands at work. It was noted that she was improved with ABX and local steroid cream. It was also noted that the hand surgeon consulted and was of the opinion that petitioner did not need incision and debridement. It

was also noted that petitioner underwent a short therapy of IV toradol while in the hospital, per the hand surgeon. Petitioner did very well and was discharged on PO ABX and local steroid cream.

On 5/26/15 petitioner followed-up with Dr. Oakey. She denied any pain, numbness or tingling. She stated that she does dressing changes BID, uses Betamethasone cream, and felt her hands were improving. She stated that she was also taking oral Amoxicillin. Petitioner had no other complaints. Dr. Oakey noted swelling and erythema on both hands. He also noted partial thickness skin loss to the dorsum of the hand with associated surrounding blisters and erythema on both hands. No drainage or evidence of infection was noted on either hand. Petitioner reported some stiffness with flexion of the fingers on the right.

On 5/29/15 petitioner followed-up with Dr. Schupbach. Petitioner's rash wasusing still blistering and moderate in severity. Dr. Schupbach instructed petitioner to continue placing mupirocin on her blisters and sore places, and continue bactrim. Dr. Schupbach was of the opinion that the biopsy was consistent with Sweet's Syndrome, but not clinically consistent, since petitioner's condition resolved with Abx, and petitioner was looking and feeling good.

Petitioner returned to Dr. Oakey on 6/10/15. Petitioner reported that her hands continued to improve. She complained of burning pain on the dorsal aspect of her thumbs over the interphalangeal area that is aggravated at the end range of flexion. She complained of a mild burning pain that is absent at rest. Petitioner reported some associated color changes on the dorsum of her hands that began at the time of the chemical injury. Dr. Oakey examined petitioner and was of the opinion that she was doing very well following her chemical injury to the dorsum of the hands and thumbs. He was of the opinion she should continue working on her range of motion. He allowed her to perform work duties with 1 pound in each upper extremity. He instructed her to avoid any exposure to chemicals.

On 6/11/15 petitioner returned to work for respondent. She worked 2 hours a day for 5 days a week at a rate of $9.25 an hour until 7/31/15.

On 7/10/15 petitioner followed up at Dr. Oakey's office and saw Crystal Sweeney, the nurse practitioner. Sweeney noted that petitioner's range of motion had improved and her skin was well healed. She noted some small vesicular areas to her bilateral thumbs with some tenderness on palpation. Petitioner reported that the gloves she used at work irritated her hands further, and also caused a burning sensation and redness. Sweeney discussed the use of cloth gloves. She instructed petitioner to continue using the topical steroid cream on her thumb areas twice daily. Sweeney released petitioner to return to work with a 5 pound lifting restriction for her

bilateral hands, as well as limiting her use of her hands to 30 minutes per hour. She instructed petitioner to wear cotton gloves, and not submerge her hands in chemicals.

On 7/31/15 petitioner retired and resigned her position with respondent.

On 8/17/15 petitioner followed up with Dr. Oakey. She reported that her hands were doing quite well. He released her to full duty.

On 9/28/15 petitioner returned to Dr. Oakey. She reported no issues with her hands and no aggravation with increasing her activities. She reported that the pain and burning she originally described had improved with treatment including her most recent home exercise program. She reported only sporadic mild burning. Dr. Oakey noted that there was a decrease in the scar tissue present at the dorsal aspect of the thumbs and hands, with good pliability on inspection and palpation of the skin. Dr. Oakey released her from his care and was of the opinion she needed no work restrictions.

On 2/17/16 petitioner presented to Dr. Gendleman at the request of the respondent. She reported that she began getting sores and blisters on her left thumb, and then switched gloves at the recommendation of her boss. She stated that despite the glove change her condition got worse. She stated that she developed redness, swelling, and tenderness later that day. She also reported that it was worse the next day so she went to the Emergency Room at St. James. A few days later she returned and was referred to Dr Schupbach. After that, her condition continued to worsen and she went to St. Joseph's in Bloomington, where she was ultimately admitted for five days. While admitted she was given IV antibiotics and her condition improved. Petitioner denied any further recurrences after returning to work, but did report some tenderness at the original left thumb site. A clinical examination revealed a little discoloration on the top of both hands, but not the fingers.

On 2/19/16 Dr. Gendleman issued a report based on the materials respondent's attorney sent him, especially the two visits to the dermatologist, Dr. Schupbach, as well as his examination of petitioner on 2/17/16. He noted that petitioner developed Sweet's Syndrome in May, 2015. He noted that Sweet's Syndrome is a rare inflammatory skin disease of unknown cause, also referred to as Acute Febrile Neutrophilic Dermatosis. He was of the opinion that it usually presents quickly with skin lesions of the hands, face, neck and arms with fever, joint pains, and an increase in white blood cells in the blood. Dr. Gendleman was of the opinion that it is often mistaken for other diseases, especially infections. He was of the opinion that Sweet's Syndrome improves over time, especially with oral and topical steroids, once the diagnosis has been made. He noted that a skin biopsy is often the best diagnostic test. Dr. Gendleman opined that petitioner's condition was not related to her work as a custodian, her exposure to chemicals, or her gloves. He was of the opinion she

should have been able to return to normal activities (including her work) relatively soon after proper treatment had begun. Dr. Gendleman was of the opinion that patients with Sweet's syndrome can develop hematological malignancies over time and therefore they should be followed regularly by their primary care physicians. Dr. Gendleman noted that Sweet's Syndrome manifests itself with a sudden onset of painful skin lesions, that can vary from bumps or nodules to patches, edematous areas, and swollen areas. He noted that it is mainly on the skin but there have been instances where manifestations are seen on the lips, mouth, internal organs, and the eyes. Dr. Gendleman noted that the hands and arms are the most common site of eruption.

Dr. Gendleman opined that his diagnosis of petitioner was Sweet's Syndrome. Dr. Gendleman based this diagnosis on the clinical presentation and photos when her symptoms first manifested themselves, plus the biopsy findings. Dr. Gendelman opined that the causes of most cases of Sweet's syndrome are unknown. He opined that some cases are associated with medicines, some with malignancies (mostly hematological malignancies), and some are idiopathic cases which can be associated with infections. Dr. Gendleman opined that someone with active Sweet's Syndrome has severe inflammation of the skin that produces swelling, blister formation, bleeding, pain and fever. He testified that it is unknown what causes the inflammation, but to the best of his knowledge it is not caused by contact with certain materials, chemicals, or any chemical stimuli. He opined that he does not know of any reported case of contact dermatitis associated with Sweet's Syndrome. Dr. Gendleman further opined that petitioner's Sweet's Syndrome was not in any way caused by her work or exposure to her gloves or chemical solutions at work. Dr. Gendleman testified that since Dr. Oakey is an orthopedic surgeon, he is not the type of physician that would treat someone with a chemical burn to the skin, allergic or dermatologic reaction to chemical exposure, or Sweet's Syndrome. Dr. Gendleman opined that from all the notes he reviewed that petitioner's condition gradually worsened, and if it was a chemical reaction it would show immediately or within hours of exposure. Dr. Gendelman testified that no doctor that examined petitioner was able to identify the product she was exposed to that would have caused her reaction. Dr. Gendleman was of the opinion that if petitioner wore the same types of gloves each day, and used the same chemicals each day, that would not support an allergic or dermatologic reaction to a chemical. Dr. Gendleman confirmed that petitioner never provided a history to any healthcare provider that the chemicals and cleaning solutions she worked with either poured or spilled on her exposed hands.

Dr. Gendleman opined that Sweet's Syndrome is something that develops suddenly and can be associated with some medications such as antibiotics, antiepilepsy drugs, anti-HIV drugs, anti high blood pressure drugs, antineoplastic drugs, antipsychotic drugs, birth control pills, diuretics, immunosuppressants, NSAIDs, and others. However, he did not think her condition was caused by any medications she was taking. He also

testified that he did not see any indication that petitioner has cancer, leukemia or malignancy. Dr. Gendleman opined that the etiology of petitioner's Sweet's Syndrome was unknown. He opined that once a person has Sweet's Syndrome it mostly goes away, but sometimes can recur if they have a malignancy, or it is drug induced, but that is rare. Dr. Gendleman did not agree with the Mayo Clinic summary of Sweet's Syndrome. He testified that any current textbook of dermatology would be better. Dr. Gendleman testified that chemicals such as those used by petitioner can cause chemical burns and blisters. Dr. Gendelman testified that Sweet's Syndrome can also follow an upper respiratory infection.

On 4/18/16 Dr. Oakey drafted a letter to petitioner's attorney following a conversation with her on 4/15/16. He noted that when he first saw petitioner in the hospital she gave him a history of having an environmental exposure while working as a custodian. He noted that he stands by his diagnosis of chemical exposure to petitioner's hands. He did not think there was any definitive way to prove a diagnosis of Sweet's Syndrome. He was of the opinion that the fact that she has no malignancy, was not given steroids, and improved, does not seem to go along with a diagnosis of Sweet's Syndrome.

On 10/14/16 the evidence deposition of Dr. Oakey, a hand orthopedic surgeon, was taken on behalf of respondent. Dr. Oakey reviewed petitioner's treatment with him through 9/28/15. Dr. Oakey's working diagnosis throughout his treatment of petitioner was bilateral hand chemical burn. Dr. Oakey testified that he has never in his career run across Sweet's Syndrome. Dr. Oakey stated that he did not have enough of a grasp of Sweet's Syndrome to accurately describe it. Dr. Oakey also testified that he did not normally treat Sweet's Syndrome in the course of his practice, but does treat burns and chemical burns. He opined that petitioner had a chemical burn to the dorsum of both hands. He further opined that petitioner's work and use of cleaning supplies either contributed to or caused the hand condition he treated. Dr. Oakey disagreed that petitioner's condition was related to Sweet's Syndrome. He stated that when he looked up Sweet's Syndrome there were a couple of symptoms that were more consistent with chemical exposure of her hands. He noted that petitioner did not appear to have any systemic issues, no history of malignancy, was not given steroids until she was given topical steroids for her treatment, and had a history of a chemical exposure.

On cross examination Dr. Oakey admitted that he was not a dermatologist, or board certified in dermatology. He also admitted that he had no real familiarity with Sweet's Syndrome other than the research he performed after talking with petitioner's attorney. Dr. Oakey testified that his record review only goes back to when petitioner was seen at St. Joseph's on 5/21/15. He testified that he did not know how long petitioner worked for respondent, or what specific cleaning chemicals she used. Dr. Oakey testified that if chemicals did not touch petitioner's hands, it would be very hard for petitioner to get a chemical burn. Dr. Oakey did not know

if petitioner did any cleaning in her house. He was of the opinion that the chemical exposure was to both hands. He testified that if petitioner had marks or lesions on her face they disappeared in a different time frame than those on her hands, and are therefore unrelated. Dr. Oakey testified that if petitioner had some sort of an infection (streaking along the skin) that could be from cellulitis. Dr. Oakey testified that he is not a dermatologist and would defer to a dermatologist regarding the diagnosis of Sweet's Syndrome. Dr. Oakey was of the opinion that topical steroids is a treatment for Sweet's Syndrome. Dr. Oakey opined that petitioner had no permanent disability as a result of her condition.

Petitioner testified that before 5/14/15 she was never diagnosed with Sweet's Syndrome; never had red bumps or blisters on her hands; was never diagnosed with cancer or leukemia; never used new gloves; never had infections or illnesses; had no respiratory conditions; and was not pregnant in the year before 5/14/15.

Petitioner testified that at some point after she retired, she came out of retirement and began working as a housekeeper at Good Samaritan in Pontiac, Il. Petitioner works 37 hours a week and earns $11.50 an hour. Petitioner testified that currently she notices an irritation on her index finger and thumb on the right. She testified that when she does dishes she wears gloves. She stated that when her hands get irritated she uses antibiotic creams and it helps. Petitioner stated that when it gets cold out the back of her hands get real bumpy and purple. She also stated that her skin starts hurting when she is in the sun too long.

On cross examination petitioner showed her hands to all parties and the arbitrator. For the record, it was noted that there was no scarring on the back of her hands. It was also noted that she had an enlarged cuticle on her right thumb and redness around the nail bed of her right index finger.

Petitioner testified that prior to 5/14/15 she worked for respondent for five years as a housekeeper without any problems. She stated that during this time her duties were the same, and she used the same gloves and cleaning solutions.

Petitioner testified that on 5/14/15 she was wearing her regular gloves and had no tears in her gloves. She also testified that before taking off her gloves she felt wetness in her gloves. However, she was adamant that no chemicals spilled on her bare hands. Petitioner testified that when she took off her gloves she saw blisters.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner is alleging that she sustained an accidental injury to her bilateral hands that arose out of and in the course of her employment by respondent on 5/14/15 when she sustained some type of chemical burn to her hands. On the date of the alleged injury petitioner claims she sustained a chemical burn to her hands while she

was using chemicals as a housekeeper for respondent. Petitioner uses the same 4 chemicals daily, and wears the same gloves every day. For 5 years before, and on 5/14/15 petitioner was performing her usual duties and noticed something on her left hand between her thumb and index finger on her left hand. She reported it to Young and he told her to change her gloves. Petitioner changed her gloves and continued working. At one point her and some fellow housekeepers cleaned an isolation room. After cleaning the isolation room petitioner continued her regular duties and completed her shift. By the end of the day, petitioner noticed that her hands were wet inside her gloves. However, petitioner specifically testified at trial that no chemicals got in her gloves or on her hands.

When petitioner arrived home her hands were swollen and hurt bad. Over the next two weeks or so petitioner remained off work, but the condition of her hands continued to worsen. Petitioner developed blisters on the back of her hands and at the base of her thumb. She felt the blisters at the base of her thumbs were from friction of the spray bottle on her hands. Despite being off work, the blisters on her hands appeared to have purulent material inside and needed to be incised and drained. Petitioner was given antibiotic ointment and Bactrim to put on her hands. Petitioner's hands did not improve, and she again returned to the emergency room at St. James Hospital on 5/17/15. In addition to the blisters on her hands, she also had a couple small blisters on her lips. The etiology of her blisters was unknown.

Petitioner was then sent to Dr. Schupbach, a dermatologist on 5/18/15. Dr. Schupbach performed a biopsy of her hands. By this time petitioner had a rash that was red, painful. blistering, swollen, and severe for the past week. At that time Dr. Schupbach's impression was rash and edema.

On 5/20/15, when her condition was still not better, she presented to the emergency room at St. Joseph Medical Center, where she reported that she worked with chemicals at work and noted blisters to the dorsum of her hands, that got worse over time. She also noted a red streak of her right arm, that was diagnosed as cellulitis. Petitioner was admitted to the hospital for 5 days of IV antibiotics and further treatment. While in the hospital she was examined by Dr. Oakey, a hand orthopedic surgeon. He believed her condition was due to some infection secondary to the chemical irritation.

After Dr. Oakey examined petitioner the results of the biopsies came back and revealed that petitioner had Sweet's Syndrome of the right ulnar dorsal hand. When petitioner was discharged her discharge report noted that she presented with bilateral hand cellulitis/eczem and chemical burn after spilling some chemicals on her hands at work. The arbitrator finds this history inconsistent with the petitioner's testimony at trial where she specifically stated that she did not spill any chemicals on her hands or in her gloves.

By 5/26/15 petitioner was feeling better and her hands were improving. Petitioner was still using the Betamethasone cream.

On 5/29/15 Dr. Schupbach told petitioner that the biopsy was consistent with Sweet's Syndrome, despite the fact that her condition resolved with Abx. Petitioner continued treating with Dr. Oakey and on 6/10/15 Dr. Oakey was of the opinion that petitioner was doing very well following her chemical injury to the dorsum of her hands and thumbs. The arbitrator does not give much weight to this opinion of Dr. Oakey, specifically because petitioner denied getting any chemicals on her hands or in her gloves. On 6/11/15 petitioner returned to work. Although she reported that the gloves irritated her hands and caused a burning sensation, her condition continued to improve.

Petitioner retired on 7/31/15. She continued to treat with Dr. Oakey until 9/28/15 when she reported no issues with her hands and no aggravation with increasing her activities. Petitioner reported that she was improved and only had sporadic mild burning. Dr. Oakey was of the opinion that petitioner needed no restrictions.

Petitioner did not stay retired. She ultimately returned to work as a housekeeper at Good Samaritan Hospital and did not report any further recurrences.

The only dermatologists that examined petitioner was Dr. Schupbach, and Dr. Gendleman. Dr. Gendleman reviewed petitioner's treating records, especially the biposy results that revealed Sweet's Syndrome in May of 2015. Dr. Gendleman opined that a skin biopsy is often the best diagnostic test. He was of the opinion that Sweet's Syndrome presents quickly with skin lesions of the hand, face, neck and arms, and improves over time, especially with oral and topical steroids, once the diagnosis has been made. He was of the opinion that it manifests itself with a sudden onset of painful skin lesions, that can vary from bumps or nodules to patches, edematous areas, and swollen areas, all of which petitioner presented with on and after 5/14/15. He also noted that there are instances where manifestations are on the lips, which was also the case with petitioner. Following his examination and record review, Dr. Gendleman opined that petitioner's condition was not related to her work as a custodian, her gloves, or to any exposure to chemicals. Dr. Gendleman's diagnosis of Sweet's Syndrome was based on the clinical presentation and photos of her symptoms when they first manifested themselves, plus the biopsy findings. Dr. Gendleman testified that he knew of no instances where Sweet's Syndrome could be caused by petitioner's work, or exposure to her gloves or chemical solutions at work. Dr. Gendleman also opined that as a dermatologist he is better qualified than an orthopedic surgeon to treat someone with a chemical burn to the skin, allergic or dermatologic reaction to chemical exposure, or Sweet's Syndrome. Dr. Gendleman opined that the fact that petitioner's condition gradually worsened was

counterintuitive to a chemical reaction which would show immediately or within hours of exposure. Dr. Gendleman also noted that it was significant that neither petitioner nor any doctor she presented to were able to identify the product she was allegedly exposed to that would have caused her reaction. He also found it significant that if the petitioner wore the same gloves and used the same chemicals every day, that would not support an allergic or dermatologic reaction to any of the chemicals or gloves. Dr. Gendleman also found it significant that petitioner never provided a history to any healthcare provider that the chemicals and/or cleaning solutions she worked with either poured or spilled on her hands.

During his deposition Dr. Oakey testified that while in the hospital petitioner gave him a history of having an environmental exposure while working as a housekeeper, and therefore stands by his diagnosis of chemical exposure. However, Dr. Oakey admitted that he did not know much about Sweet's Syndrome and did not typically treat this in his practice. He reiterated his opinion that petitioner's work and use of cleaning supplies either contributed to or caused the hand condition he treated, despite the fact that he did not review any of petitioner's medical records prior to 5/21/15. He also admitted that he did not know how long petitioner worked for respondent, or what specific cleaning chemicals she used. Dr. Oakey also agreed that if the chemicals did not touch petitioner's hands, it would be very hard for petitioner to get a chemical burn. Dr. Oakey stated that he would defer to a dermatologist regarding the diagnosis of Sweet's Syndrome, and agreed that topical steroids is a treatment for Sweet's Syndrome.

Based on the above, as well as the credible evidence, the arbitrator finds the most significant evidence in determining whether petitioner sustained accidental injuries to her hands that arose out of and in the course of her employment by respondent on 5/14/15 is the petitioner's own testimony that she had worked for petitioner for 5 years before 5/14/15 wearing the same gloves and using the same chemicals; that on 5/14/15 she had no tears in her gloves; and, that on 5/14/15 no chemicals spilled on her bare hands. She had also testified that no chemicals spilled in her gloves, despite her claim that she felt some wetness in her gloves before she took them off.

Based on this history, the arbitrator finds the opinions of Dr. Oakey less persuasive than those of Dr. Gendleman, especially given the fact that Dr. Oakey's diagnoses are based on an understanding that petitioner spilled chemical in her gloves or on her hands, which she has specifically denied. The arbitrator also is not relying on the opinions of Dr. Oakey because he himself testified that he did not even know what chemicals petitioner worked with. The arbitrator finds it hard to diagnosis a chemical burn if you don't even know what chemicals are alleged to have caused it.

The arbitrator finds the opinions Dr. Gendleman more persuasive, especially given the only objective finding was the results of the biopsy of petitioner's blisters showed that she had Sweet's Syndrome. The arbitrator also finds it significant that Dr. Gendleman pointed out that petitioner's full reaction did not appear immediately or within hours of her alleged exposure, but rather continued to manifest in the days and weeks after the alleged accident date, even though petitioner was no longer being exposed to any chemicals. The arbitrator also finds it significant that while in the hospital petitioner developed blisters on her lip, which Dr. Gendleman opined would be consistent with a diagnosis of Sweet's Syndrome. The arbitrator also finds it significant that petitioner's symptoms improved with use of the treatments recommended for Sweet's Syndrome, and even after she returned to work for respondent, and later for another employer as a housekeeper, she never had another recurrence of this condition.

Given the above, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her bilateral hands due to chemical exposure that arose out of and in the course of her employment by respondent on 5/14/15.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?
J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?
K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?
L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Having found the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her bilateral hands due to chemical exposure that arose out of and in the course of her employment by respondent on 5/14/15, the arbitrator finds these remaining issues moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brian Reynolds,
Petitioner,

vs. NO: 15 WC 34548

19IWCC0252

City of Peoria.
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 Petitioner's permanent partial disability, prior credit and being advised of the facts and law, affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that, other than as stated above, the Decision of the Arbitrator filed November 21, 2017 is hereby affirmed and adopted.

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

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

19IWCC0252

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

DATED: MAY 17 2019

Marc Parker

o-05/08/19
mp-wj
68

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REYNOLDS, BRIAN
Employee/Petitioner

Case# **15WC034548**

CITY OF PEORIA
Employer/Respondent

19IWCC0252

On 11/21/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1004 BACH LAW OFFICE
ROBERT W BACH
110 S W JEFFERSON SUITE 410
PEORIA, IL 61602

0980 HASSELBERG GREBE ET AL
J LOGAN BLOCK
401 MAIN 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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Brian Reynolds
Employee/Petitioner

v.

City of Peoria
Employer/Respondent

Case # **15** WC **34548**

Consolidated cases: **N/A**

19IWCC0252

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 K. Nowak**, Arbitrator of the Commission, in the city of **Peoria**, on **December 15, 2016**. By stipulation, the parties agree:

On the date of accident, **9/3/15**, 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 **$91,994.65**, and the average weekly wage was **$1,769.13**.

At the time of injury, Petitioner was **55** years of age, ***married*** with **2** dependent children.

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

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

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

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 Petitioner is now permanently and partially disabled to the extent of 30% loss of use of the left leg as provided in Section 8(e) of the Act. Petitioner has sustained serious and permanent injuries in this case that have resulted in an additional 15% (32.25 weeks) loss of use of his left leg above and beyond his prior injuries for which the parties stipulated Respondent is entitled to a credit of 15% of the right leg. After applying the stipulated credit, Respondent shall pay Petitioner the sum of **$755.22**/week for a further period of **32.25** weeks.

Respondent shall pay Petitioner compensation that has accrued from **12/10/15** through **12/15/16**, 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

10/27/17
Date

ICArbDecN&E p 2

NOV 2 1 2017

FINDINGS OF FACT

Petitioner, Brian Reynolds, a 55 year old firefighter, was injured on September 3, 2015, at the scene of a one car accident when he accidentally stepped into a hole, twisting his left knee. He immediately felt pain and was taken to the OSF St. Francis Medical Center Emergency Room. X-rays were negative for fracture or dislocation and showed only an old healed fracture of the proximal fibula.

Petitioner was sent to see the City's doctor at OSF Occupational Health the following day. He was given a knee brace and placed on work restrictions. An MRI on September 16, 2015 showed focal inferior surface tears of the medial meniscus, a partial tear or strain of the medial collateral ligament, and minimal degenerative changes. Petitioner was referred to Midwest Orthopedics for evaluation, and maintained on work restrictions.

Petitioner saw Dr. Michael Gibbons, an orthopedic surgeon, on October 7, 2015 and following his examination, was scheduled for surgery on November 3, 2015. The surgery revealed grade 2 chondromalacia of the lateral patella and grade 4 full thickness chondromalacia of the trochlea as well as a complex tear of the posterior two-thirds of the medial meniscus which Dr. Gibbons determined was not repairable. The meniscus was debrided and a chondroplasty was performed on the patella and trochlea.

Petitioner did post-operative physical therapy with home exercises and saw Dr. Gibbons again on December 10, 2015 for follow up. He testified that he was still having some pain and swelling in the knee at that time, but asked Dr. Gibbons to release him to return to work on a full duty basis. Petitioner explained that his regular work shift was 24 on 48 off and on his off days he worked as a copier repairman. While on restricted duty he was required to work at the fire department from 9-5 five days per week. This schedule prevented him from working his second job and caused him financial hardship. Therefore, Dr. Gibbons agreed to release Petitioner to return to work without restrictions on December 10, 2015.

Petitioner returned to work at both of his jobs but retired from the fire department after only six months in June, 2016. He testified that he felt his knee was "not the same" and that he was putting himself and others at risk by continuing to work as a firefighter.

Currently, Petitioner works almost full time as a copier repairman. He does a great deal of bending, squatting and kneeling in his job. He is required to move wheeled copiers weighing several hundred pounds and carry smaller ones weighing as much as 80 lbs.

Petitioner testified his knee pops, causes him pain in certain positions, does not bend the way it used to, and becomes stiff, sore, and aches if he does too much physical activity. He uses over the counter pain mediation, his knee brace, and the "Cryo-Cuff" his doctor gave him which ices the knee by using cold water.

Prior to this injury, Petitioner had never had any prior left knee injuries, issues, or treatment. In fact, he played amateur hockey as a goalie which he gave up due to his knee injury.

Recently, he spent the better part of three days on his feet volunteering for a church charity to prepare a chicken noodle dinner. Following this, his knee was painful and swollen and required him to use medication and his Cryo-Cuff.

On cross-examination, Petitioner admitted he had told the City doctor that his knee had returned to "baseline" at his examination on December 8, 2015. The Arbitrator notes this is immediately prior to the treating doctor's exam and full duty release which allowed Petitioner, after three months of light duty, to resume his second job as a copier repairman.

Petitioner was also asked about walking for exercise. He testified that in good weather he and his wife walked up to two miles for exercise. The Arbitrator notes that Petition's complaints on direct examination revolved around bending, stooping, lifting, kneeling, and pushing heavy objects. He did not complain of residual problems caused by walking.

Respondent sent Petitioner to Arlington Heights to be examined by Dr. Bryan Neal whose report dated December 8, 2016 was admitted into evidence. Dr. Neal's examination included testing flexion by forcing Petitioner's knee beyond the comfort range, according to Petitioner's testimony. The Arbitrator notes that Dr. Neal's 19-page report contains less than one page of examination findings. His AMA impairment evaluation was 3% of the left leg or 1% of a person as a whole.

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 the reported level of impairment determined by Respondent's examining doctor is 3% of the left lower extremity. However, impairment does not equal disability. The impairment rating is part of the determination for permanent partial disability benefits, but is not the sole or main factor. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner was employed both as a firefighter and a copier repairman. Both occupations are noted to be very physically demanding with respect to the use of his knee. This is especially true of his job as a firefighter, which he gave up, in part, due to problems with his knee following this injury. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 55 years old at the time of his injuries. Petitioner's advanced age is a substantial contributing factor to his disability as this injury has limited his physical ability at a time when his age is taking its toll as well. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner gave up his employment as a firefighter, at least in part, due to his knee condition. The Arbitrator therefore gives *some* 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 evidence of disability, as testified to by Petitioner, is corroborated by the records of treatment, especially with respect to the surgical findings of a complex tear of two-thirds of the medial meniscus which was unrepairable and chondromalacia of the patella and trochlea. While the medical records here are limited, Petitioner explained that he opted himself out of treatment and back to work by requesting a full duty release from his treating doctor so he could return to his second job. The Arbitrator finds Petitioner's explanation of his return to work, his reasons for his retirement from firefighting, and the testimony of his current knee problems to be credible. The Arbitrator therefore gives *greater* weight to this factor.

The parties stipulated and agreed that Respondent is entitled to credit of 15% permanent partial disability of the left leg for disability previously paid in 08 WC 36403.

Based on the above factors, and the record taken as a whole, the Arbitrator concludes that Petitioner is now permanently and partially disabled to the extent of 30% loss of use of the left leg as provided in Section 8(e) of the Act. The parties agreed that Petitioner received a prior award regarding his left leg. The award totaled 15% loss of use of the left leg. The result of applying that credit is that Respondent shall pay Petitioner an additional $755.22/week for 32.25 weeks on account of the current claim.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Terri French,

Petitioner,

vs. NO: 18 WC 12392

State of IL/Vienna C.C.,

19IWCC0253

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Arbitrator's Decision to reflect the correct period of temporary total disability. Petitioner testified the physician at Union County Hospital authorized her off work as of March 29, 2018, and she did not work thereafter. T. 29. Petitioner stipulated she was off work from March 29, 2018 through June 7, 2018, the date of arbitration. ArbEx1. The Commission finds Petitioner was temporarily totally disabled from March 29, 2018 through June 7, 2018, a period of 10-1/7 weeks.

The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's July 11, 2018 decision is modified for the reasons stated herein and otherwise affirmed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $959.69 per week for a period of 10-1/7 weeks, representing March 29, 2018 through June 7, 2018, that being the period of temporary total incapacity for work pursuant to §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the reasonable, necessary and related medical expenses identified in PX1 pursuant to §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit under §8(j) of the Act; provided 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 shall authorize and pay for prospective medical care including, but not limited to, treatment recommended by Dr. Paletta, pursuant to §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that 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.

DATED: MAY 2 2 2019
LEC/maw
o04/08/19
43

Stephen J. Mathis

D. Douglas McCarthy

SPECIAL CONCURRENCE/DISSENT

I concur with the majority in all aspects of its decision other than its order to compel Respondent to authorize medical treatment. This issue was previously addressed by the Court in *Hollywood Casino-Aurora, Inc. v. Illinois Workers' Compensation Commission*, 2012 IL App (2d) 110426WC, which is dispositive. The Court noted "Assuming for the sake of analysis that this provision of the Act [Section 8(a)] is sufficiently broad so as to include a requirement that an employer authorize medical treatment for an injured employee in advance of the services being rendered, the fact still remains that there is no provision in the Act authorizing the Commission to assess penalties against an employer that delays in giving such authorization." *Id.* at ¶ 19. Ordering Respondent to authorize medical treatment is meaningless where no enforcement mechanism exists under the Act. In accordance with Section 8(a) of the Act and the Court's holding in *Hollywood Casino*, I would order Respondent to provide and pay for the awarded medical expenses and/or treatment.

L. Elizabeth Coppoletti

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

FRENCH, TERRI
Employee/Petitioner

Case# **18WC012392**

STATE OF IL/VIENNA C C
Employer/Respondent

19IWCC0253

On 7/11/2018, 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 2.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0558 ASSISTANT ATTORNEY GENERAL
KENTON J OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT 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

JUL 11 2018

RONALD A. RASCIA, ACTING SECRETARY
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Terri French
Employee/Petitioner

Case # 18 WC 12392

v.

Consolidated cases: n/a

State of IL./Vienna C.C.
Employer/Respondent

19IWCC0253

An *Application for Adjustment 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 Mt. Vernon, on June 7, 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] 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, March 1, 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 $74,856.00; the average weekly wage was $1,439.54.

On the date of accident, Petitioner was 50 years of age, single with 1 dependent child(ren).

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the treatment recommended by Dr. George Paletta.

Respondent shall pay Petitioner temporary total disability benefits of $959.69 per week for 11 3/7 weeks, commencing March 19, 2018, through June 7, 2018, as provided in Sections 8(b) of the Act.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

July 5, 2018
Date

JUL 1 1 2018

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment by Respondent on March 1, 2018. According to the Application, Petitioner was getting milk from a cooler, slipped and fell on a wet floor and sustained injuries to her right shoulder, right elbow and body as a whole (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of temporary total disability benefits and medical bills as well as prospective medical treatment. Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a food supervisor. At trial, Petitioner testified that on March 1, 2018, she was serving breakfast and needed to go get some more milk. Petitioner then walked down a hallway and slipped and fell on a wet floor landing on her right elbow. Petitioner stated that she would walk in the area where she sustained the fall repeatedly throughout the work day.

Petitioner stated that the floor where she sustained the fall was wet because various pots and pans used in the kitchen were adjacent to that area and the hall extended from the dining room to the area where the garbage is disposed of. Petitioner stated that the surface of the floor was tile on top of concrete. Petitioner prepared a map of the kitchen area and marked the route that she took him blue ink and indicated spot where she sustained the fall with an "X" (Petitioner's Exhibit 7).

Following the accident, Petitioner prepared and signed an Incident Report in which she described the accident as having occurred when she was walking down the hallway in the kitchen and fell striking her elbow and shoulder. There was nothing indicated in that report about the surface of the floor having water on it (Petitioner's Exhibit 6). At trial, Petitioner agreed that she did not write anything about there being water on the floor because she thought it was "obvious."

Christopher Gotway, Respondent's food service program manager, was present at the trial and heard Petitioner's testimony. Gotway was called by Petitioner's counsel to testify. He agreed Petitioner was a hard worker and dependable employee. Gotway agreed that the map of the kitchen area prepared by Petitioner was accurate. He also acknowledged that the area where Petitioner sustained the fall was a high traffic area and that he had seen water on the floor tracked in from the front of the dining room.

Following the accident, Petitioner sought medical treatment at Union County Hospital. According to the hospital record, Petitioner advised that she worked in the kitchen of a local correctional facility and while she was walking, "...she slipped on a wet floor" and injured her right elbow and right shoulder (Petitioner's Exhibit 3).

X-rays were taken of Petitioner's right elbow and right shoulder which were negative for fractures. Petitioner was treated by Bradley Taylor, a Nurse Practitioner. Taylor ordered both physical therapy and an MRI scan. The MRI was performed on March 28, 2018, and it revealed rotator cuff tendinosis and an insertional tear of the supraspinatus (Petitioner's Exhibit 3).

Petitioner was subsequently evaluated by Dr. George Paletta, an orthopedic surgeon, who initially saw Petitioner on April 18, 2018. At that time, Petitioner informed Dr. Paletta that on March 1, 2018, she slipped and fell on some water on the floor landing on her right side. Petitioner's complaints were primarily in regard to the right shoulder. Dr. Paletta examined Petitioner and reviewed the MRI (Petitioner's Exhibit 5).

Dr. Paletta opined Petitioner had sustained a full thickness rotator cuff tear to the right shoulder as a result of the accident of March 1, 2018. In regard to further treatment, Dr. Paletta opined Petitioner could have an injection followed by therapy or undergo a surgical repair. He authorized Petitioner to continue to remain off work (Petitioner's Exhibit 5).

At trial, Petitioner testified that she received a letter from Respondent which advised that her request for a leave of absence had been granted. The letter also noted that the Workers' Compensation Unit would determine if her case was compensable (Petitioner's Exhibit 8).

Petitioner stated she received a telephone call from Deidre Price, the adjuster handling her case, who informed her that she was going to take a recorded statement from her regarding her accident. Apparently, the recorder malfunctioned, but a written summary prepared by Price was received into evidence. According to that statement, Petitioner slipped and fell in a hallway while going to get milk, the floor was made of tile and there was nothing on the floor (Respondent's Exhibit 4).

Price subsequently sent a letter to Petitioner dated April 2, 2018, which advised that her workers' compensation claim had been denied. A copy of the letter was received into evidence at trial (Petitioner's Exhibit 9).

Deidre Price was deposed on June 6, 2018, and her deposition testimony was received into evidence shortly after the case was tried (the record was left open for the limited purpose of having Price's deposition testimony transcribed). Price testified that she contacted Petitioner by telephone on March 27, 2018, as part of her investigation of Petitioner's claim. She stated there was a malfunction of her recorder so she took notes of her conversation with Petitioner. Price stated that Petitioner advised that she sustained a slip and fall accident on March 1, 2018, and Petitioner had informed her there was nothing on the floor at the time she sustained the accident (Respondent's Exhibit 3; pp 10-12).

On cross-examination, Price agreed that Petitioner did not describe the accident as either a trip or stumble. She opined that the use of the word "slipped" did not suggest that something caused the fall. She characterized the fall as either an unexplained or idiopathic fall (Respondent's Exhibit 3; pp 15-16).

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 March 1, 2018.

In support of this conclusion the Arbitrator notes the following:

Petitioner credibly testified about the circumstances of the accident she sustained on March 1, 2018.

There was no question that the slip and fall Petitioner sustained was in an area adjacent to the kitchen and the fact that there was water on the floor was foreseeable.

Petitioner agreed she did not write anything about the surface of the floor being wet, but stated that it was "obvious."

Christopher Gotway, Respondent's food service program manager, testified that Petitioner was a hard working and dependable employee. Further, he acknowledged that the area where Petitioner sustained the fall was a high traffic area and that he had seen water on the floor tracked in from the front of the dining room.

Petitioner gave a consistent history of slipping on a wet floor while at work to all of her medical providers.

The Arbitrator is not persuaded by the testimony of Diedre Price. The fact that the statement she obtained from Petitioner was not recorded because of a malfunction of her recording device makes her testimony less reliable.

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 March 1, 2018, because of the Arbitrator's conclusion of law in disputed issue (C).

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator concludes Petitioner is entitled to prospective medical treatment including, but not limited to, the treatment recommended by Dr. George Paletta.

In support of this conclusion the Arbitrator notes the following:

Dr. Paletta has opined that further medical treatment is necessary and there was no medical evidence to the contrary.

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 11 3/7 weeks, commencing March 19, 2018, through June 7, 2018.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner was temporarily totally disabled during the aforestated period of time.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)		
) SS.	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
COUNTY OF MADISON)	☐ 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

NATHAN WILLIAMS,

Petitioner,

vs. NO: 14 WC 3224

PHILLIPS 66,

Respondent.

19IWCC0254

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary total disability and permanency, and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of accident, and attaches the Decision of the Arbitrator for the purpose of the statement of facts, which is attached hereto and made a part hereof, with the additions and modifications outlined below.

The Commission reverses the Arbitrator and finds that Petitioner met his burden that he sustained a work-related injury to his right knee due to a work accident on April 29, 2013.

According to Petitioner's job description (Px10 and Rx2), Petitioner was required to spend a significant portion of his time walking, climbing ladders or stairs (up to 100 feet or higher), bending, standing on his knees, reaching, assuming awkward postures, maneuvering through tight spaces, grasping and carrying small tools or equipment, pushing and pulling, squatting and kneeling. Included in these duties, Petitioner climbed and descended spherical tanks with a spiraled and angled staircase. On April 29, 2013, while descending one of the tanks through a step/pivot motion, Petitioner felt weakness in his knee causing him to descend the remaining stairs sideways. The Commission finds that on April 29, 2013, Petitioner sustained an accident while coming down the spiral staircase of the spherical tanks while stepping down and pivoting on the angled steps.

On April 29, 2013, Petitioner began working at 5:00 p.m. in the volatiles area where the tanks were. (T. p. 32) Petitioner confirmed that this work area was not accessible to the public, and that even employees had to be cleared to climb to the top of the tank. (T. 44) He climbed on top of two very loose spherical tanks, approximately 92 steps each. He went up two of those that day. (T. p. 40) When he was going down the spiral, angled steps from one of the sphere tanks, he noticed issues with the strength of his right knee and felt a little bit of pain and stiffness. (T. p. 41) Petitioner noticed that after his shift, the pain in the right knee was increasing and his right knee swelled. (T. p. 46) There were no records evidencing degenerative changes to his knee that could have caused or contributed to cause the injury. Respondent's Section 12 examiner, Dr. Michael Nogalski, acknowledged that the activities that Petitioner did at ConocoPhillips could cause a meniscal tear. (Rx1, p. 16) Dr. Nogalski also testified that climbing, twisting, pivoting, squatting, awkward positions and placing stress on the knee in those positions can all be causative mechanisms to create an injury in the knee. (Px1, p. 12)

Based on Petitioner's testimony and the evidence submitted at trial, Petitioner's torn meniscus was work-related. The Petitioner testified he did not initially know if his injury was work-related as he thought it might have been a flare up of his previously diagnosed gout – albeit to a different area of his body. Ultimately, when Petitioner's tests for gout came back negative, he was referred to an orthopedist, diagnosed with the meniscal tear, and underwent surgery. Petitioner missed minimal work, for which he was compensated through short-term disability. Although Petitioner initially misconstrued the nature of his injury – thinking it was gout instead of a meniscal tear – it is clear that on April 29, 2013, Petitioner was able to complete his heavy-duty job duties until the accident occurred. Accordingly, the Commission finds the Petitioner has proved he sustained a work-related accident on April 29, 2013, and a causal relationship exists between said accident and his injury consisting of a right knee meniscal tear.

Based on the finding of accident and causal connection, temporary total disability benefits are awarded from June 27, 2013-July 19, 2013. Respondent is given a credit for benefits paid through short-term disability. Additionally, Petitioner is awarded the reasonable and necessary medical treatment identified in Px13, subject to the limits of §8.2, and the Respondent is provided credit for group medical payments per §8(j).

Finally, the Commission finds that Petitioner sustained 12.5% loss of use of the right leg.

- Petitioner received a 1% impairment rating. This is given some weight given Petitioner's full duty release and rapid return to work;
- Petitioner is an outside operator. This job is classified as heavy work demand level. This is given some weight;
- Petitioner was 47 years old at the time of injury. This is given some weight;
- The employee's future earning capacity was not impacted as he was able to return to full duty in the same job after minimal time off. This is given little weight;
- Petitioner does have some residual complaints regarding his right knee, but overall has reported his knee feels great and he is doing well. This is given little weight.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $958.33 per week for a period of 3 2/7 weeks, that being the period of

temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $721.66 per week for a period of 26.875 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 12.5% loss of use of the right leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $19,510.92 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 $20,848.00. 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: MAY 2 2 2019

Maria E. Portela

Thomas J. Tyrrell

Deborah L. Simpson

MEP/dmm
O:050719
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS, NATHAN
Employee/Petitioner

Case# **14WC003224**

PHILLIPS 66
Employer/Respondent

19IWCC0254

On 4/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5341 BROWN & BROWN
DAVID JEROME
5440 N ILLINOIS SUITE 101
FAIRVIEW HEIGHT, IL 62208

0734 HEYL ROYSTER VOELKER & ALLEN
TONEY TOMASO
102 E AMIN ST SUITE 300
URBANA, IL 61801

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

NATHAN WILLIAMS
Employee/Petitioner

v.

PHILLIPS 66
Employer/Respondent

Case # **14** WC **03224**

Consolidated cases: _____

19IWCC0254

An *Application for Adjustment 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 28, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 29, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 $**74,750.00**; the average weekly wage was $**1,437.50**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **1** dependent child.

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

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

Respondent shall be given a credit of $**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 $**4,697.52** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner has failed to prove that he sustained accidental injury to the right knee which arose out of and in the course of his employment. As such, all other issues are moot.

No benefits are awarded.

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

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

Signature of Arbitrator

April 11, 2016
Date

APR 17 2017

STATEMENT OF FACTS

Petitioner testified that he began working for Respondent in April 2001 as an outside Operator. He worked alternating 36 hour (three 12 hour shifts) and 48 hour (four 12 hour shifts) weeks. His main responsibilities included monitoring and maintaining equipment in certain areas at Respondent's refinery. This would include checking gauges, running equipment and generally keeping an eye on the equipment. The facility covered multiple acres, and Petitioner was responsible for a few of those acres, which he identified and circled on an aerial photo depiction of the site (Px11). The facility contained large storage tanks (conical, spherical and bullet shaped) for both heavy gasses and liquids, and sample/replica photos of some of these tanks were also submitted into evidence (Px11).

Petitioner testified that he typically worked alone. He was required to climb stairs to the top of the tanks, as well as having to go underneath them, in order to monitor valves, turn valves and make sure of the proper operation of equipment in his area of control. In addition to climbing, Petitioner described bending and kneeling and getting into awkward positions and maneuvering in tight spaces in order to monitor operations. Petitioner would use a vehicle to get around some of his work areas, but testified this was rare and he mainly would walk from place to place. He was not timed or paced in his work, so he had discretion on how slowly or quickly he would climb stairs, and the time involved thus varied.

A written "Job Analysis" for an Operator at the refinery was submitted into evidence (Px10 & Rx2). The Petitioner reviewed this and testified that it accurately depicted his activities, agreeing his job was at the "heavy work" demand level. He did agree that the document covered several different types of facility Operators, and wasn't specific to one job, but that it generally defines what every Operator at the refinery does. Specifically, he confirmed that his job involves a lot of lifting, climbing and carrying. He consistently walks 4 to 8 hours per day. He agreed he would frequently climb vertical ladders and inclined stairs with a height of 100' or more. Occasional bending and kneeling is accurate, and Petitioner testified he would be underneath tanks low to the ground in order to get to valves, look at gauges and draw water off the tanks, which is done daily. This would also involve awkward positions and maneuvering in tight spaces. He testified he would kneel on both knees to open valves, and used a valve or pipe wrench, which required force.

Petitioner acknowledged that he had been informed about accident reporting requirements when he was hired by Respondent.

Petitioner testified that on 4/26/13, three days prior to the alleged accident date, about three hours into his shift he began to experience discomfort in his right knee, including soreness, stiffness and weakness. He testified he was doing "nothing in particular" at the time of onset. He did not report this to his supervisor because he didn't think it was serious at the time. He completed his shift that day as well as the following two days (4/27 and 4/28/13), testifying he was able to complete all his work duties, but also that he continued to have weakness.

On 4/29/13, he testified that he had to climb underneath five spherical tanks in order to monitor and release water, which took approximately an hour. He had to climb to the top (67 stairs) of two of them that day to make sure valves were open. He also testified he had to climb to the top of one of the cone tanks as well (92 stairs). The large tanks in his area had anywhere from 67 to 92 steps. (see Px12).

Petitioner testified that on 4/29/13 he was going down the stairs and felt weakness in his right knee, causing him to go down the rest of the way sideways because he didn't "trust" the strength of the right knee. He also noted pain and stiffness. Petitioner testified that the stairs are spiral steps and were angled, not squared, and that: "I

turn and pivot a little bit going up and around those sphere tanks." Petitioner estimated that he would have spent 6 to 7 hours of his shift on 4/29/13 on his feet, including stairs, and that he also performed kneeling that day.

Petitioner confirmed that his work area, including the stairs, is not accessible to the general public, and that even employees had to be cleared to climb to the top of a tank.

Petitioner testified that he was able to complete his full 12 hour shift on 4/29/13 at 5 a.m. the next morning, and though he was having right knee symptoms, he did not report an accident or injury to Respondent. After he went home, Petitioner testified that he had an increase in his pain, the right knee began to swell and he had difficulty moving it. He did not have swelling associated with the symptoms he had after 4/26/13.

On 4/30/13, Petitioner testified he was unable go to work due to severe knee pain and swelling, and that he sought treatment with his family physician, Dr. Rawdon. A review of the medical records appears to indicate Petitioner initially saw Dr. Rawdon on 5/1/13. He admitted that he did not report a specific trauma or incident had occurred on 4/29 or any prior day, but explained that he did not do so because he did not believe an "injury" had occurred ("I would define it something that's sudden that affected the area that was impacted"). The 5/1/13 note indicates he complained of right knee and ankle pain with no known injury. Dr. Rawdon prescribed x-ray and physical therapy (PT). He also restricted Petitioner to light duty. (Px5 & 9).

Petitioner admitted he had undergone prior right knee treatment in 2011. He testified that he had a burning sensation in the outer right knee at that time and thought he had been stung by an insect. He testified that he was diagnosed with a right lateral meniscus strain. Records were submitted into evidence indicating right knee treatment from May to August of 2011. Dr. Rawdon's 5/17/11 report noted there was no known injury at that time. He had PT, and a discharge note appears to indicate he was pain free but had some ongoing right quadriceps weakness. A 5/21/11 MRI reflected a grade I MCL strain, and the menisci were noted to be intact. It appears he was in therapy for approximately five to six weeks and was held off work. (Px5; Rx3). The Petitioner testified that he had no further problems or treatment to the right knee before 4/29/13.

Petitioner testified that Respondent had him complete an Employee Health Report on 5/3/13. This document was signed by Petitioner, indicating the first day of injury/illness was 4/29/13, and there was a section where a patient could check a box "yes" or "no" as to whether or not the complaints arose out a work-related incident, but neither was checked, rather he wrote in the word "unknown". (Px2). Petitioner explained he indicated "unknown" because he was not sure whether he had an injury or not ("I didn't do anything to where I felt injured"), noting he initially thought he had gout. The report verifies that that Petitioner notified his supervisor. (Px2).

A5/6/13 phone note of Dr. Rawdon supports his initial suspicion that Petitioner's condition could be gout related. (Rx3). An initial PT report from Belleville Memorial Hospital, dates 5/7/13, states: "Pt states he started having right ankle and knee pain on 4/29/13 for no apparent reason." (Px7 & 9). When Dr. Rawdon's testing for gout was negative, Dr. Rawdon referred him for orthopedic evaluation with surgeon Dr. Morton. (Px9, Rx4).

Petitioner initially saw Dr. Morton on 5/28/13. The report notes right knee pain since 4/29/13 with: "no real history of any kind of trauma that he can remember. Things that make it actually worse are up and down stairs, twisting, kind of medial pivot or twist." It was noted that gout was originally suspected, and Petitioner noted he had been diagnosed a couple of years prior with a lateral meniscus strain, but that his current pain was mainly medial. An MRI was prescribed, and the 5/31/13 films indicated a torn medial meniscus, mild MCL sprain, probable small enchondroma or subcortical cyst involving the lateral femoral metaphysis, slight subluxation of

the patella and a small Baker's cyst. There also was a cystic lesion in the tibia that was to be evaluated further. On 5/30/13 Dr. Morton wrote to Dr. Rawdon indicating Petitioner's medial joint line tenderness was consistent with meniscal tear. (Px4; Px6; Px9).

A report from Midwest Occupational Medicine (it appears to be an on-site clinic), undated but titled "Occupational Injury/Illness Evaluation", notes Petitioner came in with right knee pain, and notes: "States he worked dispatching weekend of 4/26 & 4/27. No incident, no injury. No development of knee pain on job. Went home, made a meal, & went to bed. Also showered prior to bed. Woke up next morning w/R knee pain/medial. Had a small amt of swelling. Called his private MD. Had apt. His doctor thought he may have gout." Following an MRI, he was told he had torn cartilage. He had a history of right ankle problems, including gout. It was noted to be a non-occupational problem. There is a 6/17/13 pain diagram indicating medial right knee pain, but it is unclear if this was from the same date as the evaluation document or not. (Px2 & 3; Rx3).

Noting the MRI findings, Dr. Morton performed arthroscopic right knee surgery on 6/27/13. The "History & Physical" report indicates Petitioner's pain began on 4/29/13 with "no real history of any kind of trauma, that he can remember. It just actually got worse going up and down stairs, but any kind of twisting causes a fair amount of pain and discomfort. Once it started to happen, they thought maybe it was gout. . ." The operative report noted a medial meniscus tear with a fragment that "was flipped up and underneath". Other than debridement of some medial plica and minimal degenerative at the patellofemoral joint, no other abnormalities were noted. (Px4 & 7). Petitioner underwent post-surgical therapy at Memorial Sports Medicine, and on 7/2/13, Dr. Morton released Petitioner back to full duty work as of 7/15/13. However, on 7/12/13 he returned to Dr. Morton with persistent swelling, and the knee was aspirated, followed by a steroidal and lidocaine injection. (Px4 & 5). On 7/18/13, Dr. Rawdon, noting knee and heel pain, released Petitioner to return to work as of 7/19/13. (Px9).

Petitioner confirmed he did not receive TTD while off work, but did receive short-term disability benefits. After being released, Petitioner confirmed he returned to full duty work as of 7/19/13.

Petitioner testified that he sought an independent opinion at his own volition with Dr. Corey Solman on 5/16/14 (Px1), and that he discussed the history of his complaints, his workplace duties and activities, and shared with Dr. Solman copies of the photograph of the tanks he worked on and around at the refinery. He also confirmed he underwent an independent examination at Respondent's request with Dr. Michael Nogalski on 3/18/15.

Currently, Petitioner notes soreness and weakness in the right knee, with current complaints typically at a 3 or 4 out of 10 level. They get higher in severity when it rains or gets cold outside, and at that point are at an approximate 6 out of 10 pain level. He noted difficulty walking down stairs in a straight manner, and described pivoting his left foot in order to take it easy on his right knee. He takes over-the-counter medication (Ibuprofen) to deal with his pain complaints, which typically last 2 to 3 days. At a 3/27/15 visit with Dr. Morton for an unrelated left knee problem, Petitioner reported he hadn't really had any problems with the right knee after he was released, and "it feels great". (Px4 & 9; Rx4).

Respondent's production leader, Ruben Avilez testified on behalf of Respondent. He described his job as overseeing the operation of the refinery, supervising and training the Operators, oversight of the check sheets and overseeing projects. One of two Production Leaders, Mr. Avilez testified that he has five Front Line Supervisors under his supervision, and under the Front Line Supervisors are the Outside Operators, like Petitioner. He explained there are two types of Operators: 1) Inside Operators who constantly work on a switchboard; and, 2) Outside Operators, like Petitioner, who monitor the levels of equipment both inside and outside during the refinery process. Mr. Avilez noted there are anywhere between 20 and 22 Operators in his

unit, including Petitioner. He indicated he was familiar with Petitioner, as he would on average see and speak with daily, albeit briefly.

As to the Job Analysis document (Px10 / Rx2), Mr. Avilez described this document as all-encompassing of what every Operator does onsite in all the various units at the refinery, noting there are many different units throughout the facility. The description is vague enough and covers enough jobs to include what every single Operator (inside and outside) would do at the refinery, not just the activities Petitioner would perform as an Outside Operator. He estimated that, in a typical 12 hour day in April 2013, Petitioner would spend a couple of hours sporadically in the control room monitoring levels, temperatures and pressures. He would be speaking with other units and identifying the tasks he would need to perform during the shift. Petitioner would spend a no more than a couple of hours each day climbing stairs on tanks in order to do his normal monitoring tasks. He would generally spend no more than an hour kneeling during the course of a normal shift, and no greater than an hour in awkward positions in order to monitor and manipulate valves. Mr. Avilez testified that he did not believe Petitioner's position as an Outside Operator would fall under the category of a "heavy" job position, as he would rarely be required to lift or wear gear which weighed 40 to 50 pounds, as this would be a rarity for Petitioner or any Outside Operator in his unit (Volatiles). He also testified that as an Outside Operator, Petitioner would not be required to push 100 pounds, pull 185 pounds of grip 80 pounds.

Mr. Avilez noted, based upon his position, he would be provided with documentation regarding any claimed on-the-job injury, and testified that he never received any notice of Petitioner reporting a work injury between 4/26 and 4/29/13. Sometime between April and May of 2013 he had a conversation with Petitioner regarding his right knee. He testified that he asked Petitioner how things were going and at that Petitioner noted he was having "some issues" with his knees. Mr. Avilez asked Petitioner if these problems were work-related, so that he could report it and prepare the appropriate paperwork if needed, and that Petitioner said that he did not injure himself at work and his complaints were not work-related. As such, no accident report was filled out and Avilez never followed up with Petitioner regarding the knee/knees because it was not work-related.

Mr. Avilez is still a Production Leader and testified that, to his knowledge, Petitioner continues to work as an Outside Operator and is able to do the tasks assigned to him. He was not aware of Petitioner having any type of restrictions or limitations as it relates to his right knee, and he has never communicated any complaints of pain, weakness or soreness in the right knee to Avilez. However he did agree that he would only see and observe Petitioner for 15 to 60 minutes per shift, and otherwise would not be able to observe what he was actually doing, and that it was the same situation in April 2013. Mr. Avilez testified that many of the pumps, tanks and motors which Williams is required to monitor do not require him to climb, bend over, kneel or get into an awkward position. Rather, it is something he can simply walk up to and observe. He did agree that about 80% of Petitioner's time during a typical shift would be spent outside.

Mr. Avilez testified that, to his knowledge, when climbing the spiral steps up to the top of a tank, an individual does not have to pivot or angle, but rather that they could be climbed in a straight manner. (TR pg. 129)

Petitioner sought an evaluation with orthopedic surgeon Dr. Solman on 5/16/14, and the doctor testified via deposition on 8/11/15. (Px1). Dr. Solman testified that he discussing the onset of symptoms with Petitioner, his work activities, and that he reviewed the photographs contained in Px10. He also completed a physical examination. Dr. Solman testified that the main cause of a meniscus tear is a loaded twisting injury to the knee which imparts a supraphysiologic force on the meniscus and causes the tissue to rupture or tear. This requires less force as people age because the meniscus becomes more brittle over time and can tear more easily. He testified that a person can have an asymptomatic torn meniscus. Because a meniscus does not have nerve endings, it must be trapped or pulled down by the joint or bones for pain to occur. (Px1).

Dr. Solman testified that the activities petitioner performed at work could have created a meniscus tear or created a small tear, with not a whole lot of pain at the time, which can get worse over time and become symptomatic. He noted that while Petitioner had a prior right knee issue in 2011, and MRI taken at that time did not reflect a meniscus tear. He's at work activities could have caused a pre-existing meniscal tear to progress and/or trigger symptoms. (Px1). The need for treatment of a meniscal tear is based on pain and symptoms, not the fact of a tear in itself. Petitioners indication that his symptoms began while using stairs at work could be consistent with either causing the meniscal tear or aggravating an asymptomatic pre-existing tear. (Px1).

At the time he examined Petitioner post surgically, Dr. Solman noted his exam was completely normal, and petitioner indicated no pain whatsoever. X-rays indicated nothing beyond very mild arthritic changes in the patellofemoral joint. Given the lack of significant degeneration and the fact that 2011 MRI noted no meniscal tear, Dr. Solman opined that the chair was more likely more acute in nature then degenerative. Noting he did not think the petitioners chair was pre-existing, Dr. Solman opined that, barring any other outside forces or injuries prior to 4/29/13 (noting the petitioner did not describe any such outside forces or injuries), the only causative factor in his knee injury would be his work duties for the respondent. He further or pined that if the petitioner had a pre-existing tear, the same causation opinion would apply in terms of an aggravation. (Px1).

Dr. Solman reviewed the report of Dr. Nogalski. As noted, he disagreed that the Petitioners tear was degenerative in nature. He agreed that meniscal tears can occur over time and become symptomatic without a distinct trauma. He further opined that the petitioners climbing, squatting, bending and kneeling at work could make a pre-existing meniscal tear symptomatic. Noting he reviewed photographs of the stairs around the tanks that petitioner claimed at work, Dr. Solman indicated that straight stairs are enough to stress the knee, and when you add twisting on a spiral staircase it can impose further stress on the knee. Finally, Dr. Solman testified that the petitioners activities at work which involved his knees were more significant than the average person would have in their activities of daily living. (Px1).

On cross examination, Dr. Solman testified that Petitioners examination was completely normal, and if he were asked to provide an AMA rating, it would be 0% impairment. He agreed the petitioner indicated he had no specific trauma, and that the only opinion he could offer with regard to when the meniscal tear occurred is that it was sometime between the 2011 MRI and a 2013 MRI. He agreed that he had no information with regard to the frequency with which petitioner performed his various work activities other than what was indicated in his report. (Px1).

Respondent's Section 12 examiner, orthopedic surgeon Dr. Nogalski, examined Petitioner on 3/18/15, and the doctor's testimony was obtained on 9/14/15. (Rx1). He initially prepared a record review report on 12/11/14, and after his examination of Petitioner he prepared an updated report on 3/18/15. He testified that he based his opinions upon the medical records as well as his discussions with Petitioner. Dr. Nogalski concluded that Petitioner's meniscal tear was not related to his work activities as Petitioner did not report to any medical providers a specific event or injury to the right knee. Dr. Morton's operative report noted findings that reasonably indicated a meniscal tear that had flipped up underneath and caused symptoms, and there was no documentation in the records to support that even that event occurred at work. (Rx1).

Dr. Nogalski did agree that some of the activities Petitioner performed at work were the type that could have caused a meniscal tear, but that he would have expected Petitioner to have reported some event that would have reasonably indicated that such activity caused the tear. Asked about the prior 2011 MRI being negative for meniscal tear, Dr. Nogalski testified that this was not tremendously relevant in determining if the meniscal tear

was degenerative "given the variability of MRI studies as well as the relative rate of false negatives even with meniscal tears in MRI studies." He reviewed only the prior 211 MRI report, not the films. (Rx1).

On cross examination, Dr. Nogalski testified that he has seen MRI reports where age-appropriate degeneration, including to a meniscus, is not specified in the report, but he agreed that no significant degeneration was noted by the radiologist. He agreed that activities such as constant walking, climbing, bending, kneeling, reaching, awkward positions, squatting and maneuvering in tight spaces are of the type that could cause a meniscal tear. Noting "we might have to start splitting hairs" as to what constitutes a "tear", he agreed that a person can have an asymptomatic meniscus tear. He also agreed that such a pre-existing meniscal tear could be made symptomatic by the noted work activities "if directly linked by a person's statements". Had Petitioner reported a specific event and/or onset of symptoms, his causation opinion could change. Dr. Nogalski admitted that the intake form Petitioner completed for him indicated he was at work when his injury occurred. However, he testified: "If you're going to define aggravation as a cause of this condition, I do not believe that it would have been the cause or might or could have been the cause. It's reasonable that someone could experience symptoms from a meniscal tear with any activities at home or at work." (Rx1).

On further cross-exam. Dr. Nogalski agreed that Petitioner denied any right knee symptoms leading up to 4/29/13. Additionally, he was not aware of Petitioner having any work restrictions or missing any time from work until after that date. Dr. Nogalski agreed that Petitioner had a very physical job with activities that would stress the knee, and that he did not indicate any non-work activities that would similarly stress the knee. Dr. Nogalski agreed that the Petitioner's symptoms and the MRI findings of a meniscal tear are what led to the need for treatment, including surgery. (Rx1).

While Dr. Nogalski provided an AMA rating in this case of 1% impairment to the right lower extremity, his testimony indicated that he had no formal training and had taken no classes regarding the AMA 6th Edition, that he did not have Petitioner complete a Lower Limb Questionnaire as required under by the AMA 6th Edition, and that he did not use a goniometer to identify range of motion as required under the AMA 6th Edition. While Section 8.1b of the Act does not specify these requirements, the Arbitrator does believe that the AMA guide supports their relevancy in the determination of impairment, and Dr. Nogalski's testimony demonstrated a lack of knowledge as to the requirements. As such, the Arbitrator gives Dr. Nogalski's AMA impairment no weight in this case. (Rx1).

Petitioner's alleged causally related medical expenses were admitted into evidence as Px13.

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 finds that the Petitioner has failed to prove that he sustained accidental injuries arising out of and in the course of his employment on 4/29/13, and has failed to prove a causal relationship of his right knee condition to a work accident, by the preponderance of the evidence.

The Arbitrator initially notes that the evidence in this case clearly indicates that the Petitioner did not sustain a specific incident or trauma which led to the development of weakness or pain in the right knee. Virtually every

piece of evidence in this case indicates that the Petitioner simply started to have symptoms with no specific inciting incident at work. Instead, the Petitioner is mainly alleging that he sustained a work-related right knee injury due to repetitive work activities, i.e. the use of a significant number of steps on tank staircases, squatting, bending and having to get into awkward positions underneath tanks.

The Arbitrator believes that the lack of a specific inciting event supports the fact that his right medial meniscus tear was preexisting. It is accurate that the tear was not noted in 2011, but the Arbitrator finds it difficult to believe that such a tear would not have been noticed by Petitioner, if it occurred at work, in a way where he wouldn't have immediately known something occurred. That leads to the determination that the Petitioner needed to prove that the work activities aggravated the right knee condition.

Initially, the Arbitrator does not believe that the Petitioner's work activities rise to the level of "repetitive" as contemplated by the Act. This is not a situation where the Petitioner worked doing the same activity over and over again. The Petitioner's testimony indicated that the need to use stairs varied, and could be as little as once a month. While he did perform daily activities involving his knees, it was not constant, and they involved a variety of tasks.

In a repetitive trauma claim, issues of accident and causation are intertwined. In the Arbitrator's view, the fact that the Petitioner's knee became symptomatic while he was descending stairs at work does not, in and of itself, prove a causal connection between the meniscal tear and the work activity by the preponderance of the evidence. The facts indicate that at some point in time at work he began to have right knee symptoms. While he does try to pinpoint them to walking down steps on 4/29/13, the facts support that his symptoms actually began on or about 4/26/13, and continued, per his own testimony, through 4/29/13. On 4/26/13, Petitioner testified he was doing "nothing in particular" when he developed knee weakness/pain. The contemporaneous medical records do not specify that the Petitioner's symptoms began with walking down the steps. Instead, they indicate he did not know what caused the onset, but that twisting or pivoting the leg, or using stairs, tended to make the symptoms worse.

The Arbitrator also finds it significant that Petitioner initially thought his problem could be due to gout. This would support a factual finding that he had no idea in his own mind that his work activities were the cause of his problems. He did indicate it was "unknown" whether he had a work injury or not on the 5/3/13 Employee Health Report. However, the rest of the evidence in this case indicates there was nothing that occurred where he noted a specific onset other than that he began to notice weakness while he was on the stairs. A very similar history of onset was provided by Petitioner in 2011, and per his testimony on 4/26/13, i.e. that there was no specific thing that he did which triggered symptoms. Had the Petitioner made any indication that he felt an immediate feeling of pain or weakness while doing a specific activity, the Arbitrator believes it highly likely that gout would not have been the initial consideration.

It seems more likely to the Arbitrator that if, for example, the meniscus tear flap flipped up during a work activity, the Petitioner would have noticed this as a specific moment of pain increase. The records and evidence in this case do not support such an occurrence.

While there are clearly a significant number of steps that the Petitioner has to climb, the "spiral" nature of them is also somewhat questionable in the Arbitrator's mind in terms of an allegation of increased risk. As depicted, the term spiral is accurate in that the stairs curve, however the degree of that curve does not appear as significant to the Arbitrator as the Petitioner and Dr. Solman make it out to be. Admittedly, there is some difference in the stair configuration where it is curved, but it does not appear to be anything remotely close to what would be found in a residential home. Such a staircase involves a significant amount of curvature, sometimes winding all

the way around 360 degrees just to go up one floor. Here, the curvature is much more gradual. In looking at the photos, there does not appear to be a significant difference in how a person would go up or down the stairs versus straight steps. This is supported by the testimony of Mr. Avilez. Additionally, had the turning and pivoting Petitioner indicated was required to ascend and descend the stairs been competently involved in the meniscal tear, the Arbitrator believes the Petitioner would have noted at the time that he was pivoting or twisting when he had the onset of symptoms.

It is certainly possible that Petitioner's work activities caused an onset of symptoms, but it does not appear to the Arbitrator to be the more likely scenario in this case. It appears more likely that the Petitioner had a preexisting meniscal tear and indicated that he had symptoms at work. It seems highly unlikely to the Arbitrator that the meniscus tear occurred at work, or that there was a worsening of the actual pathology that may have been preexisting. The Petitioner cannot pinpoint a specific moment where he felt a tweak or some specific increase in symptoms with a specific movement or activity. To find otherwise would, in the Arbitrator's opinion, require too much speculation.

Petitioner argues that Illinois case law supports a finding of compensability in this case, and cites to the Sonderman case. In *Sonderman*, the claimant specifically indicated a feeling of ripping or tearing in the knee while descending stairs at work in a very similar type of job and situation. In this case, we do not have such an indication. *Sonderman v. Cherne Contracting Co.*, 06 W.C. 34327, 10 IWCC 0152. In the Arbitrator's view, that difference is of key importance in distinguishing the current case from *Sonderman*. The Arbitrator's review of similar case law indicates that in general, compensable cases involve a claimant who was able to point to an event occurring while using stairs where they knew something physical had occurred to their knee at a specific moment. Here, we just do not have that. In this case, the facts are clear that the Petitioner could not pinpoint any moment or event where he felt something occurred or changed in his knee. The evidence indicates instead that at some point he started to notice weakness in the knee.

Overall, the Arbitrator finds that the preponderance of the evidence supports the finding that the Petitioner failed to prove accident and causal connection.

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

Based on the Arbitrator's findings with regard to accident and causation, no benefits are awarded, and this issue is moot.

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:

Petitioner claims he is entitled to TTD benefits from 6/27/13 through 7/19/13, a period of 3-2/7 weeks. However, based on the Arbitrator's findings with regard to accident and causation, no benefits are awarded, and this issue is moot.

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

Based on the Arbitrator's findings with regard to accident and causation, no benefits are awarded, and this issue is moot.

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

Respondent claims a credit pursuant to Section 8(j) of the Act of $16,609.32. Petitioner would not stipulate to this credit, instead requiring Respondent to prove entitlement to same.

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tammy L. Karch,

Petitioner,

vs. NO: 16 WC 06882

Davita Dialysis,

Respondent.

19IWCC0255

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 17, 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.

19IWCC0255

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,000.00. 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: MAY 2 2 2019
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BNF/mw
045

Barbara Flores

Deborah Simpson

Marc Parker

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

KARCH, TAMMY L
Employee/Petitioner

Case# **16WC006882**

DAVITA DIALYSIS
Employer/Respondent

19IWCC0255

On 10/17/2018, 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 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:

4689 HASSAKIS & HASSAKIS PC
JOSUHA A HUMBRECHT
206 S 9TH ST SUITE 201
MT VERNON, IL 62864

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

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Tammy L. Karch
Employee/Petitioner

Case # 16 WC 06882

v.

Consolidated cases: n/a

Davita Dialysis
Employer/Respondent

19IWCC0255

An *Application for Adjustment 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 Mt. Vernon, on September 7, 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 ______

19IWCC0255

FINDINGS

On the date of accident, October 10, 2015, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $39,247.78; the average weekly wage was $754.77.

On the date of accident, Petitioner was 54 years of age, married 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 $83,751.44 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $83,751.44. Respondent is entitled to an overpayment of TTD benefits in the amount of $7,340.03.

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 14, 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. Mathew Gornet.

Respondent is entitled to an overpayment of TTD benefits in the amount of $7,340.03, toward permanency awarded.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

October 16, 2018
Date

OCT 17 2018

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment by Respondent on October 10, 2015. The Application alleged Petitioner sustained a "traumatic" accident that caused injuries to her neck, back, left shoulder, arm and leg, buttocks and other parts of the body (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and prospective medical treatment. Respondent stipulated Petitioner sustained a work-related accident, but disputed liability on the basis of causal relationship. In regard to the prospective medical treatment sought by Petitioner, Respondent also disputed whether the treatment was medically reasonable and necessary (Arbitrator's Exhibit 1).

Petitioner claimed she was entitled to temporary total disability benefits of 151 6/7 weeks, commencing October 11, 2015, through September 7, 2018 (the date of trial). Respondent stipulated Petitioner was entitled to temporary total disability benefits for the aforementioned period of time; however, Respondent claimed it was entitled to a credit for overpayment of temporary total disability benefits because Petitioner had been paid benefits at too high of a rate for a period of time. Petitioner and Respondent stipulated to an average weekly wage of $754.77 which entitled Petitioner to a temporary total disability rate of $503.18. As previously noted, Petitioner and Respondent stipulated Petitioner was entitled to payment of temporary total disability benefits for 151 6/7 weeks which at $503.18 per week equals $76,411.41. Respondent paid Petitioner temporary total disability benefits of $83,751.44, an overpayment of $7,340.03 (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a dialysis technician and trainer. At the time of the accident, Petitioner had worked for Respondent for over 16 years. On October 10, 2015, Petitioner and three other employees were attempting to lift/move a patient who weighed approximately 300 pounds and was a lower extremity amputee. The patient became combative when they attempted to use a lift device. They then attempted to lift the patient without the lift device and when they did, Petitioner sustained an immediate onset of pain in her back, neck, left leg and hip as well as her left shoulder/arm. Petitioner completed and signed an incident report that same day (Petitioner's Exhibit 2).

Petitioner initially sought medical treatment from Dr. Alan Froehling, an orthopedic surgeon, who saw Petitioner on October 15, 2015. At that time, Petitioner complained of neck and left shoulder pain as well as low back pain with radiating pain in the left leg. Dr. Froehling diagnosed Petitioner with a cervical strain, lumbar strain with aggravation of pre-existing chronic lumbago and degenerative disc disease (Petitioner's Exhibit 3).

Petitioner was previously treated by Dr. Froehling for a low back injury she sustained in December, 2010, when she fell on ice. This was also a work-related injury. In June, 2011, Dr. Froehling ordered an MRI scan (the radiologist report was not tendered into evidence) which, according to Dr. Froehling, revealed degenerative disc disease at L4-L5. From June, 2011, through May, 2013, Dr. Froehling saw Petitioner periodically and treated her conservatively with physical therapy and medication (Petitioner's Exhibit 3).

When Dr. Froehling saw Petitioner on January 2, 2013, Petitioner continued to complain of low back pain. He ordered additional physical therapy and another MRI scan (Petitioner's Exhibit 3).

The MRI was performed on January 17, 2013. According to the radiologist, the scan revealed a 3mm disc protrusion at L4-L5. When compared to the prior MRI scan of June, 2011, the protrusion was slightly more pronounced (Petitioner's Exhibit 3).

Dr. Froehling continued to see Petitioner through May 1, 2013. At that time, Petitioner continued to complain of low back pain, but had no radicular symptoms (Petitioner's Exhibit 3).

Petitioner experienced a "flare up" of low back pain and was again seen by Dr. Froehling on September 2, 2015. At that time, Petitioner complained of a burning sensation in the left paralumbar area above the pelvic brim. She also complained of occasional radicular pain down the left leg, but it was not "predominant." On examination, the range of motion was full, straight leg raising was negative and there were no abnormal neurological findings. Dr. Froehling prescribed medication (Petitioner's Exhibit 3).

When Dr. Froehling saw Petitioner on October 15, 2015, he authorized her to be off work and ordered an MRI scan. The MRI was performed on October 28, 2015. According to the radiologist, the MRI revealed an L4-L5 left disc protrusion with some nerve root compression. When compared to the prior MRI of January 17, 2013, the radiologist noted the pathology was "slightly worse" (Petitioner's Exhibits 3 and 4).

When Dr. Froehling saw Petitioner on December 3, 2015, he reviewed the MRI of October 28, 2015, and opined it did not reveal nerve root compression at L4-L5 on the left side. However, he noted Petitioner still had discogenic pain at L4-L5 and some sciatic symptoms. He ordered an EMG study of Petitioner's left lower extremity (Petitioner's Exhibit 3).

The EMG was performed on January 19, 2016, and it was positive for left L5 and right S1 radiculopathy. When Dr. Froehling saw Petitioner on January 29, 2016, he reviewed the EMG and recommended Petitioner undergo disc surgery at L4-L5 on the left side (Petitioner's Exhibit 3).

At the direction of Respondent, Petitioner was examined by Dr. Donald deGrange, an orthopedic surgeon, on May 6, 2016. In connection with his examination of Petitioner, Dr. deGrange reviewed medical records provided to him by Respondent. Dr. deGrange opined Petitioner had a herniated disc at L4-L5 with disc degeneration and stenosis. While he noted Petitioner had prior low back pain, she had symptoms that were not present prior to the accident, specifically, left lower extremity radiculopathy. Dr. deGrange opined the accident was a contributing factor and the surgery recommended by Dr. Froehling was appropriate (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Froehling performed back surgery on January 5, 2016. The procedure consisted of a laminectomy and discectomy at L4-L5 on the left side (Petitioner's Exhibit 6).

Following surgery, Dr. Froehling continued to treat Petitioner. Petitioner's radicular symptoms improved; however, Petitioner continued to complain of low back pain and her left leg symptoms gradually returned over time. When Dr. Froehling saw Petitioner on September 30, 2016, he was concerned Petitioner may have had a recurrent herniated disc. He ordered an MRI scan with contrast (Petitioner's Exhibit 3).

The MRI with contrast was performed on October 21, 2016. According to the radiologist, the MRI revealed a disc protrusion at L4-L5 compressing the left L4 nerve root (Petitioner's Exhibit 8).

When Dr. Froehling saw Petitioner on October 28, 2016, he reviewed the MRI. He opined Petitioner might be a candidate for a decompression at L4-L5 and possible fusion. He indicated he wanted to obtain a second opinion before considering further surgery (Petitioner's Exhibit 3).

At the request of Dr. Froehling, Petitioner was evaluated by Dr. Lukas Zebala, a neurosurgeon, on December 14, 2016. Dr. Zebala reviewed an MRI Petitioner brought with her and noted Petitioner had undergone back surgery at L4-L5. Dr. Zebala's findings on examination were negative for instability of the spine and radiculopathy. He opined surgery was not indicated (Petitioner's Exhibit 9).

Dr. Froehling saw Petitioner on December 16, 2016, and noted she continued to have mechanical low back pain on the left side. He recommended further conservative treatment including possible pain management. Dr. Froehling continued to see Petitioner through March 2, 2017. At that time, Petitioner had scheduled an appointment with Dr. Matthew Gornet, an orthopedic surgeon (Petitioner's Exhibit 3).

Dr. Gornet examined Petitioner on March 6, 2017. At that time, Petitioner advised Dr. Gornet of the accident of October 10, 2015, and the treatment she received both before and after. Petitioner informed Dr. Gornet she had left sided low back pain prior to the accident, but that her complaints afterward were different, specifically, more radicular. Dr. Gornet reviewed the MRIs of October 28, 2015, and October 21, 2016, and opined they both revealed disc pathology at L4-L5 on the left side. He diagnosed Petitioner with discogenic pain, post discectomy low back pain and radicular pain. He recommended Petitioner undergo another MRI, but with gadolinium (Petitioner's Exhibit 10).

The MRI was performed on April 24, 2017. According to the radiologist, it revealed a left foraminal tear and protrusion at L4-L5, bilateral foraminal tears at L3-L4 and a protrusion at L5-S1. Dr. Gornet saw Petitioner that same day and reviewed the MRI. He recommended Petitioner undergo an epidural steroid injection at L4-L5. He also ordered an MRI spectroscopy from L2 to S1 and a CT discogram at L3-L4 and L5-S1 (Petitioner's Exhibit 10).

The diagnostic tests ordered by Dr. Gornet were performed on June 16, 2016. The discogram at L5-S1 was normal, but the discogram at L3-L4 was provocative. The CT scan confirmed disc pathology at L3-L4 and L4-L5 (Petitioner's Exhibit 10).

When Dr. Gornet saw Petitioner on July 24, 2017, he reviewed the results of the diagnostic tests with her. At that time, Dr. Gornet recommended Petitioner undergo disc replacement surgery at L3-L4 and L4-L5 (Petitioner's Exhibit 10).

At the direction of Respondent, Petitioner was again examined by Dr. deGrange on October 30, 2017. In connection with his examination of Petitioner, Dr. deGrange reviewed medical records and diagnostic tests provided to him by Respondent. Dr. deGrange opined the cause of Petitioner's current condition was "multifactorial" and was attributable to the accident as well as her pre-existing condition. He also stated Petitioner would not be able to return to work to her job with Respondent and that a functional capacity evaluation was indicated (Respondent's Exhibit 1; Deposition Exhibit 3).

In regard to the disc replacement surgery at L3-L4 and L4-L5 recommended by Dr. Gornet, Dr. deGrange opined it was not medically necessary and cited a study from the Cochrane Library which indicated there was no compelling medical evidence for disc replacement surgery in seven random trials. Further, he opined Petitioner would have been at MMI as of January 5, 2017 (Respondent's Exhibit 1; Deposition Exhibit 3).

Dr. Gornet subsequently saw Petitioner on October 2, 2017, and August 13, 2018 (the medical record included records of various telephone conversations between Dr. Gornet and Petitioner between those dates). When Dr. Gornet saw Petitioner on August 13, 2018, he took issue with some of the statements in the Cochrane report. He reaffirmed his recommendation Petitioner undergo disc replacement surgery at L3-L4 and L4-L5.

Dr. Gornet was deposed on June 21, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Gornet's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. He testified disc replacement surgery at L3-L4 and L4-L5 was indicated and noted the diagnostic test revealed disc pathology at both levels. Dr. Gornet also stated that Petitioner was not capable of any significant employment and that disc replacement surgery gave her the best chance of a better outcome than fusion surgery (Petitioner's Exhibit 1; pp 21-24).

Dr. deGrange was deposed on July 24, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. deGrange's testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. He reaffirmed his opinion that the accident caused Petitioner's injury at L4-L5. In regard to the disc replacement surgery recommended by Dr. Gornet, Dr. deGrange testified that it was not medically reasonable or necessary. He specifically referenced the Cochrane data in support of his conclusion. He also testified Petitioner was at MMI (Respondent's Exhibit 1; pp 17, 25-26).

On cross-examination, Dr. deGrange agreed Petitioner would not be able to return to work to the job she had at the time of the accident. When questioned about what treatment she would require to alleviate her pain, Dr. deGrange recommended the use of anti-inflammatories, Tylenol and exercise (Respondent's Exhibit 1; pp 54-56).

At trial, Petitioner testified she still has constant and severe low back pain as well as pain in her left leg. Petitioner stated her activities are extremely limited and she has not been able to return to work. Petitioner acknowledged she had low back and left leg pain prior to the accident, but neither were as severe as they were following the accident. Petitioner wants to proceed with 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 October 10, 2015.

In support of this conclusion the Arbitrator notes following:

There was no dispute Petitioner sustained a work-related accident on October 10, 2015.

Petitioner had a pre-existing low back condition involving the disc at L4-L5 on the left side for which Petitioner was treated by Dr. Froehling from June, 2011, through May, 2013.

On September 2, 2015 (approximately five weeks before the accident), Petitioner was seen by Dr. Froehling because of a "flare up" of her back symptoms; however, Petitioner only had some occasional radicular pain down the left leg.

Subsequent to the accident, Petitioner had an MRI performed which revealed worsening of the disc pathology at L4-L5.

Respondent's Section 12 examiner, Dr. deGrange, opined the accident was a contributing factor to Petitioner's herniated disc at L4-L5.

Dr. Gornet ordered additional diagnostic tests which revealed Petitioner had disc pathology at L3-L4 and L4-L5.

Dr. deGrange examined Petitioner for the second time, he opined that the disc replacement surgery was not medically reasonable and necessary; however, he continued to opine that Petitioner's current condition was "multifactorial" and attributable to both the accident and Petitioner's pre-existing condition.

Based upon the preceding, the Arbitrator concludes the medical evidence mandates a determination that Petitioner's current condition of ill-being is related to the accident of October 10, 2015.

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 Exhibit 14, 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:

Respondent's dispute regarding liability for medical services was limited to the medical treatment provided to Petitioner from March 6, 2017, onward when Petitioner began treating with Dr. Gornet.

As previously stated, Petitioner's current condition of ill-being is causally related to the accident of October 10, 2015.

Prior to being treated by Dr. Gornet, Petitioner received extensive medical treatment including disc surgery, but continued to have significant low back and left leg symptoms which have prevented her from returning to work.

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 received extensive medical treatment including disc surgery, but continues to have significant low back and left leg symptoms.

Both Dr. deGrange and Dr. Gornet agree Petitioner is unable to return to work to the job she had at the time of the accident because of her pain symptoms.

Dr. Gornet opined disc replacement surgery would give Petitioner the best chance of a successful outcome.

Dr. deGrange opined disc replacement surgery was not medically reasonable and necessary; however, the only treatment he suggested was the use of anti-inflammatories, Tylenol and exercise, while conceding Petitioner is unable to return to work at her current job.

The Arbitrator is not persuaded by the opinion of Dr. deGrange because it provides no real option for Petitioner to recover from her injury and be able to return to work.

Based on the preceding, the Arbitrator finds the opinion of Dr. Gornet to be more persuasive than that of Dr. deGrange.

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

19IWCC0255

Based upon the information in the findings of fact, Respondent is entitled to a credit for overpayment of temporary total disability benefits of $7,340.03, toward permanency awarded.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Pete Fiala,
Petitioner,

vs.

NO: 15 WC 07851

White County Coal,
Respondent.

19IWCC0256

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 16, 2018, is hereby affirmed and adopted.

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

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

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

DATED: MAY 22 2019
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BNF/mw
045

Barbara Flores

Deborah Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FIALA, PETE
Employee/Petitioner

Case# **15WC007851**

WHITE COUNTY COAL
Employer/Respondent

19IWCC0256

On 10/16/2018, 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:

5236 CULLEY FEIST KUPPART & JORDAN
ROMAN P KUPPART
3 S MAIN ST SUITE #2
HARRISBURG, IL 62946

0693 FEIRICH MAGER GREEN RYAN
CHERYL L INTRAVAIA
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CARBONDALE, IL 62903

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

Pete Fiala
Employee/Petitioner

v.

White County Coal
Employer/Respondent

Case # 15 WC 007851

Consolidated cases: N/A

19IWCC0256

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **August 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. [ ] 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 Petitioner incur an occupational disease that arose out of and in the course of employment with Respondent?
D. [ ] What was the last date of exposure?
E. [x] Was timely notice of the occupational disease given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the exposure?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the last date of exposure?
I. [ ] What was Petitioner's marital status at the time of the last date of exposure?
J. [ ] Were the 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 from the occupational disease?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Occupational disease, exposure, notice, causation, disablement, Sections 1f and 6c.**

FINDINGS

19IWCC0256

On **December 21, 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 ***was*** last exposed to coal dust and fumes arising out of and the course of employment.

Timely notice of Petitioner's claim of injury ***was*** given to Respondent.

On the last date of exposure, Petitioner was **68** years of age, ***married*** with **0** dependent children.

In the year preceding the injury, Petitioner earned $**67,643.93**; the average weekly wage was $**1,326.35**.

Petitioner's current condition of ill-being ***is not*** causally related to his occupational exposure.

ORDER

Petitioner failed to prove he has an occupational disease. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Nancy Lindsay
Signature of Arbitrator

October 11, 2018

ICArbDec p. 2

OCT 16 2018

Findings of Fact and Conclusions of Law

The Arbitrator finds:

Petitioner's medical records from Carmi Community Health (EX7), Deaconess Hospital (EX9), Digestive Care Center (EX10), Midwest Ear Nose and Throat (EX11), Primary Care Group (EX13), St. Mary's Medical Group (EX14) and The Heart Group (EX15) were placed into evidence along with the examination reports and deposition testimonies of Dr. Westerfield (EX4 and EX5) and Dr. Istanbouly (PX1) as well as B-readings and curriculum vitae from Dr. Westerfield, Dr. Meyer, Dr. Tarver, Dr. Smith, Dr. Alexander, Dr. Crum and Dr. Baker (EX1, EX2, EX3, PX2, PX3, PX4, PX5, PX6, PX7, PX8, PX9 and PX10), and the B-readings from NIOSH (EX6).

Four chest x-rays were reviewed by NIOSH. The films were dated May 3, 1980, September 28, 1983, January 21, 2000 and August 22, 2000. (EX3). All of the films were all read as negative for coal workers' pneumoconiosis. (EX6 at 4-11).

A pre-operative physical exam, performed at Deaconess Hospital on January 16, 2006, noted a 20-pack year smoking history, quitting in 1976. (EX9 at 318). Petitioner was working full-time and denied dyspnea, orthopnea, wheezing and unexplained cough. *Id.* His lungs were clear to auscultation and percussion. *Id.* A chest x-ray taken February 2, 2006 revealed normal heart, lung fields, bony structures and pleural recesses. (EX9 at 352, 361). The impression stated, "normal chest." *Id.* A chest x-ray taken October 13, 2010 found the lungs were clear of active infiltrate. (EX7 at 300; EX13 at 1). The final impression stated, "no active cardiopulmonary disease." *Id.*

On January 24, 2011, Petitioner denied complaints of chronic cough, wheezing, and shortness of breath. (EX7 at 297-299; EX14 at 58-59). On February 7, 2011, Petitioner presented to Carmi Community Health ("CCH") with complaints of body aches, chest congestion, productive cough, sputum production and wheezing. (EX7 at 293-295). The respiratory exam revealed normal breath sounds with no rales, rhonchi, wheezes or rubs. *Id.* Petitioner was diagnosed with an upper respiratory infection. *Id.* Petitioner returned on December 28, 2011, with cold symptoms including body aches, chest congestion, chills, productive cough, eye itching/watering, fever to 102, frontal headache, nasal congestion, watery nasal discharge, frontal sinus pain/pressure, sore throat, moderate amount of clear-yellow sputum production and wheezing. (EX7 at 275-277). His respiratory exam was normal and he had normal breath sounds with no rales, rhonchi, wheeze or rubs. *Id.* Petitioner was diagnosed with an upper respiratory infection. *Id.*

On January 27, 2012, Petitioner denied chronic cough. (EX7 at 271-272; EX14 at 56-57). A chest x-ray taken February 22, 2012 found the lungs were clear without infiltrate and had a final impression stating, "no acute cardiopulmonary disease." (EX7 at 270; EX13 at 2). On November 6, 2012, Petitioner presented for a hernia consultation with Dr. Milikan. (EX9 at 234-235). He advised of heavy lifting as a mechanic at the mine that was causing him discomfort over the last six months and stated it could be from carrying a ladder eight months earlier. *Id.* His respiratory effort was deemed normal and his breath sounds were equal bilaterally and clear. *Id.* He wanted his hernia fixed because it limited his ability to work. *Id.*

On December 17, 2012, Petitioner presented to the Deaconess emergency room with history of pain on the left side of his chest for the last couple of days. (EX7 at 242-243; EX9 at 259-260). He denied shortness of breath. *Id.* A chest x-ray revealed "lower volume but clear lungs." (EX9 at 268). An ECG revealed normal sinus rhythm and possible left atrial enlargement. (EX9 at 272). Admission for a stress test was recommended but Petitioner refused and signed out AMA. (EX7 at 242-243; EX9 at 259-260).

Petitioner's last day at the mine was December 21, 2012. Petitioner testified, without rebuttal, that he performed his regular job that day but did not get hurt. Petitioner explained that he was scheduled for hernia surgery on January 6, 2013 and had some extra vacation days to use before then.

A treadmill study performed on January 7, 2013 revealed normal exercise tolerance for his age. (EX7 at 240-241; EX15 at 7). The EKG was normal. (EX15 at 8). On January 11, 2013, Petitioner underwent a laparoscopic right inguinal hernia repair at Deaconess. (EX9 at 239). He returned to CCH on January 28, 2013 with sinus symptoms and was diagnosed with rhinorrhea and dysphagia. (EX7 at 237-239). Petitioner presented to St. Mary's Medical Clinic ("St. Mary's") on January 30, 2013, stated he was doing great and denied shortness of breath. (EX7 at 233-235; EX14 at 54-55). An EGD was performed on February 5, 2013 due to dysphagia. (EX7 at 230-232). Petitioner's respiratory effort was described as normal and his lungs were clear to auscultation bilaterally. *Id.*

Petitioner presented to CCH on February 19, 2013 with complaints of a hacking, persistent and productive cough for the past two days with a temperature of 101. (EX7 at 222-224). He was diagnosed with acute nasopharyngitis. *Id.*

On April 15, 2013, Petitioner sought treatment for chronic nasal obstruction. (EX7 at 220-221; EX11 at 16-17). His history included a recent diagnosis of Barrett's esophagus as per a recent GI endoscopy. *Id.* Petitioner denied shortness of breath and chest pain and was assessed with a deviated nasal septum and hypertrophy of nasal turbinates. *Id.* On May 6, 2013, Petitioner presented for treatment and denied shortness of breath. (EX7 at 218-219; EX11 at 11-12). On June 18, 2013, Petitioner presented to CCH for hyperlipidemia and advised that he was physically active, lifted weights 2-3 times a week and had no health concerns at that time. (EX7 at 210-212). On July 29, 2013, Petitioner presented to Midwest ENT with dysphagia; he denied shortness of breath. (EX7 at 208-209; EX11 at 8-9). An October 14, 2013 CT scan of the abdomen revealed clear lung bases, a normal liver and calculi on the left kidney. (EX7 at 198; EX9 at 229). Petitioner returned to CCH on November 25, 2013 and denied shortness of breath, coughing and wheezing. (EX7 at 184-186). On December 27, 2013, Petitioner was "negative" for chronic cough and wheezing. (EX7 at 174-176).

On January 29, 2015, Petitioner presented to Ferrell Hospital for an x-ray.[1] Several doctors read this film. Dr. Henry Smith read the film as positive for coal workers' pneumoconiosis at a 1/0 classification, p/p, in all the lung zones bilaterally.[2] (PX2 at 1-2). Dr. Westerfield reviewed the film and found it negative for coal workers' pneumoconiosis.[3] (EX3). Dr. Cristopher Meyer read the film as negative for coal workers' pneumoconiosis.[4]

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[1] Ferrell Hospital had no reports or readings for this film.

[2] Dr. Smith is a B-reader and board-certified radiologist. (PX3 at 1-2).

[3] Dr. Westerfield is a B-reader and board-certified in internal medicine, pulmonology and sleep medicine. (EX4 at 4, 7).

(EX1 at 3-4). Dr. Robert Tarver read the film as negative for coal workers' pneumoconiosis.[5] (EX2 at 3-4). Dr. Michael Alexander read the film as positive for coal workers' pneumoconiosis at a 1/0 classification, p/p, in all the lungs zones bilaterally.[6] (PX9 at 1-2). Dr. James Crum read the film as positive for pneumoconiosis at a 1/0, p/q ILO classification in all the right lung zones and the upper and middle left lung zones.[7] (PX6 at 1).

On January 31, 2014, Petitioner presented to St. Mary's and denied chronic cough, wheezing and shortness of breath. (EX7 at 171-172; EX14 at 52-53). A pre-EGD exam for anesthesia was performed on February 4, 2014. (EX7 at 167-169). Petitioner had normal respiratory effort and his lungs were clear to auscultation bilaterally. *Id.* Petitioner presented to the Digestive Care Center on May 1, 2014 and denied chronic cough and wheezing. (EX7 at 158-160). On October 8, 2014, Petitioner presented to Midwest ENT with hoarseness following long conversations; he denied shortness of breath at that time. (EX7 at 146-147; EX11 at 5-6).

On February 6, 2015, Petitioner presented to St. Mary's and reported no shortness of breath when walking, no shortness of breath when lying down, no cough, and no wheezing. (EX7 at 131-132; EX14 at 48-51). On February 11, 2015, a copy of Dr. Smith's B-reading, was provided to CCH. (EX7 at 130). On July 6, 2015, Petitioner presented to CCH and advised that he lost 3.5 pounds and had been exercising (lifting weights) until he pulled his back. (EX7 at 119-122).

On March 3, 2015, Petitioner signed his Application for Adjustment of Claimant herein alleging 33 years of coal mine dust exposure and a last exposure date of December 21, 2012.

Petitioner was examined by Dr. Istanbouly on July 21, 2015.[8] (PX1, Exh. 2 at 1). Dr. Istanbouly noted Petitioner's employment, smoking and medical histories. *Id.* Petitioner advised that he had been coughing on a daily basis for the last 5-6 years and the cough was around the clock but worsened with strenuous activities. *Id.* The cough was mild in intensity and productive of clear sputum, roughly two tablespoons-full in size per day. *Id.* Petitioner reported no hemoptysis, no fever or chills, no night sweats and no orthopnea, although he had to raise the head of the bed due to acid reflux disease. *Id.* His heartburn was well controlled by taking Esomeprazole on a daily basis. *Id.* He snored at night but had no witnessed apnea episodes and no excessive daytime sleepiness or fatigue. *Id.* He complained of occasional nocturnal dyspnea, less than once a month, and exertional dyspnea. *Id.* Petitioner stated he was short of breath after walking three to floor blocks and that was his baseline respiratory capacity for the past six months. *Id.* He had no chest pain or tightness but stated he had occasional wheezing. *Id.* He complained of runny nose and postnasal drip mainly with meals and no dysphagia. *Id.* Dr. Istanbouly found the January 29, 2015 chest x-ray showed mild interstitial fibrosis bilaterally, consistent with early stage coal workers' pneumoconiosis, which was categorized by the B-reader as 1/0 profusion. *Id.* Petitioner's spirometry was normal with FEV1 of 2.39 (93% predicted), FVC of 3.24 (92% predicted) and

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[4] Dr. Meyer is a B-reader, board-certified radiologist and professor of diagnostic radiology at the University of Wisconsin Hospital and Clinics in Madison, Wisconsin. (EX1 at 5-6, 23).

[5] Dr. Tarver is a B-reader, board certified radiologist and professor of radiology at Indiana University School of Medicine in Indianapolis, Indiana. (EX2 at 5).

[6] Dr. Alexander is a B-reader and board-certified radiologist. (PX10 at 2).

[7] Dr. Crum is a B-reader. (PX7 at 1-2).

[8] Dr. Istanbouly is board certified in pulmonary and critical care medicine. (PX1 at 4)

FEV1/FVC ratio of 73%. *Id.* Dr. Istanbouly opined that Petitioner had coal workers' pneumoconiosis (mild case). The diagnosis was based on Petitioner's occupational history, symptoms including chronic cough, sputum production, exertional dyspnea, and chest x-ray findings. (PX1, Exh. 2 at 2). Dr. Istanbouly stated Petitioner's CWP was a significant contributor to his respiratory symptoms and, from a medical standpoint, Petitioner should not go back to work in the coal mines. *Id.*

On August 19, 2015, Petitioner presented to St. Mary's for blood in his urine. (EX7 at 107-108; EX14 at 19-22). He stated it began two weeks earlier after a long day of heavy lifting and working outside. *Id.* He denied exercise intolerance, shortness of breath and coughing. *Id.* A sleep study was performed on August 24, 2015 at Deaconess Hospital. (EX9 at 139). Petitioner advised that he slept on two pillows to deal with his Barrett's esophagus and severe reflux. *Id.* Petitioner returned to St. Mary's on September 3, 2015 and denied exercise intolerance, shortness of breath and coughing. (EX14 at 17-19). Petitioner returned on September 17, 2015 and reported that he had no exercise intolerance, no shortness of breath when walking or lying down, no cough and no wheezing. (EX7 at 103-104; EX14 at 13-16). Petitioner returned on October 8, 2015, was 100% improved and reported that he had no exercise intolerance, no shortness of breath when walking or lying down and no cough or wheezing. (EX14 at 10-13).

On October 20, 2015, Petitioner presented to CCH for dizziness. (EX7 at 98-102). He requested sleep apnea testing because he snored and his wife reported that he stopped breathing sometimes, woke up startled and couldn't catch his breath sometimes. *Id.* He was referred for a sleep study. *Id.* The sleep study pre-exam was performed on October 26, 2015. (EX9 at 133). Petitioner advised of a lot of sinus trouble. *Id.* His respiratory exam revealed no shortness of breath and occasional cough. *Id.* The testing was performed on October 28, 2015. (EX9 at 132). The report found Petitioner's upper airway anatomy and body habitus put him at risk for sleep apnea. *Id.* The assessment found obstructive sleep apnea, essential hypertension and a BMI between 30.0 and 30.9. *Id.*

On January 6, 2016, Petitioner had an EGD that revealed Barrett's esophagus without dysplasia. (EX9 at 87-88). Petitioner presented to St. Mary's on February 12, 2016 and reported no cough, no wheezing and no shortness of breath. (EX14 at 7-10). On March 14, 2016, Petitioner presented to CCH for chest discomfort. (EX7 at 75-80). He denied dyspnea, fatigue, nausea, palpitations and vomiting and stated the condition was aggravated by food. *Id.* He stated that his chest pain was associated with chronic cough. *Id.* He advised that interim episodes were becoming more frequent, lasted 1-2 minutes and resolved. He stated that it "feels like there are worms in there." *Id.* He was diagnosed with CWP, hiatal hernia, atypical chest pain. *Id.*

On September 6, 2016, Petitioner presented to CCH with head sweats that were not associated with exercise or working outside. (EX7 at 52-56). On September 23, 2016, Petitioner presented to Deaconess Sleep Center. (EX7 at 50-51; EX9 at 124). His weight was down 13 pounds. *Id.* His chest was clear to auscultation. *Id.* Petitioner was to continue with CPAP. *Id.* Petitioner returned to the Sleep Center on December 5, 2016. (EX9 at 120). He was down an additional 6 pounds. *Id.* On December 21, 2016, Petitioner presented to CCH for musculoskeletal chest pain. (EX7 at 39-42). The pain was aching and sharp was aggravated by lifting. *Id.* There were no associated symptoms and occurred mostly with lifting weights for short duration. *Id.* Petitioner questioned if it was related to black lung. *Id.* A chest x-ray and avoidance of exacerbating exercises was recommended. *Id.* A chest x-ray was taken on December 21, 2016. (EX7 at 38). The findings noted the ribs had adequate bone density normal alignment with no fracture. *Id.* The heart size was normal and the lung fields were "without acute process." *Id.* The impression found "no acute process." *Id.*

Petitioner presented to Midwest ENT on January 31, 2017. (EX7 at 31-32; EX11 at 2-3). He advised of difficulty with CPAP and denied shortness of breath. On February 8, 2017, Petitioner presented to Deaconess

Hospital emergency room with chest, arm and neck pain. (EX7 at 25-29; EX9 at 45-51). His lungs revealed equal bilateral breath sounds with no respiratory distress, no wheezes, no rales and no rhonchi. *Id.* Petitioner was put on cardiac monitoring. *Id.* A stress test was offered but he did not want to stay. *Id.* A chest x-ray found the lungs were clear. (EX9 at 60). The impression found "no significant abnormality of the chest." *Id.*

Petitioner presented to St. Mary's on February 17, 2017 and reported that he had no exercise intolerance, no cough, no wheezing, and no shortness of breath. (EX7 at 21-22; EX14 at 4-7). On March 1, 2017, Petitioner presented to the Deaconess Hospital ER with pain in his left arm. (EX7 at 13-14; EX9 at 7-8). Petitioner advised that he thought it could be from working out but wanted to get checked. *Id.* He denied shortness of breath and chest pain. *Id.* The lung exam revealed equal bilateral breath sounds, no respiratory disease, no wheezing, no rales and no rhonchi. *Id.* A chest x-ray stated, "Lungs appear clear." (EX7 at 10-11; EX9 at 12). The final impression found no evidence of focal infiltrate. *Id.* Petitioner was discharged after physicians found no overwhelming evidence that would suggest the pain in the left arm was a referred pain from coronary ischemia. (EX7 at 13-14; EX9 at 7-8). On March 6, 2017, Petitioner presented to CCH for arm pain. (EX7 at 2-5). The assessment "acute pain of left shoulder, suspect C6-7 radiculopathy." *Id.*

Dr. Westerfield examined Petitioner on May 12, 2017. (EX4). Dr. Westerfield reviewed Dr. Istanbouly's report, B-readings from NIOSH, Dr. Smith, Dr. Meyer and Dr. Tarver as well as Petitioner's medical records and summarized the material in his report. (EX4 at 1-6). Dr. Westerfield took a chest x-ray as part of his exam and read the film as negative for coal workers' pneumoconiosis. (EX4 at 13). This film was read by Dr. Glen Baker as positive for coal workers' pneumoconiosis at a 1/0, t/t, ILO classification with the findings in the mid and lower lung zones only.[9] (PX4 at 1-2). Dr. Alexander read the film as positive for coal workers' pneumoconiosis with a 1/0, p/p ILO classification in all the lung zones. (PX8 at 1-2). Dr. Meyer and Dr. Tarver read the film as negative for coal workers' pneumoconiosis. (EX1 at 1-2; EX2 at 1-2).

Dr. Westerfield's spirometry revealed an FEV1 of 2.82 (98% predicted), an FVC of 3.53 (95% predicted) and an FEV1/FVC ratio of 80 (102% predicted). (EX4 at 15). Petitioner's total lung capacity ("TLC") was 83% predicted and the diffusing capacity was 116% predicted. *Id.* Petitioner's arterial blood gas ("ABG") testing revealed a PaCO2 of 43.0 and a PaO2 of 73.0. (EX4 at 16). Dr. Westerfield interpreted the spirometry, total lung capacity, diffusing capacity and ABG testing as normal. (EX4 at 17).

Following review of his own data as well as the reports and medical records, Dr. Westerfield opined that Petitioner did not have simple or complicated CWP. (EX4 at 6). Based on his work history, Petitioner had adequate exposure to coal mine dust to develop pneumoconiosis if he were a susceptible individual; however, there was insufficient medical evidence present that this occurred. *Id.*

Dr. Westerfield further opined that Petitioner had no lung diseases and no pulmonary conditions. (EX4 at 7). He had a few respiratory symptoms and was quite physically active. *Id.* He had no radiological evidence of lung disease on chest x-ray and had no physiological evidence of respiratory injury on pulmonary function testing. *Id.* Dr. Westerfield opined that there was no medical evidence to support any respiratory disease in Petitioner related to the inhalation of coal mine dust. *Id.* Based on PFTs, Petitioner had no pulmonary impairment and no respiratory injury. *Id.* Spirometry testing by Dr. Istanbouly was normal and in Dr. Westerfield's lab, the complete pulmonary function testing which included spirometry, total lung capacity and arterial blood gas measurements were all normal. *Id.* There was also no evidence in Petitioner's clinical records which indicated any respiratory impairment. *Id.* Based on pulmonary function in Petitioner, which was normal,

[9] Dr. Baker is a B-reader and board-certified pulmonologist. (PX5 at 1).

Dr. Westerfield opined that Petitioner had the pulmonary capacity to return to his previous position in coal mine employment or work with equal energy requirements in other industries. (EX4 at 7-8). Dr. Westerfield found no pulmonary condition, disease or impairment present and made no diagnosis of lung disease of any kind. (EX4 at 8). Based on the Sixth Edition of the AMA Guides to Evaluation of Permanent Impairment 5-4, page 88, Petitioner had an impairment rating of Class 0, 0% which was no pulmonary impairment. *Id.*

Deposition of Dr. Istanbouly

Dr. Istanbouly was deposed on December 4, 2017. (PX1). Dr. Istanbouly was board certified in pulmonary and critical care medicine. (PX1 at 4). He was in private practice in Herrin, Illinois for almost 15 years. *Id.* It was mixed between inpatient and outpatient and he saw all aspects of pulmonary, critical care, and sleep medicine cases. *Id.* A significant portion of his practice was devoted solely to care and treatment of patients with pulmonary disease and roughly 40 to 50% of his patients had been exposed to coal dust at a certain point in their lift. (PX1 at 4-5). He estimated that 70% of his practice was just pulmonary disease. (PX1 at 5). Dr. Istanbouly was affiliated with his clinic. *Id.* He had been performing DOL black lung exams since 2004. *Id.*

Dr. Istanbouly reiterated his exam and report findings. (PX1 at 6-8). He explained that when someone had chronic history of daily coughing and sputum production with exertional dyspnea, he looked at the predisposing factor. (PX1 at 8). Petitioner quit smoking a long time ago, so the main predisposing factor was long-term coal dust inhalation. (PX1 at 8-9). Smoking by itself was a risk factor for chronic bronchitis and COPD in addition to some kinds of interstitial lung diseases. (PX1 at 9). But in this case, Petitioner smoked for fifteen years and quit smoking a long time ago, and his coal mining career seemed to be more relevant to explain his current respiratory symptoms. *Id.* Petitioner reported coughing daily, worse with strenuous activities for five to six years, and this was consistent with chronic bronchitis which was a form of COPD or one of the lung diseases related to long-term coal dust exposure. *Id.* The sputum production was also consistent with chronic bronchitis and in this case long term coal dust exposure was the main culprit. *Id.* Smoking was a minor factor. *Id.*

Dr. Istanbouly explained that dyspnea was difficulty breathing or shortness of breath. (PX1 at 10). Petitioner reported occasional nocturnal dyspnea. *Id.* It was relevant to Dr. Istanbouly's diagnosis because it could be explained by the rest of his respiratory symptoms which were the chronic cough, sputum production, exertional dyspnea. *Id.* This was another manifestation of lung damage related to long-term coal dust inhalation. *Id.* Exertional dyspnea was shortness of breath on exertion and was a symptom of coal workers' pneumoconiosis. *Id.* Dr. Istanbouly stated that the usual symptoms for simple coal workers' pneumoconiosis were chronic respiratory symptoms, chronic cough, sputum production, wheezing, chest tightness, and shortness of breath on exertion. (PX1 at 10-11). These were essentially the same symptoms for Petitioner. (PX1 at 11). Dr. Istanbouly stated it was possible for a person with a positive chest x-ray for CWP to be asymptomatic if it was early stage. *Id.* It was also possible for a person to have CWP and not even know they had it. *Id.*

Petitioner's physical examination was normal. (PX1 at 11). It was not necessary to have an abnormality on physical examination of the chest in order to have CWP. *Id.* It was not unusual for Petitioner to have no abnormalities on exam. *Id.* Petitioner's pulmonary function testing results were normal. (PX1 at 12). He agreed it was possible for someone to have normal PFTs and simple CWP if it was mild or early stage of the disease. *Id.* This case met the standard. *Id.* Having pulmonary testing within the range of normal did not necessarily mean that the lungs were not damaged. *Id.* It may mean that the damage was mild. *Id.* It was not severe enough to be revealed on the PFT. *Id.* Spirometry was the measure of global impairment of the both lungs as opposed to a focal impairment of a portion of the lung. *Id.* Dr. Istanbouly said it was possible for a person to have a certain amount of their lungs with focal areas of pulmonary impairment yet have normal

overall global function. (PX1 at 12-13). A person could also have shortness of breath with a normal pulmonary function test. (PX1 at 13).

Dr. Istanbouly reviewed the chest x-ray report from Dr. Smith and also reviewed the film as well. (PX1 at 13). In his practice he normally reviewed and interpreted films in the care and treatment of his patients. *Id.* He relied on his own interpretation but did not ignore the radiologist's report. *Id.* The radiologist found mild interstitial changes involving mainly bilateral upper, mid and lower zones. (PX1 at 13-14). Dr. Istanbouly agreed that the film revealed mild bilateral interstitial changes. (PX1 at 14). He felt the film was of good quality. *Id.* Dr. Istanbouly stated that someone did not have to be a B reader in order to diagnose coal workers' pneumoconiosis. *Id.* In his mind, the B reading was mainly for the classification, the profusion, the numerical system but not to make the diagnosis. *Id.* He stated there were no B-readers at the hospital he was affiliated with. *Id.* He believed the closest would be in Evansville, Indiana. *Id.*

In his practice, Dr. Istanbouly diagnosed Petitioners with CWP. (PX1 at 14-15). Dr. Istanbouly stated that it depended on whether he had a B-reading or not for his patients. (PX1 at 15). If it was for a legal purpose and he was doing the evaluation, he required a B-reading report. *Id.* If it was one of his patients who happened to be diagnosed for the first time with black lung, and he was the one who was telling him he had black lung, he did not require a B-reader for that. *Id.*

Dr. Istanbouly explained that inhaling fine particles inside the lungs caused pneumoconiosis. (PX1 at 15). Those fine particles would deposit on the lung tissue or the tiny airways and created local and chronic inflammation. *Id.* That inflammation ended up with granulation which was a scarring of the lungs and were the small round opacities revealed on the x-ray; it could also affect the small airways causing chronic inflammation, chronic bronchitis which would cause COPD. (PX1 at 15-16). He testified that not every coal Petitioner that was exposed to coal dust would develop CWP. (PX1 at 16). Pneumoconiosis caused scarring or a form of emphysema and the scar tissue was permanent and that scarring could carry on the function of normal healthy lung tissue. *Id.*

Scar tissue could create an impairment, not always, but it could. (PX1 at 17). If it was mild, early stage, no. *Id.* But if it got worse, yes. *Id.* Continuous exposure would cause it to worsen and sometimes if it was like progressive pattern of CWP, even when the exposure was over, the damage would keep progressing. *Id.* There was no cure for the condition. *Id.* There were other causes of pneumoconiosis, but coal workers' pneumoconiosis was caused by coal dust. *Id.* Nowadays when they are talking about combination of coal dust and silica. *Id.* Even in Illinois, the coal Petitioners were exposed to both coal dust and silica. *Id.*

Dr. Istanbouly opined, within a reasonable degree of medical certainty, that Petitioner's CWP was caused by long-term coal dust inhalation. (PX1 at 17). He classified the condition, based on the chest x-ray findings, physical exam, PFT and symptoms, as a mild case. (PX1 at 18). He stated that Petitioner could not have additional coal dust exposure without endangering his health. *Id.* If he continued exposure, it would mean worsening of symptoms and worsening of chest x-ray and PFT findings. *Id.* Dr. Istanbouly stated that the DOL set a safe level of exposure for someone with CWP as less than 50 micrograms. *Id.* Dr. Istanbouly could not remember the unit exactly and stated that meant moving the worker to an office within the coal mine. *Id.* Dr. Istanbouly stated that this particular patient could not safely return to the type of work he was doing. *Id.* Petitioner was disabled from performing the type of coal mining work that he did prior to his retirement. (PX1 at 19). The disability was permanent. *Id.* Dr. Istanbouly stated that CWP made an individual more susceptible to respiratory infections or pneumonias. *Id.* Based on a reasonable degree of medical certainty, Dr. Istanbouly believed that Petitioner had an impairment to his lungs as a result of his occupational exposure. *Id.*

On cross-examination, Dr. Istanbouly agreed the pulmonary function testing performed on July 21, 2015 was normal. (PX1 at 21). There was no sign of obstructive or restrictive impairment. *Id.* He did not perform perfusion capacity testing. *Id.* He reviewed the January 29, 2015 chest x-ray. *Id.* He was not a B-reader or a board-certified radiologist; when he reviewed the film he already had Dr. Smith's interpretation of the film. *Id.* Petitioner had mild or early stage CWP. (PX1 at 23). Dr. Istanbouly did not use the ILO comparison films from NIOSH when he looked at a chest x-ray. *Id.* He just looked at the film quality. *Id.*

Dr. Istanbouly did not review any of Petitioner's medical records before or during the exam; he only had what Petitioner provided which was a medical history, but no medical records. (PX1 at 23-24). Dr. Istanbouly agreed that gastroesophageol reflux disease (GERD) could cause coughing. (PX1 at 24). It was the disease itself that caused the cough, not the medicine. *Id.* Petitioner was on Nexium. *Id.* Dr. Istanbouly did not look at medical records after the exam either. (PX1 at 24-25). Dr. Istanbouly did not ask Petitioner if he had any difficulties performing his job when he was at the mine so he could not answer the question. (PX1 at 25).

The physical exam was normal. (PX1 at 25). Dr. Istanbouly could not recall if Petitioner coughed during the exam. *Id.* Petitioner did not seem to be out of breath during the examination, but Petitioner told him that he had shortness of breath on exertion and sometimes at night. *Id.* Dr. Istanbouly did not perform any exercise testing. *Id.* Dr. Istanbouly agreed that if Petitioner had the symptoms he advised him of that he probably would have told them to his own treating physicians as well. (PX1 at 25-26). In the course of his practice Dr. Istanbouly would want his patients to come in and state that they were short of breath or coughing. (PX1 at 26). Given the statements by Petitioner regarding chronic coughing and sputum production, Dr. Istanbouly expected that Petitioner's physicians would also have diagnosed chronic bronchitis. *Id.* Dr. Istanbouly stated he was more focused on the CWP but stated that Petitioner met the criteria for chronic bronchitis and would state the chronic bronchitis was under the umbrella of CWP. *Id.* Dr. Istanbouly agreed that chronic bronchitis was usually under the umbrella of COPD. (PX1 at 27). He then decided it could be under both. *Id.* He agreed there was no obstructive condition, and stated it was possible that Petitioner had early stage COPD, based on his symptoms and the normal PFT. *Id.*

Dr. Istanbouly did not decide if Petitioner had the pulmonary capacity to return to the mine solely on the pulmonary function testing. (PX1 at 27). If Dr. Istanbouly assumed the chest x-ray was negative and Petitioner had the same values on PFT, Dr. Istanbouly would still state that Petitioner should not return to the mine. (PX1 at 27-28). If Petitioner was coughing and had sputum production and dyspnea with exertion, that would be enough for Dr. Istanbouly to state that Petitioner could not go back to the mine. *Id.*

Petitioner did not tell Dr. Istanbouly why he left the mine. (PX1 at 30). As far as Dr. Istanbouly knew, Petitioner did not leave for a pulmonary condition. *Id.* Dr. Istanbouly agreed that the difference between a positive and negative chest film was very subtle when it was in "early stage," like in this case. *Id.* He would not be surprised if other B-readers read the film as negative. *Id.* But none of those B readers saw the patient, talked to him, examined him. *Id.* Dr. Istanbouly was not relying only on the x-ray, he relied on the x–ray and clinical correlation to come up with his conclusion. *Id.* He stated he noticed when it was early stage, B-readers may disagree. *Id.* He agreed that in these instances, these were almost like a borderline case. *Id.* It could go either way but to him as a physician, he always correlated clinically. *Id.*

Dr. Istanbouly expected that if radiologists working in a hospital in a coal mine area saw opacities on the chest film, that would be something noted in the report. (PX1 at 31). Dr. Istanbouly stated that he did read the film, and not just the report of the B-reader, and it was his opinion that Petitioner had mild interstitial changes consistent with CWP. *Id.* Dr. Istanbouly tried to remember if he saw the disease in all the lobes like Dr. Smith and said, "I will say yes. If I put it in my report, yes." *Id.* It was Dr. Istanbouly's opinion that 50 percent of

Petitioners who worked 32 years in the mine would develop CWP. *Id.* On redirect, Dr. Istanbouly stated that a patient did not need to have an abnormal pulmonary function test in order to be diagnosed with coal workers' pneumoconiosis. (PX1 at 32). That was the case here. (PX1 at 33). It was just a chest x-ray, symptoms and occupational history. *Id.*

Deposition of Dr. Westerfield

Dr. Westerfield was deposed on December 8, 2017. (EX5). Dr. Westerfield is a medical physician specializing in pulmonary, specifically occupational lung, disease. (EX5 at 4). He became a board-certified pulmonologist in 1980 and a B-reader in 1991. *Id.* He practiced at Commonwealth Respiratory Consultants and performed independent medical evaluations for occupational lung disease, specifically pneumoconiosis, black lung. *Id.* He also did work for any inhalational disorder like asbestosis and occupational asthma. (EX5 at 4-5). Dr. Westerfield did examinations for plaintiffs, defendants, the U.S. Department of Labor and the State of Kentucky. (EX5 at 5). These were objective evaluations and when occupational disease was present, he identified it and testified accordingly. *Id.*

Dr. Westerfield reviewed the January 29, 2015 chest film at Employer's request and also reviewed Dr. Istanbouly's IME report, the NIOSH records, B-readings and Petitioner's medical records. (EX5 at 5). He also examined Petitioner. *Id.* Those materials were the types of reports and records that he would rely upon in rendering an opinion as to whether someone had CWP or a pulmonary impairment; he liked to have as much information as he could about the claimant. (EX5 at 5-6). He liked to personally examine the individual and liked to have the pulmonary studies performed in his own lab. (EX5 at 6). It was very helpful to review outside medical reports and other x-rays. *Id.*

Petitioner's medical history revealed that he was really quite healthy with few respiratory symptoms. (EX5 at 7). He was not receiving treatment for any breathing problems. *Id.* When Dr. Westerfield saw Petitioner, he advised of a cough with some mucus in the mornings. *Id.* He was an active man who exercised and swam. *Id.* He smoked cigarettes for about 15 years at 1 pack per day but had not smoked in some time and was taking no medications for his breathing. *Id.* Dr. Westerfield explained that Petitioner had Barrett's esophagus which was an inflammation of the esophagus related to gastroesophageal reflux disease. *Id.* Barrett's esophagus was worse than GERD because it created some dysplasiac cells that could deteriorate into esophageal carcinoma. *Id.* It was followed more closely than regular reflux. *Id.* It was not caused, in any way, by coal dust exposure. *Id.*

Petitioner also had obstructive sleep apnea. (EX5 at 8). This was a condition in which the airway closed during sleep, breathing was disrupted and oxygen dropped. *Id.* Petitioner used a CPAP machine which stood for continuous positive airway pressure. *Id.* It was a device that opened the airway simply by mechanically splinting it with air pressure. *Id.* CPAP was the most common treatment for obstructive sleep apnea. *Id.* Dr. Westerfield noted that Petitioner's brother and son both had sleep apnea and that it certainly ran in the family. *Id.* It was an airway problem, an anatomical problem. *Id.* Family members with the same type of anatomy often had the same dietary habits as well and may have excess weight. *Id.* Coal dust exposure did not cause sleep apnea. *Id.*

Petitioner was taking Lisinopril, Lipitor and Nexium. (EX5 at 8). None of those prescriptions were for a pulmonary condition. (EX5 at 8-9). Lisinopril was for blood pressure; Lipitor was for cholesterol and Nexium was for reflux. (EX5 at 9). Petitioner was a hard-working man who retired from coal mining at the age of 68. (EX5 at 9). He worked in the coal preparation plant for 29 years. *Id.* This was his major job. *Id.* He also worked underground for about four years and prior to that he worked in a factory doing welding and

supervision. *Id.* Dr. Westerfield personally examined Petitioner and found him to be a very pleasant, cooperative and healthy man who looked younger than stated. *Id.* He had no remarkable findings on exam. *Id.*

Dr. Westefield explained that as a B-reader, he was required to review the chest x-ray a certain way. (EX5 at 10). To review a chest x-ray for pneumoconiosis he put up the standard films side by side with the film he was viewing and got the closest match to that film based on the ILO classification. *Id.* X-rays were graded from category 1, 2 and 3 and if large opacities were present they were graded A, B and C depending on the size. *Id.* Dr. Westerfield found no abnormalities on the January 29, 2015 chest film. *Id.* It was a normal x-ray and had no chest findings. *Id.* The x-ray from May 16, 2017 was also completely normal. (EX5 at 10-11). Dr. Westerfield also reviewed the NIOSH reports. (EX5 at 11). None of those radiologists made any diagnoses of pneumoconiosis on Petitioner's films. (EX5 at 11-12).

Dr. Westerfield explained that spirometry was a breathing test that originated in the 1840s and involved an individual taking in as deep a breath as he could and blowing it out as hard, as fast as he could. (EX5 at 12). The physicians looked at the curves and determined the total amount of air the individual blew out and the speed at which he blew it out. *Id.* They looked at the forced vital capacity (FVC), the forced expiratory volume in one second (FEV1) to determine the mechanics of the lungs. *Id.* Petitioner provided good effort during both Dr. Westerfield's testing as well as Dr. Istanbouly's testing. (EX5 at 12-13). There was no evidence of any pulmonary impairment on either Dr. Istanbouly's testing or his own. (EX5 at 13).

Dr. Istanbouly's testing had an FEV1 of 2.37 and Dr. Westerfield had an FEV1 of 2.82. (EX5 at 13). Dr. Westerfield explained that sometimes in different laboratories there would be a different performance of the test. *Id.* Both studies were still normal. *Id.* It was definitely a greater value and a better performance of the test. *Id.* He stated that if Petitioner had a coal-mine induced pulmonary condition the values would not get better over time. (EX5 at 13-14). It could get worse but it absolutely would not get better. (EX5 at 14).

Dr. Westerfield also performed lung volume measurements, diffusing capacity and arterial blood gas testing. (EX5 at 14). Dr. Istanbouly did not perform any of these tests. *Id.* The diffusing capacity measured the ability of the lungs to take oxygen out of the air and transfer it into the bloodstream which was exactly what the lungs did and this was completely normal for Petitioner. *Id.* The lung volume measurements were used to determine the total lung capacity and how much residual volume was left after an individual blew out all of his air. *Id.* These were specialized tests for pulmonary function and were used to help determine Petitioner's total respiratory ability. *Id.* All of the testing results were normal. *Id.*

Based on the testing performed at his office, as well as the testing at Dr. Istanbouly's office, there was no evidence of any lung disease in Petitioner. (EX5 at 14). He had no pulmonary impairment and no respiratory disability. (EX5 at 14-15). There were no findings of emphysema. (EX5 at 15). Petitioner subjectively reported a cough and Dr. Westerfield expected that if Petitioner had a chronic cough he would have reported it to his treating physicians. *Id.* Petitioner did not exhibit any symptoms or exertional dyspnea during the exam. *Id.*

After reviewing all the medical information, Dr. Westerfield opined that Petitioner did not have coal workers' pneumoconiosis. (EX5 at 15). There was no evidence of any lung disease and there was no evidence that coal mine dust caused any harm to him. *Id.* Based on pulmonary function testing, Petitioner had no pulmonary impairment. *Id.* He had no restrictive or obstructive lung disease. (EX5 at 16). Dr. Westerfield opined that Petitioner could return to his previous position in coal mine employment or could enjoy work with equal energy requirements in other industries. *Id.* Dr. Westerfield was familiar with the AMA guidelines for determining pulmonary impairment because he used that criteria in assessing impairment. (EX5 at 16). They were currently

on the Sixth Edition but he was required to use the Fifth Edition for Kentucky. *Id*. Based on either the Fifth or the Sixth Edition, Petitioner was a Class 0, 0%, which was no impairment. (EX5 at 17).

Dr. Westerfield had two practices: the occupational lung disease which was 50 percent or more of his practice and the other part was sleep disorders, so he did sleep medicine and actively treated patients for sleep disorders. (EX5 at 18). The occupational lung disease was evaluation and he saw patients as an independent medical exaPetitioner for the U.S. Department of Labor and the State of Kentucky, defense and plaintiff attorneys. *Id*. He agreed that if a person was a susceptible individual, the more a person worked in the coal mines the more likely they would develop CWP. *Id*. He agreed that individuals with Category 1 CWP were usually asymptomatic. *Id*. Dr. Westerfield stated that a cough was quite nonspecific. (EX5 at 19). In the Ohio River Valley, with allergies, it was very common and could be from many things. *Id*. It could be seen in an individual with pneumoconiosis but most individuals with lower categories had no symptoms. *Id*. He agreed that sputum production, exertional dyspnea and nocturnal dyspnea could be associated with CWP. *Id*. The physical exam for Category 1 CWP was usually normal. *Id*. He further agreed that it was possible for someone with Category 1 CWP to not even know that they had the condition. (EX5 at 19-20). He further agreed that it was not unusual for a person with Category 1 CWP to have normal PFTs. (EX5 at 20). If a person's pulmonary function was within the normal range it meant they had no functional impairment in terms of rating them for disability. *Id*.

Dr. Westerfield explained that the range of normal for spirometry was usually 80 percent to 120 percent. (EX5 at 19). Dr. Westerfield agreed this was a fairly wide range. *Id*. He agreed that someone could be in the range of normal yet have lost function over time. (EX5 at 21). He further agreed that the only way to know for a fact would be if you had spirometry done years before then years after. *Id*. Spirometry was a measure of the total lungs, both lungs. *Id*. He agreed it was possible remove a portion of and still have a normal PFTs. *Id*. Dr. Westerfield agreed that it was possible for a person to report shortness of breath that was not due to the lungs but still have normal pulmonary function testing. (EX5 at 21-22). Dr. Westerfield also agreed that a person could have microscopic, pathological CWP that was not seen on a chest x-ray. (EX5 at 22).

Dr. Westerfield stated that the purpose of the B reader exam was to try to get B readers to read as consistently and as close to each other as they could, but there was always disagreement. (EX5 at 22). The ILO workbook recommended that every x-ray be read by a minimum of two B-readers. *Id*. Dr. Smith read the film as positive for CWP at a 1/0 ILO classification. *Id*. The biggest disagreements were between 1/0 and 0/1. *Id*. Dr. Westerfield personally reviewed the 2015 and 2017 films. (EX5 at 22-23). He also reviewed the reports for the prior chest x-rays. (EX5 at 23). Dr. Westerfield believed that all the NIOSH films were read by B-readers. *Id*. An A reader was someone who was trained to read films based on the ILO classification and a B-reader was one who passed the exam. (EX5 at 24-25). He agreed that an A-reader could have chosen not to take the exam or failed the exam. (EX5 at 25). Dr. Westerfield only had the reader's initials and he did not know them. *Id*. He stated that NIOSH was serious about their work with this and sent the films to experienced people. *Id*.

Dr. Westerfield agreed there could be microscopic damage that probably existed in all of us. (EX5 at 28). For example, at autopsy, elderly men frequently had prostate cancer that was undetected. *Id*. There were lots of disease processes that might be present microscopically on pathology that were not recognized in life. *Id*. He stated, however, that they didn't usually biopsy folks and look at their lungs unless they had some disease that was indicated by other testing. *Id*. If there was no radiographic evidence of disease and there was no physiological evidence of disease, Dr. Westerfield did not think it was prudent or wise to search microscopically for disease. *Id*. He agreed that microscopic evaluation following biopsy would be the only way to rule out the disease. (EX5 at 28-29). Dr. Westerfield agreed that a person could have radiographically significant CWP yet still have normal spirometry, physical exam of the chest and pulmonary function like Petitioner. (EX5 at 29).

Dr. Westerfield agreed that the scarring and fibrosis from CWP was permanent and could not carry on the function of normal healthy tissue. (EX5 at 31). He agreed there was no cure for CWP. *Id.* He further agreed there was no other cause for CWP than exposure to coal dust. *Id.* Dr. Westerfield considered CWP to be a chronic slowing progressive disease. *Id.* Dr. Westerfield confirmed that he was a member of the American Thoracic Society. (EX5 at 31-32). Dr. Westerfield stated that if there was safe level of dust exposure for someone with CWP they did not know it yet. (EX5 at 32). Dr. Westerfield stated that if Petitioner had CWP he would recommend that he not work in coal dust or at least that work in an area where he had the utmost respiratory protection; however, Petitioner did not have black lung. *Id.*

Dr. Westerfield explained "adequate exposure" to coal dust as at least ten years of exposure for a susceptible individual to get pneumoconiosis. *Id.* Dr. Westerfield agreed that a person could have normal lung volume and diffusing of blood gas and still have CWP. (EX5 at 33). Dr. Westerfield stated that even if Petitioner had the symptoms claimed and the B-readers differed on categories of CWP, Dr. Westerfield could, and did, rule out pneumoconiosis with medical certainty. *Id.* When asked if it was possible that Petitioner could have it microscopically, Dr. Westerfield stated he would not recommend a biopsy for this gentleman if he were a patient or a friend of his. *Id.* Counsel stated they were not asking about a biopsy but simply asking if it was possible that he would have it microscopically in his lungs; Dr. Westerfield said it was possible. (EX5 at 34).

On re-direct Dr. Westerfield clarified that he stopped treating patients for respiratory diseases 20 years earlier. (EX5 at 34). He stated that if someone had a loss in lung function over time due to coal dust exposure, the values would not have improved like they did after Dr. Istanbouly's testing. *Id.* Lung function would deteriorate, not improve. *Id.* Dr. Westerfield became a B-reader in 1991. *Id.* Dr. Westerfield reviewed hundreds of chest x-rays a year. (EX5 at 35). If there was no biopsy or autopsy pathology, the best way to determine if someone had CWP would be imaging techniques and pulmonary testing for function. *Id.* The big picture was the respiratory functioning. *Id.* If he had normal function, then it was likely that he had no disease. *Id.* But it was possible that he did have the disease and that was why Dr. Westerfield looked at the films. *Id.* Dr. Westerfield saw no evidence of interstitial fibrosis on his review of either of the chest films. *Id.* On re-cross, Dr. Westerfield agreed that the improvement in spirometry could be differing facilities. (EX5 at 36).

The Arbitration Hearing

Petitioner's case proceeded to arbitration on August 15, 2018. Petitioner was the sole witness testifying at the hearing. Petitioner was born on July 7, 1944 and was 74 years of age at the time of the hearing. He was married for approximately 52 years before his wife passed away. He had an 11th grade education and received his GED when he was in the service. Petitioner entered the Army in October 1961 and served until October 1964. From March 1965 until February 1966 he worked at a gas station in Carmi, Illinois. In February 1966 he hired on at Babcock & Wilcox in Mt. Vernon, Indiana. He worked there until 1980 as a welder and welder foreman. He stated that his employment at Babcock & Wilcox was the only time that he did not perform heavy manual labor and that was due to union rules associated with that employment.

In March 1980, Petitioner started working in the coal mines at Inland Steel No. 2 in McLeansboro. He worked there until March 1984; in March 1984 he went to work at the Carmi mine. He worked underground as a roof bolter (five years) and a coal driller (three years). He then worked another 25 years on top in the prep plant, welding, performing plant maintenance, and running equipment. During his employment he was exposed to coal dust, welding fumes, sulfur fumes and fumes from cutting wear plates in the chutes. The conditions were worse above-ground than below ground. The underground mine always had air circulating throughout the face from the six entries. The air in the prep plant was stagnant because there were only ventilation fans on the top

floor for the first two years. After two years, the mine allowed the workers to cut the prep plant siding and put in 6x4 windows on each floor that gave a little ventilation and helped quite a bit.

Petitioner stated that he began having breathing problems a couple of years before he retired. He would notice it while walking up the belt lines because that was the most fatiguing; all five belt lines were steep and they had to carry 25-pound rollers up the belt lines along with their tools. When he was working alone, he would take breaks but did not when he worked with others because he did not want anyone to know he was having problems. Petitioner would also become winded if he had to go up all eight floors to the top of the plant. He would usually have to stop after two flights. He would occasionally have to carry his tools up the steps if the outside construction crew took the cage from the hoist. Petitioner stated the chutes were just a little wider than his shoulders which was a very confined area when he was welding or cutting. He also changed out 200-pound shaker screens (with other workers) and would also run the dozer. Petitioner stated that he worked third shift and, except for the last couple of years at the mine, there was no coal mining during that shift.

Petitioner's last day of work in the coal mines was December 21, 2012. He was working for Alliance/White County Coal, Pattiki Mine in Carmi, Illinois. He was 68 years old at the time and his job classification was "a working lead man." He had about six people working under him but he had to do the same things they did because they were under-manned. He was exposed to and did breathe coal dust on that day. On the last day at the mine, Petitioner performed his regular job, walking the belt lines and going through the plant, making sure everything was okay, checking with his people, making sure their jobs were going right. It was the last day of work before Christmas shut down. Petitioner was scheduled for hernia surgery on January 6, 2013 and used some extra vacation time so he wouldn't have to go back the day after New Year's Day like everyone else. He was off for about four weeks after the surgery and he retired in the middle of February 2013. He retired because he was getting older and couldn't really handle the job because walking the belt lines wore him out. Petitioner did not advise anyone at White County Coal that he was leaving due to a pulmonary condition when he left the mine.

Petitioner's treating physician was Dr. Stricklin in Carmi. A few years earlier, Petitioner went to Dr. Stricklin for bronchitis and was given antibiotics. That was the last time Dr. Stricklin assisted Petitioner with any kind of breathing problem. Petitioner confirmed he was not using any type of inhaler and was not taking any breathing medications. Petitioner stated that his physicians took x-rays but never diagnosed him with pneumoconiosis. Petitioner stated he currently had breathing problems. He estimated that he could walk about one city block on flat level ground at a normal pace before he would notice a change in his breathing. He noticed this on a trip to New York City to visit his brother the previous year. He could only do two flights of stairs. His breathing worsened after leaving the mine because he could not keep up with his grandson when racing in the swimming pool. Petitioner's pool was 36 feet long and he would have to stop at the end and catch a little breath before he could swim back. Petitioner's breathing problems effected his daily life. He used a riding mower to cut his lawn now instead of push mowing it, had difficulty moving 40 35-pound pavers and had difficulty carrying a case of water from the street to his garage.

Petitioner began smoking when he was 15 and quit 15 years later in 1975. He smoked about one pack a day during that time. In addition to his breathing problems, Petitioner had high blood pressure, high cholesterol, acid reflux problems and used a CPAP. Petitioner agreed it would be fair to state that he completed his job every day at the mines, but at the end it was getting harder than when he began. He just did not show it to anybody. When asked if he could do his last job in the coal mines physically, Petitioner answered, "Not sufficiently."

The Arbitrator concludes:

Section 6(c) of the Occupational Disease Act requires an employee to file a claim for benefits within three years of the last date of exposure. 820 ILCS 310/6(c). Claims for coal workers' pneumoconiosis must be filed within five years of employee's last date of exposure. *Id.* Petitioner's last date of exposure was on December 21, 2012 and his claim was filed on March 11, 2015. Therefore, Petitioner's claim is valid for any occupational disease, including coal workers' pneumoconiosis.

The Occupational Disease Act requires the employee to prove he was disabled within two years of his last date of exposure. 820 ILCS 310/1(f). Disablement is defined under the Act as an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body, or the event of becoming disabled from earning full wages at the work in which the employee was engaged when last exposed to the hazards of the occupational disease by the employer from whom he or she claims compensation, or equal wages in other suitable employment. 820 ILCS 310/1(e). Therefore, pursuant to Sections 1(e), 1(f) and 6(c), the employee must show that he was disabled from coal workers' pneumoconiosis or any other occupational disease prior to December 21, 2014.

During the arbitration hearing the Arbitrator had the opportunity to observe Petitioner while he testified. Petitioner showed no signs of breathing difficulties nor did he cough during the hearing. He appeared very physically fit.

Coal Workers Pneumoconiosis.

Petitioner's NIOSH records, that spanned from 1980 to 2000, were all negative for coal workers' pneumoconiosis. (EX6). None of the chest x-rays in Petitioner's medical records, that spanned from 2000 to 2017 diagnosed coal workers' pneumoconiosis. (EX7 at 312; EX9 at 352, 361; EX7 at 300; EX13 at 1; EX7 at 270; EX13 at 2; EX9 at 268; EX7 at 38; EX9 at 60; EX7 at 10-11; EX9 at 12). An October 14, 2013 abdominal CT scan noted clear lung bases. (EX7 at 198; EX9 at 229). The chest x-ray from January 21, 2000 specifically found the film was negative for CWP (EX7 at 312) and the film from February 2, 2006 found normal lung fields (EX9 at 352, 361). The October 13, 2010 and February 22, 2012 films found Petitioner's lungs were clear of active infiltrate and had a final impression of "no active cardiopulmonary disease," (EX7 at 300; EX13 at 1; EX7 at 270; EX13 at 2). The December 17, 2012 chest x-ray found clear lungs. (EX9 at 268). The December 21, 2016 found the lung fields were "without acute process." (EX7 at 38). Both the February 8, 2017 and March 1, 2017 chest x-rays found the lungs were clear. (EX9 at 60; EX7 at 10-11; EX9 at 12).

The experts reviewed two films: January 29, 2015 and May 12, 2017. The first film taken at Ferrell Hospital on April 29, 2015 had no reading from that facility. The film was read as positive for CWP at a 1/0 ILO classification by Dr. Smith, Dr. Alexander and Dr. Crum. Dr. Smith and Dr. Alexander found the disease in all zones with p/p opacities. Dr. Crum found the disease in all lobes but the bottom left zone with p/q opacities. Dr. Istanbouly reviewed the film and found it was "early stage," "mild" CWP with interstitial fibrosis. He could not recall which zones the disease was in. The film was also reviewed by Dr. Westerfield, Dr. Meyer and Dr. Tarver who all read the film as negative for the disease. (EX3; EX1at 3-4; EX2 at 3-4).

A second film was taken as part of Dr. Westerfield's IME in May of 2017. Both Dr. Baker and Dr. Alexander read the film as positive for CWP at a 1/0 ILO classification but Dr. Baker classified the opacities as t/t in the mid and lower zones only and Dr. Alexander classified the opacities as p/p in all the lung zones. Dr. Westerfield, Dr. Meyer and Dr. Tarver read the film as negative for CWP. (EX4 at 13, EX1 at 1-2; EX2 at 1-2).

Considering all of the radiological evidence, as well as Dr. Istanbouly's statement that the hospital radiologists would note any findings similar to opacities in their reports, the preponderance of the evidence fails to support a finding that Petitioner has coal workers' pneumoconiosis. Even if Petitioner had the disease, there is no film prior to December 21, 2014 diagnosing the condition and there is no testimony that Petitioner had the disease in the two-year period required by 820 ILCS 310/1(f). Petitioner's decision to stop working for Respondent on December 21, 2012 was completely voluntary. As he explained it, he was scheduled for hernia surgery and needed to use vacation time. After the hernia surgery, he decided to retire. Furthermore, Petitioner's history to Dr. Istanbouly is not supported by the medical records as they fail to corroborate a history of daily coughing for five to six years.

Chronic Bronchitis

Dr. Istanbouly opined that Petitioner's symptoms were consistent with chronic bronchitis. (PX1 at 26-27). These symptoms included coughing with sputum production for the past 5-6 years. (PX1, Exh. 2 at 1). Dr. Istanbouly attributed these symptoms to Petitioner's coal dust exposure. (PX1). Dr. Istanbouly did not review Petitioner's medical records either prior to or after the exam (PX1 at 23-35) but stated that he expected Petitioner would have reported these same symptoms to his treating physicians. (PX1 at 26). Dr. Istanbouly could not recall if Petitioner coughed during his examination. (PX1 at 25). Petitioner provided no testimony regarding either coughing or chronic bronchitis. Petitioner's medical records revealed complaints of cough on February 7, 2011 (EX7 at 293-295), December 28, 2011, (EX7 at 275-277), February 19, 2013 (EX7 at 222-224), October 26, 2015 (EX9 at 133) and March 14, 2016. (EX7 at 75-80). None of those physicians diagnosed chronic bronchitis or claimed the cough was caused by coal dust exposure. *Id.* Conversely, Petitioner specifically denied cough on January 16, 2006 (EX9 at 318), January 24, 2011 (EX7 at 297-299; EX14 at 58-59), January 27, 2012 (EX7 at 271-272; EX14 at 56-57), November 25, 2013 (EX7 at 184-186), December 27, 2013 (EX7 at 174-176; EX10 at 42-44), January 31, 2014 (EX7 at 171-172; EX14 at 52-53), May 1, 2014 (EX7 at 158-160; EX10 at 10-12), February 6, 2015 (EX7 at 131-132; EX14 at 48-51); August 19, 2015 (EX7 at 107-108; EX14 at 19-22); September 17, 2015 (EX7 at 103-104; EX14 at 13-16); October 8, 2015 (EX14 at 10-13), February 12, 2016 (EX14 at 17-19), and February 17, 2017 (EX7 at 21-22; EX14 at 4-7). "Declarations of an injured person to the treating physician as to his physical condition, and the cause thereof, are admitted into evidence for the reason that it is presumed that a person will not falsify such statements to a physician from whom he expects and hopes to receive medical aid." *Shell Oil v. Industrial Commission*, 2 Ill.2d 590, 602 (1954). Petitioner's repeated denials of the condition to his treating physicians outweigh Dr. Istanbouly's opinion. The preponderance of the evidences fails to support a diagnosis of chronic bronchitis or that Petitioner's cough was due to coal dust exposure.

Dyspnea and Shortness of Breath

Dr. Istanbouly also attributed Petitioner's symptoms of dyspnea and shortness of breath to coal dust exposure. (PX1 at 8-9, 10). Dr. Istanbouly stated that Petitioner did not seem to be out of breath during the examination but Petitioner told him the condition occurred with exertion and at night. *Id.* Dr. Istanbouly did not perform any exercise testing. (PX1 at 25). Dr. Istanbouly believed that Petitioner would have reported these symptoms to his treating physicians. (PX1 at 25-26). Petitioner testified that he had shortness of breath, however, Petitioner's medical records reveal Petitioner denying dyspnea and/or shortness of breath on January 16, 2006 (EX9 at 318), January 24, 2011 (EX7 at 297-299; EX14 at 58-59); December 17, 2012 (EX7 at 242-243; EX9 at 259-260), January 30, 2013 (EX7 at 233-235; EX14 at 54-55), April 15, 2013 (EX7 at 220-221; EX11 at 16-17), May 6, 2013 (EX7 at 218-219; EX11 at 11-12), July 29, 2013 (EX7 at 208-209; EX11 at 8-9), November 25, 2013 (EX7 at 184-186), January 31, 2014 (EX7 at 171-172; EX14 at 52-53), October 8, 2014 (EX7 at 146-147; EX11 at 5-6), February 6, 2015 (EX7 at 131-132; EX14 at 48-51), August 19, 2015 (EX7 at 107-108; EX14 at

19-22), September 3, 2015 (EX14 at 17-19), September 17, 2015 (EX7 at 103-104; EX14 at 13-16), October 8, 2015 (EX14 at 10-13), October 26, 2015 (EX9 at 133), February 12, 2016 (EX14 at 7-10), March 14, 2016 (EX7 at 75-80), January 31, 2017 (EX7 at 31-32; EX11 at 2-3), February 17, 2017 (EX7 at 21-22; EX14 at 4-7), and March 1, 2017 (EX7 at 13-14; EX9 at 7-8). Petitioner's repeated denials of the condition in his medical records are inconsistent with Petitioner's testimony and outweigh Dr. Istanbouly's opinion. "Declarations of an injured person to the treating physician as to his physical condition, and the cause thereof, are admitted into evidence for the reason that it is presumed that a person will not falsify such statements to a physician from whom he expects and hopes to receive medical aid." *Shell Oil v. Industrial Commission,* 2 Ill.2d 590, 602 (1954). The preponderance of the evidence fails to support a finding that Petitioner has dyspnea and/or shortness of breath and further fails to support a finding of an occupational disease. For these reasons, benefits are denied and all other issues are moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph Edwards,
Petitioner,

vs. NO: 16 WC 24420

19IWCC0257

Padgett Building & Remodeling.
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that, other than as stated above, the Decision of the Arbitrator filed February 28, 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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $59,000.00. 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: MAY 2 2 2019

Marc Parker

Barbara N. Flores

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mp-wj
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DISSENTING OPINION

I respectfully dissent from the Decision of the majority. The Commission affirmed and adopted the Decision of the Arbitrator, issued pursuant to Sections 8(a) and 19(b) of the Act. The Arbitrator found that Petitioner's current condition of ill-being of the lumbar spine was causally connected to a work accident, awarded 69 weeks of temporary total disability benefits (to the date of arbitration), $38,250.55 in current medical expenses, and ordered Respondent to authorize and pay for prospective surgery recommended by Dr. Gornet. I would have modified the Decision of the Arbitrator to find that Petitioner reached maximum medical improvement from his work-related injury as of February 14, 2017, that the current condition of ill-being of his lumbar spine was causally related to an intervening accident, and accordingly I would have denied benefits after February 14, 2017.

Petitioner sustained a stipulated accident on June 17, 2016 in which he suffered an injury to his lumbar spine. He came under the care of orthopedic surgeon, Dr. Kelly, who noted that Petitioner complained of 90% back pain and 10% right-leg pain. Petitioner had an MRI on June 30, 2016. On October 4, 2016, Dr. Kelly noted that Petitioner's leg-pain had resolved. Dr. Kelly recommended work hardening. After work hardening, Petitioner had a Functional Capacity Evaluation ("FCE") on February 13, 2017. Petitioner was rated to be able to work at the heavy physical demand level, with the ability of lifting 95 pounds occasionally, lifting 40 pounds over head frequently, and carrying 75 pounds occasionally. Petitioner's job required very heavy physical demand level.

On February 14, 2017, Petitioner returned to Dr. Kelly who noted that Petitioner rarely still had pain with heavy lifting. Dr. Kelly declared Petitioner at maximum medical improvement, released him to work with restrictions pursuant to the FCE, recommended Petitioner try to get an accommodation from his employer for the minimal difference between the heavy physical demand level and very heavy physical demand level, and released Petitioner from treatment.

Petitioner called Dr. Kelly's office on April 4, 2017 reporting that a few days earlier he was getting out of a chair at home and felt a "pop" in his back. Petitioner reported he was "brought to his knees" and it took his breath away. He wanted to be treated for this "new" situation. Dr. Kelly informed Petitioner that no new testing or treatment was authorized, and it might not be covered by either workers' compensation or his group insurance. Petitioner transferred his medical records from Dr. Kelly to Dr. Gornet.

Petitioner first saw Dr. Gornet on May 13, 2017. Dr. Gornet placed restrictions on Petitioner consisting of lifting no more than 25 pounds, no repetitive bending/lifting, and being able to alternate sitting/standing. He also ordered another MRI. In comparing the new MRI to the prior MRI, Dr. Gornet noted that his condition had worsened in the interim. Eventually, Dr. Gornet recommended two-level disc replacement surgery.

Petitioner testified that after his last visit to Dr. Kelly he worked out at the YMCA and did yard work. He also testified that when he began treating with Dr. Gornet his condition had worsened, which was the reason Dr. Gornet placed the greater restrictions on his work activity. Initially, Petitioner did not remember any intervening accident or that he reported feeling a pop in his back. However, later on cross examination he testified that he was watching television at home when he felt a pop in his back. He also agreed that he called Dr. Kelly seeking treatment for increased pain.

In my opinion, Petitioner did not sustain his burden of proving that his current condition of ill-being was causally related to his work accident on June 17, 2016. Rather, the medical records indicate that Petitioner had recovered from his work-related injury at the time his FCE determined the extent that he was able to work, a heavy physical demand level. At that time, Dr. Kelly declared him at MMI, released him to work at the heavy demand level, and released him from treatment. In my opinion, the incident around April 1, 2017 constituted an intervening, non-work-related accident and his current condition of ill-being is causally related to that intervening accident. I base that opinion on Dr. Kelly's declaration of Petitioner at MMI as of February 14, 2017, his release of Petitioner to work at a heavy physical demand level and from treatment at that time, Petitioner's worsened condition after that incident both objectively (MRI findings) and functionally (much stricter restrictions after that accident), and the fact that surgery was not recommended prior to that accident, but it was after the accident.

For the reasons stated above, I would have modified the Decision of the Arbitrator to find that Petitioner reached maximum medical improvement from his work-related injury as of February 14, 2017, that his current condition of ill-being of the lumbar spine was causally related to an intervening accident, and accordingly I would have denied benefits after February 14, 2017. Therefore, I respectfully dissent from the Decision of the majority.

Deborah L. Simpson

Deborah L. Simpson

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

EDWARDS, JOSEPH
Employee/Petitioner

Case# **16WC024420**

16WC026548

PADGETT BUILDING & REMODELING
Employer/Respondent

19IWCC0257

On 2/28/2018, 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:

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

2593 GANAN & SHAPIRO PC
ROBY JAVORONOK
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

19IWCC0257

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JOSEPH EDWARDS
Employee/Petitioner

v.

PADGETT BUILDING & REMODELING
Employer/Respondent

Case # **16** WC **24420**

Consolidated cases: **16 WC 26548**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **October 13, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☒ What were Petitioner's earnings?

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

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

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

K. ☒ Is Petitioner entitled to any prospective medical care?

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other ______

FINDINGS

On the date of accident, **June 17, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$46,799.50**; the average weekly wage was **$1,073.38**.

On the date of accident, Petitioner was **46** 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 **$28,724.05** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$28,724.05**.

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

ORDER

As explained in the Arbitration Decision, Petitioner's current condition of ill-being with regard to his low back is causally related to the accident of June 17, 2016. Petitioner has not reached maximum medical improvement.

Respondent shall pay reasonable and necessary medical services totaling **$38,250.55**, as set forth in Petitioner's Exhibit 1, subject to the medial fee schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for amounts previously paid.

Respondent shall pay for prospective medical treatment related to his lumbar spine, including surgery, as recommended by Dr. Gornet.

Respondent shall pay Petitioner temporary total disability benefits of **$715.59** per week for **69 weeks**, for a total of $49,375.71 for the period of June 18, 2016, through October 13, 2017, the date of hearing, related to his accident of June 17, 2016. Respondent shall receive credit for benefits previously paid in the amount of $28,724.05, and shall pay the remaining amount of **$20,651.66**.

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

February 26, 2018
Date

FEB 28 2018

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JOSEPH EDWARDS
Employee/Petitioner

19IWCC0257

v.

Case #: **16 WC 24420**
(DOA 6/17/16)
Consolidated with
16 WC 26548
(DOA 2/18/16)

PADGETT BUILDING & REMODELING
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

This cause came before the Arbitrator on Petitioner's Section 19(b) Petition. The parties stipulated that Petitioner sustained two separate accidents which arose out of and in the course of his employment, on February 18, 2016, and June 17, 2016. Both accidents resulted in injuries to his low back. The parties stipulated that all current disputed issues are related to the accident on June 17, 2016, (16 WC 24420) and not the accident on February 18, 2016 (16 WC 26548). Those issues are causal connection, Petitioner's earnings, liability for past and prospective medical services and charges, and liability for temporary total disability. Upon Petitioner's oral motion at arbitration, and with no objection by Respondent, the cases were consolidated *instanter*.

At the time of both accidents, Petitioner was 45 years old, single, and had three dependent children. He was employed by Respondent as a union carpenter and foreman, and had been so employed for more than ten years.

Petitioner testified that on **February 18, 2016,** (16 WC 26548) he was hanging cabinets on a wall when he began experiencing low back pain. He sought treatment at Express Medical Care, missed four days of work, and then returned to full duty. No issues with regard to this first accident were in dispute at this hearing.

Petitioner's second low back injury occurred on **June 17, 2016,** (16 WC 24420) while he was moving a base cabinet while still on his knees. Petitioner testified that he was lifting and sliding a cabinet sideways when he felt something in his back pop that "dropped [him] to [his] hands" and rendered him unable to stand on his own. He was helped to his feet and went home

early, hoping his symptoms would resolve. Petitioner testified that his symptoms have remained since that time and he has been unable to return to work since that date. While Respondent agrees that Petitioner's second injury also arose out of and in the course of his employment, Respondent disputes causal connection beyond February 14, 2017, the reasonableness and necessity for medical expenses beyond February 14, 2017, liability for temporary total disability benefits beyond May 14, 2017, liability for prospective medical care, and Petitioner's claimed average weekly wage. Respondent also believes that Petitioner sustained an intervening accident on or about April 4, 2017. Petitioner testified he had no previous low back injuries or treatment prior to his first work accident in February of 2016.

Following the second injury, Petitioner presented to the emergency department of Belleville Memorial Hospital on June 19, 2016, with complaints of pain in his low back and into his right leg for three days after lifting a cabinet at work. Lumbar x-rays were unremarkable. Petitioner was given a Toradol injection and prescriptions for acetaminophen with codeine, cyclobenzaprine, and ibuprofen. He was given work restrictions of no lifting and instructed to follow up at Memorial Pain Center. PX4.

On June 22, 2016, Petitioner presented to Memorial Pain Center and was evaluated by Dr. Anderson. He reported a consistent history of the accident, indicating that the incident "took his breath away". He complained of severe sharp pain in his lower lumbar region and right leg weakness. Dr. Anderson assessed lumbar pain with radiation down the right leg. He ordered an MRI and physical therapy and advised Petitioner to continue light duty restrictions. PX5.

On July 5, 2016, Petitioner returned to Dr. Anderson. He complained of lower back pain, greater on the right, which radiated into both hips and down the right lateral leg. He described a dulled sensation along with a sensation that his right leg was weaker than his left at times. It was noted that he had undergone a lumbar MRI on June 30, 2016. The Arbitrator notes, however, that the actual MRI report was not included in the record. Dr. Anderson noted that the radiologist interpreted the MRI as revealing: (1) disc bulge with superimposed protrusion and extruded fragment at L4-5 asymmetric to the right; (2) bilateral neuroforaminal narrowing at L4-5; and (3) disc bulge at L5-S1 with posterior annular tear and left neuroforaminal narrowing. On examination, there was increased pain with range of motion, positive straight leg raise on the right, decreased sensation on the right lateral calf, and abnormal gait of favoring the right leg. Assessment was right lumbar radiculitis. Dr. Anderson recommended a selective nerve root block at right L5 and referral to physical therapy. PX5. The Arbitrator notes this is the final treatment record from Dr. Anderson/Memorial Pain Center.

On July 12, 2016, Petitioner presented to Dr. Matthew Kelly at Washington University Physicians. He reported he was lifting something heavy at work and felt a popping feeling with immediate low back pain and some leg pain. He advised the leg pain had subsided but the back pain was still substantial, with 90% of his current pain coming from the back and 10% coming from his right leg. He noted that the pain travelled through his right buttock and down into his right thigh, calf, and foot. He had no left leg pain. Dr. Kelly noted that Petitioner had tried anti-inflammatory medication and oral opioid medication without lasting relief, but was "not particularly interested in surgery". He was notably "very dissatisfied with his current state of health" and indicated he had missed three and a half weeks of work because of the pain. Dr. Kelly

noted that Petitioner had been unable to return to work because of substantial low back pain which he rated as 5/10 and which was exacerbated by bending, walking, or any other activity. Dr. Kelly reviewed the MRI and noted findings of an extruded right-sided paracentral disc fragment at L4-5 and disc degeneration with an annular tear at L5-S1. He recommended Petitioner remain off work with no lifting greater than ten pounds. He noted that Petitioner was "at substantial risk of reherniation with reinjury if he returns to work at this time". He recommended six additional weeks of healing, followed by physical therapy. PX6.

Petitioner returned to Dr. Kelly on August 23, 2016, and reported continued back pain and occasional right leg pain. It was noted that he had "a steppage gait on the right" when walking. Petitioner reported he had been working with physical therapy and could pick up 15 pound boxes with minimal pain. Dr. Kelly noted he would need to pick up 50 to 75 pound boxes on a routine basis. Petitioner was kept off work and was to continue physical therapy, working on core strengthening. He was instructed to return in six weeks. PX6.

On October 4, 2016, Petitioner followed up with Dr. Kelly and reported his leg pain had mostly resolved, but he had some right-sided lateral thigh paresthesias. He also had persistent low back pain and paraspinal spasms type pain. Petitioner reported he had been participating in physical therapy with work hardening exercises and believed he was making some progress. He stated he would like to return to work and would like to avoid surgery. Dr. Kelly's assessment remained herniated nucleus pulposus and annular tear syndrome. He recommended four more weeks of graduated work hardening. PX6.

On November 8, 2016, Petitioner returned to Dr. Kelly and reported he had slowly increased his activity with physical therapy. He was lifting a bit more but the time duration was still short. He reported his pain was improved, but he felt he was only 50% better and "far from his baseline". Dr. Kelly recommended continued therapy with work hardening and simulation exercise. He noted Petitioner "should remain out of work until he has returned to his baseline". Petitioner followed up on December 6, 2016, and reported he had not completed a work hardening program with physical because it was denied by insurance and they had requested a second opinion. He continued to report low back pain with occasional severe pain with activity. He was instructed to remain off work. Dr. Kelly continued to recommend work hardening, but noted they would wait for the second opinion. PX6.

On December 7, 2016, Petitioner was evaluated by Dr. Benjamin Crane, Respondent's Section 12 examiner. He reported a consistent history of his two separate accidents at work. He further reported that his current complaint was primarily back pain, which he rated at 4-5/10 at its best and 8/10 at its worst. He advised that the pain was made worse with activities of daily living, and that he had trouble sitting for an extended period of time and rising from a seated position. He advised he could sit, stand, and walk for an unlimited time, but may experience discomfort when doing so. Dr. Crane reviewed the MRI, as well as a surveillance video of Petitioner sitting in the bleachers during a basketball game. He assessed low back pain, which he causally related to Petitioner's work injury of June 17, 2016. Dr. Crane agreed with the recommended work hardening three days a week, followed by a functional capacity evaluation. He did not recommend anything surgical. With regard to restrictions, he recommended light duty with no bending, pulling, pushing, or stooping, no lifting more than ten pounds, and no overhead lifting. He

recommended restrictions remain in place pending review of the FCE results to evaluate potential permanent restrictions prior to being released at maximum medical improvement. PX19.

On February 13, 2017, Petitioner underwent an FCE, which demonstrated that Petitioner was able to perform work that fell within the "heavy" category, but not the "very heavy" demand level of his employment. The evaluation also limited Petitioner to only *occasional* bending, occasional floor to waist lifting up to 95 pounds, frequent lifting overhead up to 40 pounds, and occasional carrying up to 75 pounds. It was noted that Petitioner's job required tolerances of *frequent* bending, floor to waist lifting up to 110 pounds, overhead lifting up to 50 pounds and carrying up to 110 pounds. Consequently, the required job tolerances were not met. PX9.

Petitioner returned to Dr. Kelly on February 14, 2017, and reported that he continued to have some back pain but was making progress. Dr. Kelly noted that the FCE placed Petitioner in the "heavy" job category and that his job requirements fell into the "very heavy" category. He placed Petitioner at maximum medical improvement and advised that his "future work should be in the heavy duty category". He recommended Petitioner speak with his employer to see if accommodations could be made for these limitations. He further recommended that Petitioner continue to work with physical therapy to increase his strength, including core musculature. PX6.

Petitioner subsequently began suffering from anxiety and depression, due to his work injury. He sought care and treatment with Dr. James Wade, who noted the onset of anxiety and depression symptoms since his back injury along with weight gain. Dr. Wade treated Petitioner with medications such as Trintellex, Xanax, and Celexa, and continued to monitor Petitioner's symptoms. PX10.

On March 17, 2017, Dr. Crane provided an addendum opinion after reviewing notes from the physical therapist during work conditioning and the FCE. He believed that the FCE demonstrated a relatively full and consistent effort, and noted the study showed Petitioner fell into what was described as a "heavy" physical demand labor category, though his job required a "*very* heavy" demand. He opined that the difference between the two categories was very minimal and recommended Petitioner return to work without restriction as the difference between the heavy and the very heavy demand was small. Dr. Crane noted that if Petitioner continued to do his home exercises, he would have no difficulty doing the very heavy lifting, and he could ask for assistance for some of the repetitive heavy lifting while at work, if necessary. RX8.

The records from Dr. Kelly's office reflect that Petitioner called on April 4, 2017, and reported he had not yet gone back to work yet, and had been trying to increase his activity at home, including working in his yard/garage, and going to the YMCA. The record noted that a few days prior he was at home getting up from his chair when he felt a "pop" in his back, which brought him to his knees and took his breath away. Petitioner stated he wanted to see someone regarding this new issue. Dr. Kelly's nurse advised him that his problem may not be considered under workers' comp, and advised that Petitioner may want to see Dr. Gornet, as he does much more low back work comp work and may be able to assist Petitioner with his issue. Petitioner thereafter made an appointment with Dr. Kelly for May 2, 2017, though the nurse noted it would most likely need to be canceled but she would wait to her from the work comp team. RX4.

Dr. Kelly's records reflect that his office called Petitioner on April 6, 2017, advising that no further treatment or testing was authorized as his claim was moving towards settlement. Petitioner stated he was not aware of that and would be calling back. Petitioner called back on April 13, 2017, asking that his information be sent to Dr. Gornet's office for further treatment at which time he was again advised that his new issue may not be covered by work comp or his private insurance, and it would be up to Dr. Gornet's office as to how to handle the situation. Petitioner acknowledged he was aware it might not be covered, but requested the referral anyway. Petitioner was going to call Dr. Gornet's office and get a visit set up. RX4.

Petitioner testified that the incident referred to in Dr. Kelly's records was simply him getting up from a chair at home and that he was doing nothing other than sitting and watching television when this occurred. He further testified that this was the same pain as he had been experiencing since his work injuries. He expressly denied any sort of intervening accident or trauma. He testified that he attempted to return to Dr. Kelly, but that his office would not provide further care because they could not obtain approval from Respondent and did not believe Respondent would cover the expenses for additional treatment. As such, Dr. Kelly referred Petitioner to Dr. Gornet.

On May 13, 2017, Petitioner presented to Dr. Matthew Gornet of The Orthopedic Center of St. Louis, upon referral by Dr. Kelly. He reported a consistent history of the accident of June 17, 2016, and his treatment to date. He also reported the earlier work accident in February 2016 and noted he had been off work for four days and returned without issues. He denied any prior low back problem of significance. Dr. Gornet noted that despite the physical therapy and FCE restrictions recommended by Dr. Crane, Petitioner continued to have pain and symptoms which were significantly affecting most aspects of his life and his quality of life. After reviewing Petitioner's records, Dr. Gornet believed that he could be improved to the point where he could return to his former employment if Petitioner was motivated to do so. He prescribed Meloxicam and Cyclobenzaprine, recommended a new MRI scan, and referred Petitioner for injections. He again placed Petitioner on light duty, with restrictions of no lifting over 25 pounds, no repetitive bending or lifting, and instructions to alternate between sitting and standing as needed. PX11.

Petitioner presented to Dr. Boutwell upon referral by Dr. Gornet for the recommended epidural steroid injections at L4-5 on June 22, 2017, and L5-S1 on July 6, 2017. PX13. Petitioner underwent a lumbar MRI on July 26, 2017. It revealed central disc herniations at L4-5 and L5-S1, larger at the L4-5 level, annular fissures at both levels with bilateral foraminal narrowing, and disc bulge with flattening of the dura at L3-4. PX12. Petitioner returned to Dr. Gornet on July 24, 2017, and reported temporary relief following the injections by Dr. Boutwell, but stated that his symptoms returned. Dr. Gornet reviewed Petitioner's new MRI scan and noted the obvious L4-5 and L5-S1 injuries as well as the subtle suggestion of an annular tear at the L3-4 level. He recommended a CT discogram at L3-4 to determine whether it was a source of pain, as well as MRI spectroscopy from L2-S1 to determine any other provocative levels. Given that Petitioner had tried and failed conservative measures, Dr. Gornet recommended surgery, and stated this was Petitioner's best option for returning to full-duty work with no restrictions. PX11.

Petitioner underwent the MRI Spectroscopy on August 9, 2017. The Arbitrator notes that the report following this study included no summary or findings paragraph, but rather only

provides a "Pfirrmann scale analysis" and a "Modic Grade". PX12. Petitioner underwent the discogram August 22, 2017, which showed a non-provocative disc at L3-4. PX14.

Petitioner returned to Dr. Gornet on September 14, 2017, who went over the results of the diagnostic testing. Dr. Gornet noted that based on the test results, Petitioner had two-level disc pathology. He recommended a two-level disc replacement at L4-5 and L5-S1. He again opined that such surgery gave Petitioner the best chance of returning to work full duty with no restrictions, but noted he would be off work for six to nine months post-surgery. PX11. The Arbitrator notes this is the final treatment record from Dr. Gornet.

On September 6, 2017, Petitioner was again examined by Dr. Crane pursuant to Section 12. He reported pain on average of about 6/10 and as high as 10/10 after sitting for an extended period of time or rising from a sitting position. Dr. Crane reviewed Petitioner's most recent diagnostic studies and reiterated his prior opinion that there was nothing that needed to be done surgically for Petitioner, as he did not appreciate any change from his initial examination. Based on Petitioner's functional capacity evaluation, Dr. Crane opined that Petitioner was at maximum medical improvement and could return to work without restrictions at a very heavy demand level. Respondent also asked Dr. Crane to comment on what it alleged to be an intervening accident on April 4, 2016, when Petitioner arose from a chair and felt severe pain. Dr. Crane's comments in response to this series of questions were as follows:

Q4: Please inquire if there were any other inciting events or incidents that occurred following his release from care at MMI on February 14, 2017, that caused a significant increase in his symptoms, such as when going to the YMCA and performing yard work.

A4: The patient reported no other incidents following his declaration of MMI of February 14, 2017, that would be contributing to his continued back pain.

Q5: Please address the record of April 4, 2016, [sic] and confirm the date the incident occurred a few days earlier when getting out of a chair, such as if was on April 1, 2016 [sic]?

A5: I am unaware of any change in the date of injury as it relates to this petitioner

Q6: What is your diagnosis as it relates to the incident that occurred at Petitioner's home on or around April 1, 2017, after he was released from care on February 14, 2017? Further please identify whether the incident explained in the phone record of Dr. Kelly on April 4, 2016, [sic] causes a permanent aggravation, or at a minimum, an acceleration of any pre-existing deleterious process faster than the normal degenerative process of human aging to his back condition.

A6: The time frame between release at MMI and recurrence of his symptoms was under two months. As such, I feel his initial injury at work is the prevailing factor in causing his back pain and need for subsequent treatment.

Although Dr. Crane indicated that he did not appreciate any change in Petitioner's condition since his initial IME that would change his treatment recommendations, he stated that he believed the additional diagnostic tests recommended by Dr. Gornet as well as any additional physical therapy and injections were reasonable and necessary as they related to Petitioner's work injury of June 17, 2016. He recommended no change in Petitioner's restrictions as outlined in his initial IME. He gave Petitioner an impairment rating of 3% "permanent partial impairment" of the lumbar spine. PX20.

Dr. Gornet testified by way of deposition on July 26, 2017. He is a Board Certified Orthopedic Surgeon whose practice is devoted to surgery and treatment of the spine. He testified

that Petitioner was referred to him by his first physician, Dr. Kelly. He testified that Dr. Kelly specializes in the treatment of deformity or scoliosis, whereas he specializes in the treatment of back pain. They refer patients to one another based on the needs of the patients. PX16.

Dr. Gornet testified that he was familiar with the job duties of a union carpenter, having treated many of them in the past. He noted that they must generally be certified to lift 75 to 100 pounds or more and bend, which was consistent with the goal tolerances of Petitioner's functional capacity evaluation. He testified that Petitioner was unable to meet these demands and was therefore unable to return to full duty work as a union carpenter, which was also the ultimate conclusion expressed through the "unmet" categories of the functional capacity evaluation. He testified that when Petitioner failed to gain lasting relief from conservative measures such as epidural steroid injections and therapy, Petitioner's last option for returning to his former occupation was surgery. Dr. Gornet testified that he would anticipate Petitioner would return to his former employment within six to eight months after surgery, with 85% odds of success. PX16.

Dr. Gornet testified that he would be willing to allow Petitioner to return to work that could accommodate his restrictions. He cautioned that Petitioner would have to be followed because his condition, if left untreated, would progress. This was especially true given that there were already objective signs of worsening on Petitioner's MRI as well as increased subjective complaints from Petitioner. Given Petitioner's increased subjective complaints, Dr. Gornet modified and increased Petitioner's restrictions so as not to do further harm to his condition. PX16.

On cross-examination, Dr. Gornet testified that he was aware that Dr. Crane did not recommend surgery. He was unaware that Dr. Kelly also did not recommend surgery. PX16.

Petitioner testified that his condition has gotten worse since he was discharged from physical therapy. He would like to undergo the surgery recommended by Dr. Gornet, to allow him to return to his pre-injury state and return to his employment.

Mr. David Padgett was present on behalf of Respondent and was called to testify by Petitioner. Mr. Padgett testified he is the General Manager and owner of Padgett Building and Remodeling, which performs construction and remodeling. He testified that Petitioner is a union carpenter whose job involved a broad range of work. He was shown Respondent's Exhibit 3, which he identified as a job description for Petitioner's job duties. He testified that Petitioner's job required the performance of activities that fell within the "very heavy" category, which involved carrying more than 100 pounds. He acknowledged that he had never been able to provide any sort of light duty work for Petitioner.

Mr. Padgett acknowledged that he received a copy of Petitioner's functional capacity evaluation shortly after it was completed in February, and that he was aware of Petitioner's restrictions at that time. He acknowledged that after receiving the FCE, he did not offer Petitioner any heavy duty work from April 11, 2017, through July 31, 2017. He testified that if Petitioner could return in that capacity, Respondent could provide assistance with the job duties that fell outside his restrictions. However, Mr. Padgett then went on to inquire as to Petitioner's bending restrictions, as detailed in the FCE. He noted that the FCE indicated Petitioner could bend only on an *occasional* basis. He testified that Respondent would not be able to accommodate that

restriction, as Petitioner would need to be able to lift on a ***frequent*** basis. He testified that he could accommodate Petitioner in the heavy demand category ***only if*** he would be able to perform frequent bending. Since Petitioner cannot frequently bend, he stated, "I'm not going to put him back to work and hurt him more." He testified that he would be able to make accommodations for the other limitations, but not the bending restriction. He further testified that he would not be able to accommodate the restrictions set down by Dr. Gornet, which placed Petitioner in a lighter duty.

With regard to Petitioner's work and wage history, Mr. Padgett testified that Petitioner was never guaranteed a 40-hour work week. He testified that all of his carpenters are under the understanding that they can be at home any day of the week due to the business cycle. He explained that lack of work could be due to work being subcontracted, the weather, or the like.

In addition to Mr. Padgett's testimony, Petitioner produced correspondence/text messages from Respondent confirming that Petitioner's restrictions could not be met.

CONCLUSIONS OF LAW

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

In support of the Arbitrator's decision relating to issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

A claimant has the burden of proving by a preponderance of the credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. *Parro v. Industrial Commission*, 260 Ill.App.3d 551, 553 (1st Dist. 1994).

The parties stipulated that Petitioner sustained two separate accidents which arose out of and in the course of his employment, on February 18, 2016, and June 17, 2016. Both accidents resulted in injuries to his low back. The parties further stipulated that all current disputed issues are related to the accident on June 17, 2016, (16 WC 24420) and not the accident on February 18, 2016 (16 WC 26548). As such, the Arbitrator finds that Petitioner's current condition is not causally related to his accident of February 18, 2016 (16 WC 26548).

The Arbitrator finds that Petitioner's current condition of ill-being is causally related to his work accident of June 17, 2016, (16 WC 24420) and that he has not reached maximum medical improvement. In so concluding, the Arbitrator finds significant that the record is consistent throughout with regard to Petitioner's complaints and objective findings, which started immediately after the accident.

The record establishes that the first time Petitioner had any sort of low back problem was following his accidental work injuries, and particularly the injuries that occurred on June 17, 2016. No physician, including Respondent's examiner Dr. Crane, disputed that Petitioner's current condition of ill-being was causally connected to his injury of June 17, 2016.

Respondent relied upon two factors in support of its position of termination of benefits. First, Respondent argued that Petitioner had been placed at maximum medical improvement by Dr. Kelly on February 14, 2017, and that any problems he had after that time were not causally related to his work accident. However, being placed at MMI does not necessarily sever any causal connection between the accident and future complaints. The very purpose of Sections 8(a), 8(d), 8(e), and 19(h) of the Act is to provide compensation and/or future medical care to employees for their causally related disabilities after they have been placed at maximum medical improvement.

Second, Respondent argued that Petitioner sustained an intervening injury on April 4, 2017, when he simply stood up from a seated position and felt a pop and pain. The Arbitrator finds that this incident falls short of any sort of intervening accident. Merely experiencing symptoms following a work-related injury while performing other activities does not rise to the standard of intervening cause. *Lasley Constr. Co., Inc. v. Industrial. Comm'n*, 274 Ill.App.3d 890, 893 (5th Dist. 1995). See also *Vogel v. Industrial Comm'n*, 354 Ill.App.3d 780, 786 (2nd Dist. 2005). 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. As the Court in *Lasley*, aptly put it, "The fact that other incidents, whether work related or not, may have aggravated claimant's condition is irrelevant." *Id.* See also *Teska v. Industrial. Comm'n*, 266 Ill.App.3d 740 (1st Dist. 1994) (finding no intervening accident since there would have been no aggravation due to bowling "but for" the original work related accident and the initial injury).

In *Teska*, the claimant injured his back in a workplace accident and underwent surgery on his spine. *Teska v. Industrial Comm'n*, 266 Ill.App.3d 740 (1st Dist. 1994). After the surgery, his condition improved but he still continued to experience numbness and pain in his neck, shoulder, and left arm. While bowling, he experienced a sharp pain in his neck that radiated into his left arm. He subsequently underwent a second surgery. The Commission denied the claimant benefits for the second surgery, finding that his condition of ill-being was the result of an intervening accident (bowling). On appeal, the *Teska* court reversed the Commission's decision as being contrary to the manifest weight of the evidence. *Id.* at 740. The court noted that "[e]very natural consequence that flows from the injury which arose out of and in the course of the claimant's employment is compensable under the Act, unless caused by an independent intervening accident." *Id.* at 742. In overturning the Commission's decision, the court noted that the claimant's condition "would not have progressed to the point it did but for his original work-related accident." The court stated: "Merely because claimant experienced an upsurge of neck pains while bowling * * * does not mean the causal connection was broken." *Id.* at 742-743.

In the instant case, Petitioner was not even engaging in any sort of activity; he simply stood up from his chair at home, and experienced the same pop and pain that he suffered at the time of his original work injury while he was lifting a work cabinet, and had been suffering since. The Arbitrator gives substantial weight to the law, and to the fact that even Respondent's Section 12 examiner did not believe that Petitioner sustained any sort of new accident or intervening trauma as a result of the incident when specifically asked about the incident. Dr. Gornet and Dr. Crane both clearly stated that Petitioner's complaints are directly related to the accident injury that occurred on June 17, 2016.

Based upon the foregoing and the record in its entirety, the Arbitrator finds that Petitioner met his burden of proof on the issue of causation.

In support of the Arbitrator's decision relating to issue (G), Petitioner's earnings, the Arbitrator finds the following:

Petitioner stipulated during trial that the wage information contained within the Wage Report, Respondent's Exhibit 6, was true and accurate. The Wage Report includes wage statements during the 52 weeks preceding the injury that showed earnings of $47,537.31 including overtime, and $46,799.50 excluding overtime. There was no evidence or testimony offered to establish that Petitioner's overtime was mandatory. Accordingly, the Arbitrator finds that Petitioner's qualified earnings during the year before his injury were $46,799.50.

With regard to Petitioner's average weekly wage, Section 10 of the Act provides that when an employee has been employed during the entire 52 weeks preceding the injury, but has not worked for 5 or more calendar days during that time, whether or not in the same week, "then the earnings for the remainder of such 52 weeks shall be divided by the number of weeks and parts thereof remaining after the time so lost has been deducted". 820 ILCS 305/10. In *Sylvester v. Industrial Comm'n*, the Supreme Court held that the appropriate method for calculating a claimant's average weekly wage under these circumstances was to divide the total number of days worked over the previous 52 weeks by five and then divide the claimant's total earnings for the previous 52 weeks by that number. *Sylvester v. Industrial Comm'n*, 197 Ill. 2d 225 (2001).

Respondent attempted to show that the above method of calculation did not apply in this case. In support of that position, Respondent pointed out that Petitioner was never guaranteed a 40-hour work week and that all carpenters knew that they can "just be at home" any day of the week. Respondent took the position that this showed that Petitioner was not considered a full-time employee, and as such the rules concerning weeks and parts thereof did not apply, as part-time employees are not considered to have "lost" days because they are not regularly scheduled to work five days a week. The Arbitrator notes that although Mr. Padgett testified that Petitioner was not guaranteed 40 hours a week, he did not go so far as to testify that Petitioner was considered part-time. Further, the Wage Report itself (RX6) indicates that Petitioner's "normal full work day" was eight hours and his "normal full work week" was five days. The questions regarding "if part-time employee" were left blank.

The Arbitrator finds that Respondent's arguments regarding the calculation of wages are not persuasive and further finds that the method set out in *Sylvester* is the appropriate method. Petitioner was employed for a full year prior to his accidental injury, but only worked 218 days, the equivalent of 43.6 weeks. Using the aforementioned qualified earnings of $46,799.50, the Arbitrator finds Petitioner's average weekly wage is $1,073.38 ($46,799.50 ÷ 43.6 weeks).

In support of the Arbitrator's decision relating to issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury. *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill.App.3d 463, 470 (4th Dist. 2011).

In light of the Arbitrator's findings with respect to issue (F), the Arbitrator finds that medical services rendered to date were reasonable and necessary in Petitioner's care and treatment relative to his accident of June 17, 2016. The Arbitrator finds that Respondent is liable for the following medical bills as set forth in Petitioner's Exhibit 1, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act, and subject to prior payments. Respondent did not claim a credit under Section 8(j).

1. Express Medical Care	$ 316.00
2. Belleville Memorial Hospital	$ 1,350.63
3. The Pain Center at Memorial Hospital	$ 300.00
4. Clinical Radiologists	$ 67.00
5. Washington University Physicians	$ 560.00
6. Benchmark Physical Therapy	$ 6,400.00
7. Athletico Physical Therapy	$ 1,257.90
8. Dr. James Wade	$ 725.00
9. Dr. Matthew Gornet	$ 7,768.20
10. MRI Partners of Chesterfield	$ 5,750.00
11. Dr. Kaylea Boutwell	$ 3,128.00
12. Orthopedic ASC of Chesterfield	$ 4,476.82
13. St. Louis Spine & Orthopedic Surgery Center	$ 3,911.00
14. CT Partners of Chesterfield	$ 2,240.00
TOTAL	**$38,250.55**

The Arbitrator ***declines*** to award charges billed by Dr. Gornet for CPT code 99080, Special Report. A provider may not charge a fee for writing a standard report that is generated in the normal course of treatment. Although a provider may charge an additional fee for a special report that is unusual or outside the standard reporting form, the Arbitrator finds that none of the medical reports admitted into evidence meet this standard. As such, charges for such reports are not reasonable and the Arbitrator finds that Respondent is not liable for them. Specifically, the following charges are not reasonable and Dr. Gornet is not entitled to payment: (1) 5/13/17, $33.00; (2) 7/24/17, $33.00; and (3) 9/14/17, $33.00. In addition, the Arbitrator ***declines*** to award charges billed by Dr. Gornet for Cipro medication on July 24, 2017, in the amount of $186.00. His treatment record for that day makes no mention of this medication, nor any reason for its necessity.

The Arbitrator ***declines*** to award charges listed from CEP America Illinois/Med America Billing Services in the amount of $457.00. Though the charges were listed on the cover sheet of Petitioner's Exhibit 1, no bill for the service was included within the contents of the Exhibit.

In support of the Arbitrator's decision relating to issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

Upon establishing causal connection and the reasonableness and necessity of recommended medical treatment, employers are responsible for necessary medical care required by their employees. Specific medical procedures or treatment that have been prescribed by a medical service provider have been "incurred" within the meaning of the statute, even if they have not yet been paid for. *Plantation Mfg. Co. v. Industrial Comm'n*, 294 Ill.App.3d 705, 710 (2nd Dist. 1997).

The parties disagree as to whether Petitioner is a surgical candidate. Dr. Crane stated that he would not recommend surgery, but acknowledged that Petitioner was physically limited to the tolerances outlined in his functional capacity evaluation, which precluded him from returning to regular duty work. Petitioner's manager, Mr. Padgett, testified that he cannot accommodate restrictions of only occasional bending.

If left untreated, Petitioner would not be able to return to work. Petitioner testified without rebuttal that his condition has worsened since he has not been participating in physical therapy. Furthermore, Dr. Gornet stated that Petitioner would have to be followed, because Petitioner's condition would progressively worsen further, given that there were already objective signs of worsening on Petitioner's MRI as well as increased subjective complaints from Petitioner. Given Petitioner's increased subjective complaints, Dr. Gornet modified and increased Petitioner's restrictions so as not to do further harm to his condition. Dr. Gornet testified that the recommended surgery would give Petitioner an 85% chance of success for return to his former employment without restrictions within six to eight months of the procedure. Petitioner testified that he wishes to undergo the surgery recommended by Dr. Gornet in order to return to his pre-injury state and return to his former employment.

In light of the Arbitrator's findings with respect to issue (F), the Arbitrator finds that Petitioner has not reached maximum medical improvement and is in need of further care. The Arbitrator finds that Respondent is liable for prospective medical care for Petitioner's low back, including the surgery recommended by Dr. Gornet.

In support of the Arbitrator's decision relating to issue (L), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

In order to be eligible for temporary total disability benefits, a claimant must prove not only that he did not work, but also that he was unable to work. *City of Granite City v. industrial Comm'n*, 279 Ill.App.3d 1087 1090 (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). The ability to do light or restricted work does not preclude a finding of temporary total disability. *Archer Daniels Midland Co. v. Industrial. Comm'n*, 138 Ill.2d 107 (1990), citing *Ford Motor Co. v. Industrial Comm'n*, 126 Ill.App.3d 739 (1984).

Petitioner's manager Mr. Padgett unequivocally testified that light duty has never been offered to Petitioner, and that he was not able to accommodate Petitioner's restrictions of occasional bending in accordance with the FCE. Petitioner is therefore entitled to continued temporary total disability benefits until such time as he reaches maximum medical improvement.

In light of the Arbitrator's findings with respect to issues (F) and (K), the Arbitrator finds that Petitioner was temporarily and totally disabled from June 18, 2016, through October 13, 2017, that being the date of arbitration, a period of 69 weeks. The Arbitrator notes that Petitioner's attorney, in alleging 120 5/7 weeks of disability, clearly made a mathematical error on the stipulation sheet.

With respect to Petitioner's accident of February 18, 2016, Petitioner testified he was off work for four days and alleged he was entitled to TTD benefits from February 18 through February 22, 2016. However, there is no evidence in the record to substantiate this claim. The Arbitrator finds that Petitioner did not meet his burden of proof with regard to this claimed period of entitlement to TTD benefits.

Having found that Petitioner's average weekly wage was $1,073.38, the Arbitrator finds that his temporary total disability rate is $715.59. Respondent is liable for temporary total disability benefits of $49,375.71, representing the period of June 18, 2016, through October 13, 2017, a total of 69 weeks. The parties stipulated and the Arbitrator finds that Respondent previously paid benefits of $28,724.05 and is entitled to a credit for same. Respondent is therefore liable for the remaining amount of $20,651.66.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kelly Claypool,
Petitioner,

vs.

Nos. 17 WC 00211
17 WC 00212

MedStar Ambulance,
Respondent.

19IWCC0258

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 wage calculations, benefit rates and permanent disability, and being advised of the facts and law, modifies the consolidated Decisions of the Arbitrator as stated below and otherwise affirms and adopts the Decisions of the Arbitrator, which are attached hereto and made a part hereof.

Regarding the issue of wage calculations, the Commission finds Petitioner was not concurrently employed at the time of the accident on November 30, 2016. Petitioner had been employed by Respondent, MedStar Ambulance, since 2011. In June of 2015, Petitioner began working full-time for Belleville Memorial Hospital (Belleville Memorial). She continued working for Respondent on a part-time, sporadic basis. On October 15, 2016, Petitioner left her job at Belleville Memorial and increased her hours with Respondent to full-time. She "cashed out" all of her paid time off and terminated her relationship with Belleville Memorial. Petitioner did not testify that she had any intention of returning to Belleville Memorial. Thus, *Flynn v. Industrial Comm'n*, 211 Ill. 2d 546 (2004) and *Jacobs v. Industrial Comm'n*, 269 Ill. App. 3d 444 (1995), finding concurrent employment where an employee was temporarily laid off from his primary job due to seasonal nature of the work, are distinguishable. The employment relationships in *Flynn* and *Jacobs* had not been "wholly severed" as in the case before us.

19IWCC0258

Because we do not find Petitioner was concurrently employed at the time of her accident, we cannot include her wages from Belleville Memorial in determining her average weekly wage. Furthermore, because the nature of Petitioner's employment with Respondent changed substantially on October 15, 2016, we believe it is appropriate to only consider Petitioner's earnings during that six-week period. See *Drone v. Fabick Machinery Co.*, 05 IWCC 0554. We underscore that Petitioner worked full-time, exclusively for Respondent during the six weeks prior to her injury. Petitioner testified that in her new position her workweek/schedule was 24 hours on, 48 hours off. The record before us reveals that she worked as scheduled until her November 30, 2016 accident. Petitioner's regular earnings and mandated overtime, computed at a straight time rate, total $4,366.01. Dividing $4,366.01 by six weeks yields an average weekly wage of $727.66.

Turning to the issue of permanent 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 factor (ii), the Commission notes Petitioner was an emergency medical technician, which is a physically demanding job. At the time of the arbitration hearing, Petitioner was working 40 hours a week for Respondent as a billing and coding specialist in patient accounts, a sedentary job. Although Petitioner is optimistic about being able and qualified to work as an emergency medical technician in the future, the record speaks to the contrary. After a disc replacement surgery at L5-S1, Petitioner suffers from residual pain in the right hip, which is worse with physical activity or exertion. Respondent has not permitted Petitioner to return to work as an emergency medical technician. The Commission gives considerable weight to the loss of profession.

Regarding factor (iii), the Commission notes Petitioner was 29 years old at the time of the arbitration hearing. The Commission gives considerable weight to this factor because Petitioner has a long work life ahead of her.

Regarding factor (iv), the Commission notes a decreased earning capacity. Petitioner currently works 40 hours a week at an hourly wage of $13.00. Had she stayed in the position of emergency medical technician for Respondent, she would likewise be earning $13.00 an hour in regular wages, plus additional earnings for at least eight hours a week of mandated overtime. The Commission gives considerable weight to this factor.

19IWCC0258

Regarding factor (v), the Commission notes Petitioner underwent a disc replacement surgery at L5-S1. Petitioner testified to residual pain in the right hip, which is worse with physical activity or exertion. Postoperative medical records from Dr. Gornet show Petitioner complained of right hip/buttock pain, which Dr. Gornet thought was referred pain. Dr. Gornet did not impose any permanent restrictions. The Commission gives considerable weight to this factor.

Having carefully considered and weighed the foregoing factors, the Commission believes the proper measure of disability is 25 percent of the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decisions of the Arbitrator filed June 27, 2018, are 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 $485.11 per week for a period of 4 3/7 weeks, from September 1, 2017 through October 1, 2017, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the medical bills in evidence, pursuant to §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $436.60 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 permanent disability to the extent of 25 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.

19IWCC0258

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: MAY 22 2019

o-04/04/19
mp/sk
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Marc Parker

Barbara N. Flores

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CLAYPOOL, KELLY
Employee/Petitioner

Case# 17WC000211

17WC000212

MEDSTAR AMBULANCE
Employer/Respondent

19IWCC0258

On 6/27/2018, 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 2.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

1433 McANANY VAN CLEVE & PHILLIPS
STEVE A McMANUS
505 N 7TH ST SUITE 2100
ST LOUIS, MO 63101

STATE OF ILLINOIS)

)SS.

COUNTY OF MADISON) 19IWCC0258

- [ ] 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

KELLY CLAYPOOL
Employee/Petitioner

v.

MEDSTAR AMBULANCE
Employer/Respondent

Case # 17 WC 00211

Consolidated cases: 17 WC 00212

An *Application for Adjustment 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 23, 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. [x] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **November 30, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$42,851.85**; the average weekly wage was **$824.07.**

On the date of accident, Petitioner was **27** years of age, ***single*** with **0** dependent child(ren).

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

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

Respondent shall be given a credit of **$14,330.28** in TTD and TPD, $- for maintenance, and $- for other benefits, for a total credit of **$14,330.28.**

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

ORDER

Respondent shall pay reasonable and necessary medical services of contained in Petitioner's group exhibit, as provided in § 8(a) of the Act.

Respondent shall be given credit for medical benefits that have already been paid through its group carrier, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in § 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of 549.38/week for a further additional period of 4 3/7 weeks, commencing **September 1, 2017**, through **October 1, 2017**, as provided in § 8(b) of the Act. Respondent shall further pay the difference between the amount previously paid to Petitioner and Petitioner's correct benefit rate to correct the underpayment of benefits.

Respondent shall pay Petitioner permanent partial disability benefits of **$494.44/week for 75 weeks**, because the injuries sustained caused the **15%** loss of the **body as a whole**, as provided in § 8(d)2 of the Act.

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

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

Edward Lee 6/23/18

Signature of Arbitrator Date

JUN 27 2018

FINDINGS OF FACT

The parties stipulated that Petitioner sustained accidental injuries that arose out of and in the course of her employment as an EMT on November 30, 2016, and again December 3, 2016. (AX1; T.11-12) She has worked for Respondent for 6 years, and her shifts were typically 24 hours long. (T.12, 32-33) Petitioner testified that in the year preceding her injuries, she was also employed at Belleville Memorial Hospital as an Emergency Room Technician from June of 2015 until October of 2016. (T.12-13, 16) She testified that MedStar management was fully aware that she was working for Memorial in the year preceding the injury, because they worked around her schedule. (T.13-14) She testified that one of her managers, Mr. Scott Sigler, even witnessed her working at Memorial, because he drove an ambulance truck en route to Belleville Memorial Hospital and on arrival would enter the building while she was working and acknowledge her. (T.14). Petitioner ceased working for Memorial shortly before her injury and resumed working full-time for MedStar Ambulance. (T.15) The record reflects that Respondent had a rule that Petitioner was not able to work for eight hours before returning to her 24 hour shift. (T.33) Petitioner also stated that all of the overtime that she worked was mandatory. (T.24-25, 42)

On November 30, 2016, Petitioner was transferring a paralyzed patient from the hospital to a nursing home, and as she moved the patient into the nursing home bed, she injured her back. (T.16-17) Petitioner briefly took off work to recover and returned to work on December 3, 2016, at which time she sustained her second back injury while handling a 911 call. (T.17-18) Petitioner testified that after arriving at Memorial Hospital with the patient, she pulled the occupied stretcher out of the back of the ambulance and bore the full weight of the patient, causing a shot of pain through the right side of her lower back. (T.18) Petitioner suffered no prior injuries and required no treatment to her low back prior to these accidents. (T.12) Respondent disputes Petitioner's average weekly wage, the reasonableness and necessity of Petitioner's medical care, entitlement for temporary total disability benefits from September 1, 2017 through October 1, 2017, and the nature and extent of the injury. (AX1)

Petitioner sought care for her injuries at Belleville Memorial Hospital Emergency Room, where she was treated for right lower back pain radiating into her right gluteal with tingling into her toes. (PX3) When x-rays were benign, Petitioner was prescribed pain medication and muscle relaxers and released with a diagnosis of strain and spondylosis with myelopathy or radiculopathy of the lumbar region and instructed to seek follow-up care. *Id.* Petitioner then sought treatment with her primary care physician, Dr. Urdaneta, who also noted her symptoms of right sided low back pain and right foot numbness. (PX4, 12/8/16) Dr. Urdaneta took Petitioner off work with hopes that she would improve with rest and conservative care. *Id.* Petitioner, however, continued to be symptomatic, and returned with complaints of worsening back and gluteal pain with pain radiating to the right foot and numbness. (PX4, 12/23/16) Petitioner reported that her foot numbness caused her to slip down her stairs recently. *Id.* Dr. Urdaneta recommended an MRI and referred Petitioner to a specialist. *Id.*

Petitioner then came under the care of Dr. Matthew Gornet, who saw Petitioner on January 5, 2017, and obtained an MRI which showed a right paracentral annular tear with protrusion at L5-S1. (PX5; PX6, 1/5/17) Dr. Gornet noted the history of Petitioner's injuries and her chief complaints of low back pain to the right side, right buttock, and right leg with intermittent numbness and tingling in the right foot. (PX6, 1/5/17) Dr. Gornet also noted the incident where Petitioner's right lower extremity numbness caused her to slip and fall down her stairs, but noted this caused no injury to her back. *Id.* His examination demonstrated decreased sensation of the S1 dermatome on the right and a positive straight leg raise test. *Id.* After reviewing the MRI and agreeing that it showed an obvious annular tear central and to the right at L5-S1, which was consistent with Petitioner's complaints, Dr. Gornet recommended conservative care by way of physical therapy, injection at L5-S1, medication, and physical restrictions of no lifting greater than 10 pounds, no repetitive bending or lifting with, and frequent alternating between sitting and standing as needed. *Id.*

When Petitioner returned to Dr. Gornet on March 9, 2017, she continued to be symptomatic with right-sided low back and buttock pain and intermittent right leg pain. (PX6, 3/9/17) Dr. Gornet noted that the injections at L5-S1 did provide Petitioner some relief, albeit temporary. *Id.* Dr. Gornet recommended a CT discogram at L4-5 and L5-S1 as well as an MRI spectroscopy to confirm the L5-S1 level as the source of her pain given the subtle suggestion of an annular tear on the left at L4-5, and kept Petitioner on restricted status. *Id.* The CT discogram demonstrated a non-provocative disc at L4-5 and a provocative disc at L5-S1 with a posterior annular tear. (PX6, 3/28/17) Petitioner was noted to be stoic without any functional overlays during the procedure. *Id.* Petitioner's MRI spectroscopy also showed the most painful disc chemicals at L5-S1, while L4-5 was negative. (PX6, 4/24/17) Given that all of Petitioner's diagnostic studies pinpointed L5-S1 as the source of Petitioner's pain, Dr. Gornet recommended disc replacement versus fusion at L5-S1, and he requested a VMA motion analysis to determine the best course of action. (PX6, 4/24/17, 6/19/17).

On June 21, 2017, Dr. Gornet performed anterior decompression and disc replacement at L5-S1. (PX6, 6/21/17) Intraoperative findings confirmed the existence of a large central annular tear over and above the block discectomy at L5-S1. *Id.* Petitioner reported dramatic improvement following surgery, but continued to report some right buttock pain and referred hip pain. (PX6, 7/10/17, 8/17/17, 9/28/17) Dr. Gornet referred Petitioner for physical therapy. (PX6, 9/28/17) Petitioner slowly improved with additional physical therapy, and on January 26, 2018, she was released to full-duty on February 5, 2018. (PX6, 12/18/17, 1/26/18) Dr. Gornet stated that Petitioner was to remain under restrictions through February 4, 2018, to complete her recovery. (PX6, 1/26/18) He noted, however, that Petitioner had already begun working under her restrictions. *Id.*

Despite the improvement resulting from surgery, Petitioner testified that she continues to have soreness and pain in her right hip that increases with exertion or physical activity. (T.23) Petitioner currently works on patient accounts in billing and coding, and she no longer earns

overtime during the mandated extra shift required of EMTs. (T.10, 24-25) Petitioner testified that Respondent has not allowed her to take the weight lifting test that would allow her to return to work as an EMT. (T.26)

Respondent had Petitioner examined by Dr. Robert Bernardi, a neurosurgeon, who testified by way of deposition. (RX1) He examined Petitioner on October 17, 2017, four months after her surgery with Dr. Gornet, and he noted the history of Petitioner's lifting injuries. *Id.* at 8-9, 12. He acknowledged that Petitioner, a 5'4" female, was a smaller individual and observed, "I would say she's kind of a small woman to do this kind of work. I've seen big men hurt their backs doing this work. I mean, if you have to pull really heavy people out of a bathtub and down a flight of steps, this can involve quite a bit of lifting in awkward positions. *Id.* at 10. He testified that he believed Petitioner was an honest, forthright patient. *Id.* at 10. At the time of his examination, Petitioner's primary complaint was pain in the right hip and buttocks area. *Id.* at 13-14. His physical examination also demonstrated tenderness in Petitioner's right buttock slightly above the greater trochanter. *Id.* at 12.

Dr. Bernardi looked at Petitioner's imaging studies taken on December 3, 2016, and stated that these were normal with no evidence of degeneration. *Id.* at 14-15. He also viewed the lumbar spine MRI taken on January 5, 2017, and stated that he believed it was normal as well. *Id.* at 15. He found no evidence of disc bulging or herniation. *Id.* at 16. When asked specifically about the annular tear or fissure at L5-S1 identified by Dr. Gornet, he stated that he did not appreciate same. *Id.* at 16. He believed Petitioner suffered from non-specific back pain of uncertain etiology. *Id.* at 18. He felt that Petitioner's emergency room visit and her initial course of physical therapy was reasonable, along with her MRI scan and medication, but felt that nothing beyond these was reasonable or necessary as it related to any pathological condition produced by her work accidents. *Id.* at 19.

Dr. Bernardi did not believe that Petitioner suffered from any type of condition affecting her lower extremities secondary to nerve irritation, and he did not believe the lumbar discography, spectroscopy, epidural injections, or the surgery was necessary to treat Petitioner's condition. *Id.* at 20-24. He did not believe epidural injections were an effective treatment tool, and he did not believe that discography was an objective or reliable diagnostic tool. *Id.* at 21-23. He testified that he had no knowledge of what the VMA motion analysis test was or how it was used in treating back pain. *Id.* at 29. He also testified that even if he did believe that Petitioner suffered an annular fissure, these were normal signs of aging he would not have recommended surgery. *Id.* at 33-35. He disagreed with Dr. Gornet's belief that tears aren't present in discs that are young and healthy, and he testified that by the age of 40 approximately 80% of the population has at least one disc degenerating, with some starting earlier. *Id.* at 35-36.

On cross-examination, Dr. Bernardi testified that "almost universally" all of his independent medical evaluations are performed at the request of insurance carriers or employers. *Id.* at 42. He performs two evaluations per week on average and charges $3,000.00 for the evaluation and $1,800.00 for a deposition. *Id.* at 42-43. He testified that Respondent's letter

requesting the examination was three pages long and included a medical summary, a list of the records enclosed, and a list of questions to be addressed. *Id.* at 43-44. He sees approximately 25 to 30 patients a week and performs a variable number of surgeries. *Id.* at 42. He performed 5 to 6 per week over the last two weeks. *Id.* at 42.

Dr. Bernardi acknowledged that Petitioner was a young, 28-year-old who sustained no prior injuries to her lumbar spine prior to her two work injuries. *Id.* at 45. Dr. Bernardi acknowledged there were no records documenting any prior lumbar spine treatment for Petitioner. *Id.* at 45. He admitted that there was no reason to doubt or disbelieve Petitioner's history of her injuries. *Id.* at 46. He admitted that lifting a patient at an awkward angle could cause lumbar spine disc injury or aggravate an underlying degenerative condition and cause it to be symptomatic and required treatment without necessarily causing nerve route impingement. *Id.* at 46. He also admitted that the S1 nerve root begins in the buttock, extends down the back of the thigh and calf, and goes into the foot, and he admitted that decreases sensation in the S1 dermatome was suggestive of a process affecting the S1 nerve root. *Id.* at 47-48. He admitted that Petitioner's symptoms of low back pain into her right buttock and pain and numbness occasionally going into her leg and toes was consistent with an L5-S1 disc injury. *Id.* at 52-53. He acknowledged that Petitioner failed conservative care prior to undergoing surgical treatment. *Id.* at 51. He also acknowledged that while Petitioner continued to have a level of symptoms following surgery, she was better than she was prior to the procedure. *Id.* at 48. He does not perform disc replacements in his own practice. *Id.* at 42.

On further cross-examination, Dr. Bernardi could not recall whether he reviewed the radiologist's report when he reviewed Petitioner's MRI scan, but he acknowledged that the Dr. Ruyle, also identified a right paracentral annular tear at L5-S1. *Id.* at 49. He, though, disagreed with them both and stated his belief that even if he did agree with their finding, there was no correlation between trauma and annular tears or fissures; he believed that annular tears or fissures can only occur over time. *Id.* at 49-50. He admitted, however, that a patient can develop increased symptoms without necessarily having a discernible change on imaging studies, or they can have visible pathology and be asymptomatic. *Id.* at 51. He therefore agreed that the driving force behind making a treatment recommendation is a patient's symptoms. *Id.* at 51.

Dr. Bernardi acknowledged that Petitioner obtained temporary relief from the epidural steroid injections recommended by Dr. Gornet. *Id.* at 52. He did not know whether CT discograms were accepted by the FDA, and he is not involved in any of the FDA studies that Dr. Gornet participated in with regard to the use of discography. *Id.* at 54. He acknowledged that patients are blinded during the procedure and are not made aware of what level is being injected. *Id.* at 54. He was not provided with the MRI spectroscopy. *Id.* at 55-56. Dr. Bernardi acknowledged that the operative report confirmed the existence of an L5-S1 annular tear. *Id.* at 56. He admitted that he did discover that the VMA motion analysis performed by Dr. Gornet was an FDA cleared test, *Id.* at 57. He was unaware, however, that the study is reimbursed by group

insurance carriers. *Id.* at 57-58. He admitted that Petitioner never returned to her baseline or pre-injury status of being symptom free prior to undergoing surgery. *Id.* at 60.

Dr. Gornet also testified by way of deposition. (PX15) He is a board certified orthopedic surgeon who specializes in spine surgery. *Id.* at 4. He sees 120 patients per weeks and does on average 5 to 10 surgeries per week. *Id.* at 5. He treats patients, and he performs independent medical evaluations at the request of all parties, including judge ordered examinations. *Id.* at 5-6. He is also involved in medical research and publishes his findings. *Id.* at 6. He testified that he develops new types of diagnostic evaluations to determine the best treatment for structural back and neck pain, and he testified that his research is peer-reviewed and has won awards. *Id.* at 6. He also travels around the world to lecture on his findings. *Id.* at 6.

Dr. Gornet testified that Petitioner reported her main complaint as low back pain to her right side and right buttock with intermittent right leg pain, numbness and tingling into her right foot. *Id.* at 7-8. She advised that her problems began on or about November 30, 2016, after she lifted a paralyzed patient and felt immediate pain followed by spasms. *Id.* at 8. He found it significant that Petitioner had no prior problems of significance in her low back. *Id.* at 8-9. He also testified that the MRI scan showing an obvious annular tear central to the right at L5-S1, best seen on STIR sequence #11, was consistent with her back, buttock and leg symptoms. *Id.* at 10. He also testified that his diagnosis of nerve root irritation was objectively corroborated by findings of decreased sensation at S1 on the right, though Petitioner's primary problem was structural back pain resulting from L5-S1 injury in the form of an acute annular tear as a result of the lifting incidents on November 30, 2016, and December 3, 2016. *Id.* at 10-12.

Dr. Gornet explained that an annular tear is essentially a fissure or loss in integrity of the annulus that is a progression towards a herniated disc. *Id.* at 33-34. Prior to that point, however, the outer fibers may just protrude, which is diagnosed as a disc protrusion. *Id.* at 34. He also explained that annular tears are not simply a spontaneous injury, but they are caused by applying mechanical load to a disc that cannot handle same. *Id.* at 46-47. He explained that a weakened state from degeneration contributes to the mechanical loading problem, because it reduces the loading threshold of the disc; hence, the terms traumatic or non-traumatic are irrelevant as it pertains to defining disc injury. *Id.* at 46-47.

Dr. Gornet testified that he used the MRI spectroscopy to take a chemical biopsy of Petitioner's disc to objectively measure the structural chemicals in the disc that produce back pain. *Id.* at 12. He testified that the procedure is now performed at multiple institutions that have the appropriate equipment and software to improve success rates in treating structural back pain. *Id.* at 12-13. Dr. Gornet also testified that discography or the CT discogram is a "tried-and-true method" of evaluating structural back pain that is used to determine whether a structural lesion shown on a static MRI scan is indeed painful and whether the patient's complaints correlates with objective pathology shown on the imaging studies. *Id.* at 13. He testified that the procedure is accepted by the FDA, and he even stated that he just began a new stem cell study with the FDA where one of the entrance criteria is an objective discography. *Id.* at 13.

Dr. Gornet stated that both the spectroscopy and discography highlighted L5-S1 as the source of Petitioner's pain; the spectroscopy showed significant painful chemicals at L5-S1 while the L4-5 level above was negative, and the discogram showed a provocative L5-S1 disc corroborated by the annular tear shown on the CT scan. *Id.* at 13-14. Dr. Gornet stated that his diagnosis unequivocally confirmed by the intraoperative findings during surgery, which consisted of a large central annular tear that propagated to the right side. *Id.* at 15. He also noted that Petitioner's symptoms improved dramatically following surgery, but she was not sufficiently recovered enough to be released to return to work full duty until February 5, 2018. *Id.* at 15-16. He testified that all of Petitioner's care and treatment was reasonable and necessary to treat Petitioner's work-related accidental injury.

Dr. Gornet testified that he did not agree with Dr. Bernardi's opinions regarding the injections given to Petitioner and stated:

> Again, we already know that she had some nerve irritation objectively, she had objective pathology to the right side on her MRI, and the purpose was to cure and relieve the effects of the injury itself. What we're trying to do is reduce the inflammatory response. Those injections I thought were appropriate, the next step in conservative care to move forward to see if we could make her better without doing a more invasive procedure. *Id.* at 18-19.

He also disagreed with Dr. Bernardi's opinion that discography was a subjective diagnostic tool that was an insufficient basis for surgical recommendation. *Id.* at 19. He stated:

> Well, again, given the fact that the patient is blinded to what we're injecting, then that is highly unlikely. If the patient doesn't know which disc we're injecting and somehow decides incidentally that one disc is completely normal and the other disc is abnormal and causes her typical back pain but she doesn't know which disc I'm injecting, I find that inconsistent with the facts. Second is we have an independent nurse in the room who is talking to the patient and grading the patient's responses. That independent nurse would again give separate data that's usually contained in the note.
>
> Finally, there's objective pathology on the CT scan which correlates identically to the objective pathology on the MRI, and those – that correlation is significant, and it is exactly right where the patient describes their structural back pain. So all of these things coming together make it not necessarily a subjective test. It has to be interpreted. And if we go even further and look at that, we know that MRI scans are not necessarily a predictor of whether a patient has pain or no pain, but yet we use our clinical skills as providers to interpret the MRI scan in conjunction with a patient's subjective complaints to decide whether an anatomic problem is meaningful or not meaningful. Discography is only a test in that fashion to help us better understand the pathology and whether or not it correlates with subjective complaints. It is no different than an MRI. *Id.* at 19-20.

Dr. Gornet testified that the information Dr. Bernardi has about MRI spectroscopy is out of date and inconsistent with current findings. *Id.* at 20-21. He stated:

> I can tell you that we have submitted a paper, and that paper correlates discography and MRI spectroscopy with significant clinical outcomes. It is peer-reviewed, it's already accepted for publication, and it received an extremely high score in the most prestigious lumbar spine society in the world. And so this information allows us to better select patients with structural back pain, and what we found is a correlation between discogram and MRI spectroscopy was predictive, and it was predictive of a successful outcome to a level of 95 to 97 percent, which is off the charts.
>
> And so in this situation, I would say Ms. Claypool is no different. She had a positive MRI, she had a positive MRI spectroscopy, and a positive CT discogram, all at L5-S1, with no other level involved, and she's had a very good result and returned back to work full duty. I don't think that there's really any argument that what we evaluated, saw, and treated was not only her work injury but we've significantly benefitted her. *Id.* at 21-22.

He later explained that MRI spectroscopy is used for tissue analysis, not just brain tumors, including myelopathy and spinal cord issues. *Id.* at 51.

Dr. Gornet testified that the scoliosis films were necessary to his treatment recommendations, because they reveal how a person is anatomically aligned or their "sagittal balance," which has a direct impact on postoperative results. *Id.* at 23. The antibiotics he recommended were used to reduce the risk of infection from surgery. *Id.* at 23-24. With regard to the Zoloft, Dr. Gornet testified that postoperative patients tend to have chemical imbalances and fluctuations in their body similar to postpartum depression that can lead to depressions. *Id.* at 23-24. As for the VMA motion analysis, Dr. Gornet testified that this was necessary to make sure that Petitioner did not have any unusual translation that was not picked up on regular films that would contraindicate disc replacement and necessitate fusion. *Id.* at 24. He testified that the VMA motion analysis is a widely accepted, commercially available test that is reimbursed by every group insurance company. *Id.* at 24.

Dr. Gornet also testified that Petitioner's spine is normal following her surgery, and that she is able to return to work as an EMT. *Id.* at 22. Petitioner, however, testified that Respondent has prevented her from doing so. (T.26)

CONCLUSIONS OF LAW

Issue (G): What were Petitioner's earnings?
Issue (K): What temporary benefits are in dispute? (TTD)

The Act provides, "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. . . When the employee is working concurrently with two or more employers and the respondent employer has knowledge of such employment prior to the injury, his wages from all such employers shall be

considered. The Arbitrator calculates Petitioner's earnings for MedStar in the year preceding the initial injury as follows:

MEDSTAR				
Pay Period	Days	Hrs	Gross $	OT Rate
12/11/2015	1	18.25	$ 223.56	
12/25/2015	1	24.5	$ 300.13	
1/22/2016	1	12	$ 147.00	
2/5/2016	1	12	$ 147.00	
2/19/2016	1	7.75	$ 94.94	
3/4/2016	1	23.25	$ 284.81	
4/29/2016	1	23.25	$ 284.81	
5/13/2016	0	0	$ -	
5/27/2016	0	0	$ -	
6/10/2016	0	0	$ -	
6/24/2016	0	0	$ -	
7/8/2016	0	0	$ -	
7/22/2016	5	58.5	$ 731.25	
8/5/2016	4	46.5	$ 581.26	
8/19/2016	1	12	$ 150.00	
9/2/2016	0	0	$ -	
9/16/2016	1	11	$ 137.50	
9/30/2016	0	0	$ -	
10/14/2016	1	22.25	$ 278.13	
10/28/2016	6	80	$ 1,000.01	12.75
OT @straight pay		33.75	$ 430.31	
11/11/2016	6	80	$ 1,020.00	12.75
OT @straight pay		53	$ 675.75	
11/25/2016	4	80	$ 1,020.00	12.75
OT @straight pay		17.25	$ 219.94	
Days Worked:	35		$ 7,726.40	

The Petitioner's concurrent employment during the majority of the year preceding the injury will be considered. Petitioner's earnings for Memorial are as follows:

MEMORIAL HOSPITAL				
Pay Period	Days	Hrs	Gross $	OT Rate
11/28/2015	10	80	$ 1,004.10	
OT @straight pay		8	$ 102.48	12.81
12/12/2015	10	72	$ 887.21	

12/26/2015	10	72	$ 901.45	
1/9/2016	10	80	$ 994.52	
OT @straight pay		8.75	$ 109.64	12.53
1/23/2016	10	80	$ 1,064.31	
OT @straight pay		19.5	$ 256.82	13.17
2/6/2016	10	80	$ 1,064.72	*
OT @straight pay		16	$ 210.88	13.18
2/20/2016	10	80	$ 1,028.74	
OT @straight pay		16	$ 205.76	12.86
3/5/2016	10	80	$ 972.56	
OT @straight pay		7.75	$ 98.81	12.75
3/19/2016	10	80	$ 1,125.89	
OT @straight pay		9.75	$ 129.29	13.26
4/2/2016	8	80	$ 1,051.10	*
OT @straight pay		23.75	$ 318.49	13.41
4/16/2016	8	80	$ 1,179.37	*
OT @straight pay		36.25	$ 534.69	14.75
4/30/2016	8		$ 1,355.33	*
OT @straight pay		20	$ 333.40	16.67
5/14/2016	8	80	$ 1,243.05	*
OT @straight pay		37	$ 584.97	15.81
5/28/2016	8	80	$ 1,283.59	*
OT @straight pay		40	$ 642.00	16.05
6/11/2016	8	80	$ 1,359.65	*
OT @straight pay		27.5	$ 471.08	17.13
6/25/2016	8	80	$ 1,215.52	
OT @straight pay		13.5	$ 205.07	15.19
7/9/2016	8	80	$ 1,311.06	*
OT @straight pay		13.25	$ 217.96	16.45
7/23/2016	8	80	$ 1,361.18	*
OT @straight pay		21.75	$ 371.93	17.1
8/6/2016	8	80	$ 1,385.50	*
OT @straight pay		7.75	$ 129.35	16.69
8/20/2016	8	80	$ 1,214.57	*
OT @straight pay		8.25	$ 137.78	16.7
9/3/2016	8	80	$ 1,334.68	*
OT @straight pay		15.5	$ 258.54	16.68
9/17/2016	8	80	$ 1,316.22	
OT @straight pay		5.75	$ 88.21	15.34
10/1/2016	8	80	$ 1,353.51	*
OT @straight pay		8.5	$ 133.88	15.75
10/15/2016	8	80	$ 2,546.73	
OT @straight pay		2	$ 29.90	14.95

Weeks Worked:	48		$ 35,125.45	

The Arbitrator finds that the Respondent was aware of Petitioner's employment at Memorial Hospital and that she worked concurrently within the 52 weeks before the accidents. Therefore, the Petitioner is allowed to use both incomes in determining her average weekly wage. The Arbitrator, from the payroll evidence, finds that the Petitioner between the two jobs always worked at least a full week. Accordingly, the Arbitrator will use 52 weeks in calculating the AWW. From the two employers the Petitioner earned $ 7,726.40 plus $ 35,125.45 for a total of $ 42,851.85. Dividing that by 52 gives an AWW of $ 824.07.

Based upon the above findings, the Arbitrator concludes that there has been an underpayment of temporary total disability benefits. The Request for Hearing also indicates that all benefits have been paid except for the period of disability from September 1, 2017, through October 1, 2017. (AX1) Respondent paid temporary total disability benefits from December 1, 2016 through February 1, 2017, and from June 21, 2017, through August 30, 2017. *Id.* Respondent also paid temporary partial disability benefits from February 2, 2017, through June 20, 2017. *Id.* The record reflects that Petitioner was not released to return to work light duty following her surgery until October 2, 2017, as indicated by Dr. Gornet's treatment note of September 28, 2017. (PX6, 9/28/17) Consequently, Petitioner is entitled to an additional month of temporary total disability from September 1, 2017, through October 1, 2017, in addition to the difference between the benefit amount paid by Respondent and the correct amount of benefits owed secondary to a finding of an AWW of $ 824.07.

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

Upon a claimant's establishment of a causal nexus between injury and illness, employers are responsible for the employees' medical care reasonably required in order to diagnose, relieve, or cure the effects of the claimant's injury. *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill.App.3d 705, 691 N.E.2d 13 (2000); *F & B Mfg. Co. v. Indus. Comm'n*, 325 Ill.App.3d 527, 758 N.E.2d 18 (1st Dist. 2001).

The Arbitrator finds the opinion of Dr. Gornet to be more persuasive than the opinion of Dr. Bernardi with regard to the reasonableness and necessity of Petitioner's care and treatment. The evidence is clear that Petitioner failed conservative care at the time surgery was recommended. Dr. Bernardi acknowledged during his deposition that Petitioner had not returned to her pre-injury baseline prior to her surgery. The Arbitrator finds the diagnostic and therapeutic approach of Dr. Gornet via imaging studies and injections reasonable in light of Petitioner's condition. The Arbitrator finds Dr. Bernardi lacking in credibility, given his opinion that Petitioner did not suffer from an annular tear when it was identified by two different radiologists during Petitioner's MRI and CT scans and by Dr. Gornet on objective imaging studies and

during surgery. He further conceded during his deposition that all of Petitioner's symptoms and complaints aligned with Dr. Gornet's diagnosis. The Arbitrator further notes that Petitioner had a good recovery and was able to return to her full duty work.

The Arbitrator therefore orders Respondent to pay the reasonable and necessary medical expenses contained in Petitioner's group exhibit and shall indemnify and hold Petitioner harmless from any claims made by any medical providers for which it claims credit for expenses already paid.

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 are to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) 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).

(i) **Level of Impairment**: Neither Party submitted an AMA rating. Therefore, the Arbitrator gives no weight to this factor.

(ii) **Occupation**: Petitioner continues to be employed by Respondent, but in a sedentary position. Respondent has not permitted her to return to her former employment. (T.10, 24-25) The Arbitrator gives some weight to this factor.

(iii) **Age**: Petitioner was 27 years old at the time of her injury. She is very young and has many years over which she must live and work with her condition. Under *Jones v. Southwest Airlines*, 16 I.W.C.C. 0137 (2016), the Arbitrator gives moderate weight to this factor.

(iv) **Earning Capacity**: Petitioner testified that she is no longer able to earn overtime in the current billing and coding position Respondent placed her in following her injury. (T.10, 24-25) Petitioner testified that Respondent has not allowed her to take the weight lifting test that would allow her to return to work as an EMT. (T.26) The Arbitrator places significant weight on this factor.

(v) **Disability**: As a result of her accidental injuries, Petitioner injured her lumbar spine, with her most prominent injury being an annular tear at L5-S1 with disc protrusion. Petitioner failed conservative care and ultimately required surgery by way of L5-S1 disc replacement. Despite the improvement resulting from surgery, Petitioner testified that she continues to have soreness and pain in her right hip that increases with exertion or physical activity. (T.23) The Arbitrator finds Petitioner's complaints consistent with the medical records. Petitioner reported dramatic improvement following surgery. Dr Gornet noted she is clinically doing very well, but still having some right hip pain. (PX6) The Arbitrator gives greater weight

to this factor. Based upon the foregoing, the Arbitrator finds that Petitioner sustained serious and permanent injuries that resulted in the 15% loss of her body as a whole.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CLAYPOOL, KELLY
Employee/Petitioner

Case# **17WC000212**

17WC000211

19IWCC0258

MEDSTAR AMBULANCE
Employer/Respondent

On 6/27/2018, 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 2.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

1433 McANANY VAN CLEVE & PHILLIPS
STEVE A McMANUS
505 N 7TH ST SUITE 2100
ST LOUIS, MO 63101

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

19IWCC0258

- [ ] 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

KELLY CLAYPOOL
Employee/Petitioner

v.

MEDSTAR AMBULANCE
Employer/Respondent

Case # 17 WC 00212

Consolidated cases: 17 WC 00211

An *Application for Adjustment 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 23, 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

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

FINDINGS

On **December 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 **$42,851.85**; the average weekly wage was **$824.07**.

On the date of accident, Petitioner was **27** years of age, ***single*** with **0** dependent child(ren).

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

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

Respondent shall be given a credit of **$14,330.28** in TTD and TPD, $- for maintenance, and $- for other benefits, for a total credit of **$14,330.28**.

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

ORDER

Adjudicated in companion case No. 17 WC 00211.

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

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

6/23/18
Date

JUN 27 2018

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

TYRES JONES,

Petitioner,

19IWCC0259

vs. NO: 14 WC 6878

AMERICAN STEEL FOUNDRIES,

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 causal connection, total temporary disability, and prospective medical, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part 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).

Findings of Fact & Conclusions of Law

1. On February 16, 2014, Petitioner was employed as a chainer helper for Respondent and sustained a back injury while twisting and lifting pallets. Petitioner's position required him to lift and stack the 20-pound pallets onto a cart. Petitioner initially presented to Respondent's dispensary on February 18, 2014 with complaints of right waist-level back pain. Petitioner was released with Ibuprofen.

2. Petitioner thereafter presented to chiropractor Dr. Mark Eavenson on February 24, 2014. After lumbar X-rays revealed mild to moderate degenerative changes, Dr. Eavenson

diagnosed Petitioner with a lumbar disc protrusion and took Petitioner off work on February 25, 2014 to go for an MRI. The lumbar MRI revealed broad based disc protrusions and facet arthropathy resulting in mild lateral spinal canal stenosis and bilateral foraminal encroachment at L3-L4 and L4-L5, as well as another broad based disc protrusion at L1-L2. Upon review of the MRI, Dr. Eavenson took Petitioner off work until further notice and referred him to orthopedic surgeon Dr. Matthew Gornet.

Petitioner returned to Dr. Eavenson over 70 times from February 26, 2014 to July 30, 2014. Treatment provided at each visit included electrical stimulation followed by an ultrasound, and beginning on March 11, 2014, it also regularly included the chiropractic manipulation of Petitioner's lumbar spine. Additionally, Petitioner regularly participated in physical therapy sessions on the same days of his chiropractic treatments from February 26, 2014 to July 30, 2014.

3. Petitioner also began seeing Dr. Gornet on March 17, 2014, at which time Dr. Gornet opined that Petitioner's symptoms were causally related to his work accident. When Petitioner returned on April 20, 2014, Dr. Gornet found Petitioner's X-rays and the location of his back pain correlated with an annular right L4-L5 tear and recommended injections. Petitioner received a right L4-L5 epidural space injection on April 21, 2014, a right L3-L4 epidural space injection on May 7, 2014, and a L4-L5 epidural steroid injection on May 19, 2014.

   After reporting improvement, Dr. Gornet returned Petitioner to full duty work on July 31, 2014. Petitioner returned to work as a welder inspector at that time and remained working in that position through the date of hearing with the exception of a few months Petitioner was off work for an unrelated carpal tunnel surgery.

   On October 30, 2014, Petitioner returned to Dr. Gornet and reported worsening symptoms. Dr. Gornet found Petitioner's recent MRI showed progression of the L3-L4 disc pathology and recommended more injections. Petitioner received a right L4-L5 epidural steroid injection on November 24, 2014 and a right L3-L4 epidural steroid injection on December 8, 2014.

   On January 15, 2015, Dr. Gornet indicated Petitioner was still working despite pain affecting most aspects of his life. Dr. Gornet opined that Petitioner may require a spinal fusion with a possible disc replacement at L3-L4 and L4-L5; however, he wanted to first exhaust all conservative measures. Petitioner continued to treat with pain medication, muscle relaxants, and anti-inflammatories. On September 10, 2015, Dr. Gornet reported Petitioner still had significant symptoms but no focal deficits on examination.

   Petitioner thereafter underwent a lumbar radiofrequency ablation of the right L3-L4, L4-L5, and L5-S1 facet joint nerves on August 9, 2016 and another lumbar ablation to the left side of the same discs on August 23, 2016. Petitioner did not return to Dr. Gornet until

October 3, 2016, at which time Dr. Gornet recommended a CT discogram and MRI spectroscopy to determine if Petitioner would benefit from surgery.

Petitioner underwent the discogram with X-ray interpretation at L4-L5 and L5-S1 as well as facet blocks on November 8, 2016. It found a non-provocative disc at L5-S1, a provocative disc at L4-L5, and a presumed provocative disc at L3-L4. A CT was also obtained and showed a L4-L5 annular tear with a broad based protrusion across the midline resulting in central and foraminal stenosis with associated posterior hypertrophy, a partial annular L5-S1 defect without full-thickness annular tear, and advanced degenerative disc disease at L3-L4. Upon review of the tests on November 21, 2016, Dr. Gornet recommended an anterior lumbar disc replacement at L3-L4 and L4-L5.

Petitioner last presented to Dr. Gornet on January 18, 2018. At that time, Dr. Gornet reviewed a copy of the independent medical examination report produced by Dr. Michael Chabot on March 27, 2017. Dr. Gornet defended his use of the MRI spectroscopy, stating that although it was a new tool, it was currently being performed at multiple institutions and utilized for additional diagnostic information. Dr. Gornet further argued Dr. Chabot's diagnosis of lumbar strain was illogical because he was unaware of any patient who had a lumbar strain for four years. Instead, Dr. Gornet opined Petitioner had likely injured his underlying degenerative discs at L3 to L5 and caused them to be more symptomatic.

4. The parties thereafter deposed Dr. Gornet on June 4, 2018. Dr. Gornet testified Petitioner's symptoms and treatment were causally related to his February 16, 2014 accident. He found Petitioner was not yet at maximum medical improvement, because Petitioner could be treated with surgery to improve his quality of life. However, Dr. Gornet admitted he had not reviewed any of Petitioner's treatment records predating February 2014 and indicated Petitioner had not informed him of any prior back problems of significance. Dr. Gornet testified the basis of his opinion assumed that to be factually correct and he had relied on his patient to be truthful. Dr. Gornet also admitted the MRI spectroscopy had not been approved by the federal government as an alternative to discography.

5. At hearing, Petitioner admitted to seeking pre-accident treatment for back pain and injuring his low back in two motor vehicle accidents, but denied he ever missed work or had to limit his activities due to low back pain before his work accident. He further testified he was never prescribed physical therapy or pain medications for his low back before 2014.

   However, Petitioner's treatment records show a substantial prior history of low back injuries and problems. The earliest record is from October 13, 2006, when Petitioner called Dr. Oladele Ajao to report he had hurt his back and wanted X-rays.

   Petitioner reported another low back injury to Respondent's dispensary on December 18, 2007. Petitioner indicated he had pulled his right lateral lumbar area while pushing a casting. Lumbar X-rays obtained on January 16, 2008 revealed mild degenerative changes,

marginal osteophytic spurring, and scoliosis of the upper lumbar convex. Dr. Ajao thereafter diagnosed Petitioner with a low back strain on January 24, 2008 and prescribed physical therapy and muscle relaxants.

When Petitioner began physical therapy on February 6, 2008, the therapist noted Petitioner's past medical history included a slipped low back disc, a prior low back work injury that was treated with therapy, and another prior back injury from a motor vehicle accident. Petitioner reported having intermittent back pain for years and indicated he was sometimes unable to bend, had to quit bowling, and had discontinued exercise. He further expressed difficulty tying his shoes, kneeling, squatting, reaching out to his front, and going to sleep. In a February 28, 2008 progress note, Petitioner indicated he was using pain medication and muscle relaxants once or twice daily for severe back pain. Petitioner was still working but said his foreman was aware of the situation and gave him jobs that did not involve bending. Petitioner continued treating with pain medication and anti-inflammatories into June 2008.

Several months later, on December 3, 2008, Petitioner informed Dr. Ajao he had recently sought emergency care for back pain. Dr. Ajao prescribed Motrin and noted Petitioner's prior history of right low back strains. Petitioner continued treating with Dr. Ajao from May 13, 2010 to June 11, 2010 for ongoing low back pain.

On October 1, 2010, Petitioner returned to Respondent's dispensary and complained of back pain from pushing and pulling castings. Petitioner denied an examination at that time but requested an appointment with the company doctor. A few months later, on December 22, 2010, Petitioner informed Dr. Ajao he had injured his back doing some lifting, but it had gotten worse when he tried to move a patient at work. Petitioner reported he had gone to urgent care, where he was placed on light duty and prescribed Vicodin. Dr. Ajao diagnosed Petitioner with low back pain with radiation to the left lower extremity and severe cervical spine stenosis.

Petitioner thereafter requested medical leave from December 28, 2010 to January 28, 2011 for his back injury. FMLA paperwork indicated Petitioner had worsened his back pain while trying to move a patient at work as a certified nursing assistant around December 8, 2010. The form indicated Petitioner's condition would cause episodic flare-ups that would periodically prevent Petitioner from preforming his job duties.

6. On March 27, 2017, Dr. Michael Chabot provided an independent medical examination report that took into consideration Petitioner's pre-accident records, including but not limited to, Dr. Ajao's records dating back to 2003. Dr. Chabot testified consistent with his report at deposition on June 29, 2018. Dr. Chabot diagnosed Petitioner with advanced degeneration at L3-L4, L4-L5, and to a lesser extent L1-L2 with broad based disc bulging, foraminal stenosis, and mild central canal narrowing. He noted Petitioner's longstanding pre-accident history of back pain and opined that his disc degeneration was not work-

related. He instead attributed it to chronic and progressive changes that would have progressed regardless of Petitioner's activities.

Dr. Chabot further opined that Petitioner had sustained a work-related strain but had reached maximum medical improvement on December 25, 2014 consistent with Dr. Richard Katz's impressions. He further opined that Petitioner's same-day chiropractic and physical therapy treatments were excessive and Petitioner did not require any additional testing or treatment as related to his work accident. Lastly, Dr. Chabot testified the MRI spectroscopy was not accepted in the spine surgeon community as a valid alternative to discography or a diagnostic tool used in conjunction with discography.

7. Dr. Richard Katz also provided independent medical examination reports and testified consistent with his reports at deposition on June 14, 2018. When Dr. Katz first examined Petitioner for his low back claim on April 29, 2014, he lacked adequate records, but believed Petitioner had sustained a benign lumbosacral sprain. Dr. Katz testified Petitioner had normal lumbar range of motion, normal lower extremity reflexes and muscle strength, and negative straight leg raising at this examination.

   On May 21, 2014, after reviewing Petitioner's records, Dr. Katz concluded Petitioner had suffered a benign lumbar strain with preexisting degenerative lumbar spine changes and had reached maximum medical improvement after three months of rehabilitation. On May 22, 2014, Dr. Katz provided a note indicating Petitioner could work without restrictions.

   Dr. Katz further opined it was redundant billing for Petitioner to have been treated by his chiropractor and physical therapist on the same day. At deposition, Dr. Katz testified there was no evidence that such co-treatment at the same time was more efficacious than just being treated by one of the disciplines; and therefore, it was not reasonable nor necessary.

   On December 10, 2014, Dr. Katz examined Petitioner again and found neither Petitioner's examination nor MRI to be suggestive of surgical pathology. Dr. Katz thereafter reviewed recent MRIs on December 25, 2014 and opined that Petitioner had multilevel degenerative disease with a hereditary degenerative pattern. He again found Petitioner's problems were not work related and required no work-related restrictions.

   Dr. Katz last examined Petitioner on September 10, 2015 and found severe tightness in Petitioner's hamstrings and lumbar spine. He again opined the degenerative low back changes were not work-related, but recommended physical therapy for Petitioner's unrelated postural and muscular issues. Dr. Katz further provided a 5% AMA impairment rating for the spine, indicating Petitioner had a Class 1 impairment with a documented history of a sprain and continued complaints of axial pain.

8. This matter proceeded to a §19(b) hearing on July 18, 2018. In the Decision issued on September 17, 2018, the Arbitrator found Petitioner failed to prove causation after July 31,

2014, and therefore, denied temporary total disability benefits and medical expenses incurred after July 31, 2014.

Following a careful review of the entire record, the Commission finds Petitioner achieved maximum medical improvement on December 25, 2014. The Commission further concludes Dr. Gornet's lack of knowledge of Petitioner's prior back problems makes his causation opinion less reliable than the opinions of Dr. Chabot and Dr. Katz. Dr. Gornet testified the basis of his opinion assumed that Petitioner did not have any prior back problems of significance that affected his quality of life or required treatment, and if his reliance on that fact was incorrect, it could change his opinion. Because Dr. Gornet was not provided with correct and complete information on Petitioner's prior medical history, his opinion loses persuasiveness.

Conversely, Dr. Chabot and Dr. Katz were aware of Petitioner's prior medical history and both concluded Petitioner had achieved maximum medical improvement for a causally related lumbar strain. Dr. Chabot found Petitioner was at maximum medical improvement on December 25, 2014 in agreement with Dr. Katz's impressions. The Commission notes that although Dr. Gornet had released Petitioner to full duty work on July 31, 2014, Dr. Gornet clarified at deposition that he had not placed Petitioner at maximum medical improvement on that date. Because Petitioner was not placed at maximum medical improvement on July 31, 2014, despite being returned to full duty, and the more persuasive opinions of Dr. Chabot and Dr. Katz support a conclusion that Petitioner was at maximum medical improvement by December 25, 2014, the Commission modifies the Decision of the Arbitrator to reflect the December 25, 2014 maximum medical improvement date.

In doing so, the Commission denies Petitioner entitlement to medical expenses incurred after December 25, 2014, including but not limited to the MRI spectroscopy, which the Commission notes has not been medically accepted as an alternative to discography. All prospective medical treatment is likewise denied.

The Commission further relies on the opinions of Dr. Chabot and Dr. Katz to find the same-day chiropractic treatments and physical therapy sessions Petitioner attended from February 26, 2014 to July 30, 2014 excessive. Dr. Katz found there was no evidence such same-day co-treatment was more efficacious than just being treated by one of the disciplines; and therefore, it was not reasonable nor necessary. In determining such duplicative co-treatment was not reasonable nor necessary, the Commission modifies the Decision of the Arbitrator to award only Petitioner's physical therapy treatment and not the same-day chiropractic treatment from February 26, 2014 to July 30, 2014.

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 17, 2018, is modified as stated herein.

IT IS FURTHER ORDERED that Respondent shall pay reasonable and necessary medical services that relate only to treatment regarding Petitioner's low back condition before December 25, 2014, as provided in Sections 8(a) and 8.2 of the Act. All medical treatment after December 25, 2014 is denied.

IT IS FURTHER ORDERED that Respondent is not liable for Petitioner's chiropractic treatment with Dr. Eavenson from February 26, 2014 to July 30, 2014. Respondent remains liable for Petitioner's same-day physical therapy sessions from February 26, 2014 to July 30, 2014.

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: MAY 23 2019

Deborah L. Simpson

Barbara N. Flores

DLS/met
O: 4/4/19
46

DISSENT

I find that the evidence supports the Petitioner's claim that his current condition is causally related to his accident of February 16, 2014.

First, the chain of events before and after the accident supports causation. Before the accident, the Petitioner had evidence of pre-existing degenerative disc disease in the lumbar spine,

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as testified to by both Dr. Gornet and Dr. Chabot. He also had some treatment of the lower back dating back to 2006 from his family doctor, Dr. Oladele. However, the treatment differed from that he received after the accident in several ways.

The Petitioner's pre-accident treatment was sporadic in nature. He was seen once in 2006, treated for several months in 2008 and had a month of care in late 2010 and early 2011. Post-accident, his treatment has been continuous, except for the time when he treated for carpal tunnel syndrome. The Petitioner treated with Dr. Evanson shortly after the accident through the end of July 2014. He was referred to an orthopedic specialist, something that was never done before the accident, for treatment beginning in March 2014. The Petitioner has seen that doctor, Dr. Gornet, on a continuous basis since then.

Additionally, no doctor had ever ordered an MRI nor prescribed epidural injections or a TENS unit prior to the accident. Not only have they all been prescribed and tried since the accident but the MRI's, beginning with one done about a week after the accident, have all showed evidence of disc protrusion and foraminal stenosis at L3-4 and L4-5.

The Petitioner had, by all accounts, a fairly physical job with the Respondent for the past 15 years. He performed the job from early 2011 until his accident on February 16, 2014 at full duty without any record of injury or lower back treatment. After the accident, he was restricted by his physicians for over five months. He testified that he did return to his regular job in early August 2014 but said that his lower back pain has continued. While his credibility is of some concern, the objective findings found on the MRI's and seen in Dr. Gornet's examinations support the Petitioner's testimony.

Dr. Gornet has recommended surgery based upon the failure of conservative care and the MRI findings. Dr. Chabot agrees that the Petitioner has advanced degenerative disc disease with foraminal stenosis but does not believe surgery is warranted. Dr. Chabot's position has more to do with the reasonableness of the proposed treatment than causation. Clearly, the treatment prescribed by Dr. Gornet is a reasonable option.

Also, while Dr. Gornet may not have had a complete understanding of the Petitioner's prior treatment, he did know that the Petitioner had a pre-existing condition. He testified extensively about the likelihood that the Petitioner's discs were degenerative and likely caused some symptoms prior to the accident. His causation opinions were based upon the radiologic studies and the diagnostic testing done, as well as his various examination findings.

I agree with the Arbitrator that the Petitioner's failure to elaborate to the doctors on the extent of his pre-existing problems does affect his credibility. If the issue were one of accident or notice, for example, his credibility might be more of a problem. However, the issue here is causation. Even if you were to discount the Petitioner's subjective complaints made to his treatment providers, the objective findings referred to above support causation.

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I believe this case fits the longstanding law in Illinois, as expressed by the Supreme Court in the *Sisbro, Inc. v. Indus. Comm'n* opinion, 207 Ill. 2d 193 (2003), that an accident need only be a cause of the resulting injury. The chain of events in this case, as well as the opinions of Dr. Gornet, support that conclusion.

I do agree with the majority opinion concerning the issues of concurrent chiropractic and physical therapy treatment as well as whether the Respondent would have been responsible to pay for the MRI spectroscopy performed by Dr. Gornet.

D. Douglas McCarthy

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

19IWCC0259

JONES, TYRES
Employee/Petitioner

Case# **14WC006878**

AMERICAN STEEL FOUNDRIES
Employer/Respondent

On 9/17/2018, 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 2.26% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICE
DAVID M GALANTI
PO BOX 99
E ALTON, IL 62024

0385 BOGGS AVELLINO
STEVEN J McMAHON
2900 FRANK SCOTT PKWY WEST 988
BELLEVILLE, IL 62223

19IWCC0259

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)

Tyres Jones
Employee/Petitioner

v.

American Steel Foundries
Employer/Respondent

Case # 14 WC 006878

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **July 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. [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, **February 16, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**40,471.58**; the average weekly wage was $**861.10**.

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

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

Petitioner *is* entitled to temporary total disability benefits from **2.24.14** through **7.31.14**, a period of **22 4/7 weeks.**

Respondent *shall* be given a credit of $**n/a** for TTD, $**n/a** for TPD, $**n/a** for maintenance, and **$5,731.43** for non-occupational indemnity disability benefits, for a total credit of $**5,731.43**.

Respondent *is* entitled to a general credit for any medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Denial of benefits

Petitioner's request for prospective medical care is denied. Petitioner failed to prove that his current condition of ill-being in his low back is causally related to his work accident. Petitioner failed to prove ongoing causation after July 31, 2014.

Temporary Total Disability benefits

Respondent shall pay temporary total disability benefits of **$574.10/week** for **22 4/7 weeks**, commencing on **February 24, 2014**, through **July 31, 2014**, as provided in Section 8(b) of the Act.

Medical benefits

Respondent shall pay the reasonable and necessary medical services incurred by Petitioner through July 31, 2014 as set forth in PX 7, pursuant to the Medical Fee Schedule and as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of for any medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

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

Signature of Arbitrator

September 11, 2018
Date

ICArbDec19(b)

SEP 17 2018

FINDINGS OF FACT and CONCLUSIONS OF LAW

The Arbitrator finds:

Medical records dating back to 2003 were admitted into evidence.

Petitioner has been a patient of Dr. Ajao's since December 1, 2003. He saw the doctor that day after claiming he had sustained an injury to his left leg on November 13th while at work when a heavy object weighing over 2000 lbs. fell on his lower leg. No back complaints were noted. (RX 3)

Dr. Richard T. Katz examined Petitioner on February 9, 2006 for purposes of an independent medical examination. Petitioner worked for Respondent as a welder, having begun there on July 11, 2003. Petitioner was being examined for symptoms suggestive of carpal tunnel syndrome, bilaterally. (Ex. 2 to RX 2)[1] Petitioner denied any difficulty with neck pain or numbness/tingling of the lower extremities. A history of back pain and joint pain was noted. Dr. Katz reached no conclusions regarding Petitioner's upper extremity complaints as he needed additional information.

Dr. Katz performed a nerve conduction study on February 16, 2006. (Ex. 2 to RX 2) A review of a job description and videotape was discussed in a report dated April 4, 2006. (Ex. 2 to RX 2)

On October 3, 2006 Petitioner telephoned Dr. Ajao's office reporting he had hurt his back and wished to see the doctor because he wanted an x-ray. Petitioner was advised to go to Quick Care or the ER. (RX 3, p. 6)

Dr. Katz issued a supplemental report regarding Petitioner's upper extremities on December 27, 2006. (RX 2, dep. ex. 2)

On December 18, 2007 Petitioner presented to Respondent's Dispensary reporting that he had "pulled something" while pushing a bolster and feeling pain in his right side. He was to see the company doctor. When examined by the company doctor Petitioner again reported feeling a pull in the right lateral lumbar/right posterior rib area area while pushing casting points. Petitioner denied any SI or groin pain but noted symptoms when twisting or bending and felt "tight." He denied any radicular symptoms. Petitioner was given ice and Ibuprofen and an ace wrap to the area. (RX 4)

Petitioner returned to Respondent's Dispensary on December 20, 2007 with ongoing symptoms in the right flank area but which were now constant and worse with turning. On examination, he was noted to have minor tenderness to palpation in the lower ribs, but no point tenderness. Observation was recommended with a recheck after the Christmas Break. (RX 4)

On January 16, 2008 Petitioner underwent lumbar spine x-rays at Southwest Medical Center, per the request of Dr. Vyas. Mild degenerative changes were noted. (RX 3, p. 7)

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[1] The yellow highlighting contained in Ex. 2 to RX 2 was not done by the Arbitrator.

On January 24, 2008 Petitioner was seen by Dr. Ajao for back and neck pain and headaches. The doctor noted he had last seen Petitioner on July 12, 2006. Petitioner was in his usual state of health until six weeks earlier when he reportedly hurt his back pulling a caster at work. He had been seen by the company doctor. His symptoms were "slow him down" by the medications but he was having trouble sleeping at night because of the discomfort. Petitioner had also been in a car accident three weeks earlier and sustained a neck injury. He had seen Dr. Vyas in Chesterfield and was told he had a concussion. The headaches which he had not had before were now much worse. He also complained of dizziness. He was diagnosed with a right lower back strain and therapy was recommended along with x-rays. (RX 3, pp. 8 - 10)

On February 6, 2008 Petitioner appeared at Gateway Regional Medical Center for an initial physical therapy evaluation. Petitioner gave a history of his motor vehicle accident. His complaints included pain in his neck, the right side of his mid back and the lower back. He also reported headaches. Petitioner's pain in his back was described as a "6/10" and "8-9/10" in the right middle of his back. The pain was sharp and aching. Petitioner was managing his pain with medication three times a day and a muscle relaxer two times a day. He had also undergone two pain shots. His goal was to "get rid of the pain." The therapist noted that Petitioner had a "significant medical history" in the past for a "slipped disk" in his lower back. He had injured his lower back years ago at work and was treated with exercise and therapy. He also had a back injury from another motor vehicle accident. Petitioner had undergone bilateral carpal tunnel surgery about one year earlier, including right elbow surgery. Petitioner further related that he had been having intermittent back pain for years which he rated from "5 – 10/10" at times. He self-treated with over-the-counter medications. He also had a history of intermittent neck pain. Petitioner reported that he was sometimes unable to bend, had difficulty bowling, and had to discontinue exercise. He described his sitting tolerance as about 15 minutes. He reported difficulty getting out of bed in the morning, tying his shoes, kneeling and squatting, reaching out to the front and trouble getting to sleep. His lifting tolerance was 25-30 lbs. Petitioner worked full-time as a welder, without any restrictions. On exam Petitioner had increased lumbar lordosis and an anterior pelvic tilt. He had limited flexion and bending with complaints of pain in the right rib cage. Therapy was recommended 2-3 times a week for 2-4 weeks.

Petitioner attended physical therapy on February 28, 2008 reporting some improvement but not feeling as good as he should. He denied any pain when lying down but it would begin as he would get out of bed and get worse, especially if he had to go to work. His back pain was rated a "constant' "5/10" with periodic increases to "9/10." His right mid-back pain was "on and off" at "5/10." Petitioner reported he had limited sitting ability of 15-20 minutes and was not lifting more than 25-30 lbs. His walking tolerance was 45-60 minutes. Standing was limited to 60 minutes due to neck pain. Bending was limited due to back pain. Petitioner reported difficulty with dressing due to bending and difficulty reaching overhead due to neck pain. Petitioner was continuing to work but his foreman was aware of his situation and trying to give him jobs that didn't involve a lot of bending. He had tried exercising at the Y but had to give it up due to dizziness. (RX 3, p. 17)

Dr. Ajao re-examined Petitioner on March 4, 2008 regarding his neck and back pain and other complaints. Petitioner reported improvement in his back pain but ongoing and considerable neck pain. They also discussed his complaints of dizziness. (RX 3, p. 21)

On March 7, 2008 Dr. Ajao issued a script for ongoing neck and back pain therapy. (RX 3, p. 24)

Dr. Ajao examined Petitioner on April 2, 2008 primarily for an upper respiratory infection. His notes, however, indicate that Petitioner admitted to benefiting from physical therapy. (RX 3, p. 25)

Petitioner returned to see Dr. Ajao on June 6, 2008 regarding his neck and back pain. He had completed his physical therapy session but still reported neck and back pain. On exam, his lower back was tender. He was given a script for Naproxen and Flexeril, the latter of which were not be taken when driving or operating machinery. (RX 3, p. 27)

Petitioner returned to see Dr. Ajao on December 3, 2008 regarding chest pain and back pain. He had been seen in the emergency room with back pain. Dr. Ajao prescribed Motrin. (RX 3, p. 3)

Petitioner returned to see Dr. Ajao on December 17, 2008 regarding his chest pain and pain in his hands and elbows. No back complaints were noted at that visit. (RX 3, p. 33)

Petitioner underwent a physical examination for nursing school on September 25, 2009. Dr. Ajao noted a history of neck and right lower back strain. Petitioner was told he needed to see a cardiologist for his abnormal stress test and he had cancelled or "no showed" on at least three occasions. He also appeared to have symptoms of carpal tunnel syndrome and was referred to an orthopedic/hand surgeon for consultation. (RX 3, p. 35) Petitioner followed up with Dr. Ajao after seeing the cardiologist and having a normal cardiac catheterization. School papers were issued. (RX 3, p. 37)

Dr. Gil Vardi examined Petitioner on October 19, 2009 regarding his chest pain. He noted complaints of back pain. Petitioner's cholesterol medications were adjusted. (RX 3, p. 45)

Petitioner returned to see Dr. Ajao on May 13, 2010 reporting dizziness, occasional headaches, and low back and neck pain. On exam, low back tenderness was noted. He was prescribed 800 mg. Ibuprofen for his back pain along with x-rays. (RX 3, p. 40)

Petitioner's lumbar spine x-ray taken on May 28, 2010 did not show any evidence of lumbar spine disease. (RX 3, p. 47)

Petitioner returned to see Dr. Ajao on June 11, 2010 regarding his history of dizziness and sinusitis. His medications included 800 mg. of Ibuprofen. The doctor recommended that Petitioner work on improving his posture regarding his low back and if the pain persisted, an MRI would be appropriate. He was released to return as needed. (RX 3, p. 50)

Petitioner reported to Respondent's Dispensary on October 1, 2010 complaining of back pain from pushing and pulling castings. He denied undergoing an exam but did request an appointment with the company doctor and one was scheduled for October 7, 2010. There is no indication that the appointment was kept or cancelled. (RX 4)

Petitioner presented to Dr. Ajao's office on December 22, 2010 after having last been seen on "01/11/10." Petitioner reported he was "doing some lifting and injured his back. This got worse when he went to work and he was trying to move a patient. He went to the Urgent Care Center where he was seen and evaluated. He was taken off full duty and placed on light duty." Petitioner was also prescribed some Vicodin. He stated that the pain was in the left side of his lower back and radiated down his left lower leg with some numbness and tingling to the left thigh. He did not recall seeing a neurosurgeon in Belleville. Straight leg raise was "intense" on the left and limited to about 10 degrees. There was point tenderness on the left lower part of his back and a radicular sensation in the anterior and posterior part of his left thigh. The doctor's assessment was left-sided low back pain with radiation to the left lower extremity and severe spinal stenosis of the cervical spine. He was prescribed a short course of prednisone and the doctor was going to look into the neurosurgical referral. (RX 3, p. 51)

On December 23, 2010 Dr. Ajao referred Petitioner to Drs. Poulos and Yazdi regarding neck pain and severe spinal stenosis. (RX 3, p. 54) On December 27, 2010 the doctor signed off on a Request for Leave of Absence form due to a back injury. (RX 3, p. 55) Petitioner was working part-time (evenings) as a CNA at Clealon Douglas-Macon. (RX 3, p. 57) In the Medical Section of the form (RX 3, p. 58) a request was made for medical facts related to the leave. The doctor wrote, "Back pain after [illegible] while moving. Back pain worsened while at work after he was trying to move a patient." (RX 3, p. 58)

In a noted dated February 8, 2011, the office of Drs. Poulos and Yazdi advised Dr. Ajao that Petitioner did not make an appointment having advised the office that he was doing better. (RX 3, p. 62)

On August 6, 2012 Petitioner was seen by Dr. Ajao for kidney stones. Petitioner's past medical history included "chronic low back pain." (RX 3, p. 63)

On September 17, 2012 Dr. Ajao examined Petitioner regarding hand complaints. (RX 3, p. 65)

Dr. Ajaos re-examined Petitioner on December 19, 2012 for multiple complaints including left lower leg swelling, a headache, dizziness, and painful arms. No specific low back complaints were voiced. (RX 3, p. 67)

Dr. Katz re-examined Petitioner on February 14, 2013 regarding bilateral upper extremity complaints. A pain diagram was completed showing cervical, upper back and bilateral upper extremity complaints. X-rays of Petitioner's hand were reviewed on February 21, 2013. An impairment rating was issued on October 23, 2013. (RX 2, dep. ex. 2)

On February 17, 2014 Petitioner completed a "Statement of Injured Party." He provided an accident date of February 16, 2014 stating that while moving casting plates he "felt pain" in his back at the waist on the right side. He did not seek treatment for the symptoms and didn't report it until the 17th because the pain was not that severe. Petitioner denied any pain, discomfort, numbness, or other symptoms to those injured body parts before this incident. (RX 5)

On February 18, 2014 Petitioner presented to Respondent's Dispensary complaining of right back pain at the level of his waist. He stated, "I would like to report an injury that happened yesterday @ about 2:30 p.m. or 3 p.m. I was lifting plates. I was moving them over to a cart. The cart was on my left side so I would pick one up & move it to the left on the cart. I felt a sharp pain and it got worse. I put some heat one [sic] it last night. I didn't report it because I couldn't find my supervisor." Petitioner was noted to have no guarding, a normal gait, no swelling and was not tender to touch. Petitioner further reported that he had been moved to that area the day before because the department was short-handed. Petitioner requested 200 mg. Ibuprofen and then left. (PX 1; RX 4)

Petitioner signed his Application for Adjustment of Claim in this matter on February 21, 2014. He alleged that he injured his back lifting a pallet. (AX 2)

Upon the referral of his attorney[2], Petitioner next sought medical care from Dr. Eavenson on February 24, 2014. Petitioner gave a history of lifting pallets and stacking them. At one point he turned the wrong way and felt a sharp stabbing pain in his lower back. He initially used Icy Hot at home and the next day he could barely walk. He reported the injury. Petitioner related being diagnosed with a strain and being placed on Ibuprofen and being told it would hurt for a few weeks. Unfortunately, it had continued and worsened and he presented for evaluation. His current complaints included lower back pain with bilateral calf pain. Petitioner's past medical history was positive for a back strain in the 1980s for which he was treated at the Central Medical Center and no surgery was required. He denied taking any medications currently. On examination Petitioner was uncomfortable with bilateral lumbar spasms and diffuse tenderness being noted. Straight leg raise was positive with pain appearing to be at L5-S1. He was diagnosed with a lumbar disc protrusion. (PX 2, p. 48/50) An MRI of a lumbar spine was recommended and, if the MRI was positive, a referral to a surgeon. (Id.) Petitioner was placed on light duty restrictions (Id.)

Petitioner began losing time from work as of February 24, 2014. (AX 1)

An MRI of the lumbar spine was obtained on February 25, 2014. The Radiologist's impression was a broad-based disc protrusion at L1-2 and facet arthropathy resulting in mild lateral spinal canal stenosis and bilateral mild foraminal encroachment at L3-L4, L4-L5. (PX 5 at 15).

Petitioner followed up with Dr. Eavenson on February 25 and 26, 2014. The therapist noted that, per the patient, his MRI showed herniated discs. The MRI was reviewed by Dr.

[2] See Dr. Chabot's written report attached to his deposition.

Eavenson on February 25, 2014 and Dr. Eavenson agreed with the Radiologist's findings. (RX 2 at 46). Dr. Eavenson referred Petitioner to Dr. Gornet. (Id.).

Petitioner returned to see Mr. Voss, the therapist, and Dr. Eavenson on February 27, 2014. Mr. Voss noted Petitioner tolerated treatment without incident. Petitioner told the doctor he was really hurting that day. Dr. Eavenson was going to try and get him in to see Dr. Gornet the following week or week thereafter. (PX 2, p. 38)

Petitioner returned to see both Mr. Voss and Dr. Eavenson on March 3, 2014, reporting to the doctor that he was getting worse. He returned to see both on March 4, 2014. He tolerated therapy without incident but when seen by the doctor reported feeling "awful" with low back pain and numbness in both his legs. When he coughed, it would bring him to his knees. He was worse when seen by the doctor on March 5th. (PX 2, pp. 33 – 37)

On March 6, 2014 Petitioner attended therapy and told Mr. Voss his back was feeling a little better. (PX 2, p. 29) When seen by Dr. Eavenson he reported lower back pain and a lot of achiness in both legs. (PX 2, p. 28)

On March 10, 2014 Petitioner told Mr. Voss his back was worse but he didn't know why. He performed his exercises with discomfort. When Dr. Eavenson examined Petitioner, he described himself as "all locked up today." (PX 2, p. 26)

Petitioner saw Dr. Eavenson and Mr. Voss on: March 11, 2014; March 12, 2014; March 13, 2014; and March 17, 2014. On the 17th he advised that he was seeing Dr. Gornet that day. He had ongoing complaints of low back pain and was noticing a lot of pressure in his lower back, especially on the right side. When undergoing therapy with Mr. Voss, he did so without complaint. (PX 2, pp. 18 – 25)

Dr. Gornet first saw Petitioner on March 17, 2014. As part of the exam, Petitioner completed a questionnaire as well as a pain drawing. Petitioner presented with a chief complaint of low back pain to both sides, both buttocks and hip and down both legs to his knees as well as a pain up to his mid back. His right side was slightly worse than his left. Petitioner gave a history of being sent down to stack and lift pallets and doing what he described as "chaining". During that time, he felt pain. He has been seeing Dr. Eavenson for three weeks and has had some mild improvement but still, fairly, significant pain. He was on restrictions although he didn't know the specifics. Petitioner did not recall any previous problems of significance with his back. He had been working for Respondent for eleven years. Dr. Gornet diagnosed central protrusions at both L3-L4 and L4-L5 resulting in lateral recess stenosis and foraminal stenosis. (Id. at 27). Dr. Gornet recommended continued conservative care with Dr. Eavenson and if he was not improved by the next office visit, a trial of injections. (Id.).

Petitioner was next seen by Dr. Gornet on April 10, 2014. Petitioner was improved and now localized his pain to the right side and right buttocks and hip, rather than bilaterally as before. (Id. at 25). Dr. Gornet opined that his pain was being generated by an annular tear at L4-L5 on the right side as indicated by the MRI. (Id.) Epidural injections were recommended.

Petitioner followed up with Dr. Eavenson and Mr. Voss on March 18, 2014 noting the doctor wanted him to continue his treatment for the next three weeks and if he didn't improve he would consider injections and then surgery. Petitioner reported a lot of pain the night before and difficulty sleeping. When seen by Mr. Voss he told him Dr. Gornet had recommended six more weeks of therapy. (PX 2, pp. 15 – 16)

Petitioner continued to treat with Dr. Eavenson and Mr. Voss on March 18, 20, 24, 25, 26, 27, and 31, 2014. (PX 2, pp. 1 – 14)

Petitioner continued to follow up with Dr. Eavenson and Mr. Voss in April and May of 2014. As of April 1, 2014, the doctor noted "he seems to have taken turn for the worse. He is having more pain in the right lower back," (PX 2, p. 112/114)

Dr. Gornet re-examined Petitioner on April 10, 2014 noting Petitioner had undergone six weeks of conservative care and his symptoms seemed to be improving to some extent but his pain was now really localized to the right side and the right buttock and hip whereas it had previously been bilateral. He recommended a steroid injection at L3-4 and L4-5 transforaminally as well as one epidural at L4-5. He was to continue light duty. (PX 3, p. 25)

Dr. Katz was asked to re-examine Petitioner on April 29, 2014 regarding issues with his hands and arms in regard to his 2012 claim. He was also asked to examined Petitioner regarding his low back injury of February 16, 2014. Petitioner completed a pain drawing showing cervical bilateral shoulder, central back and lower back complaints and symptoms in his legs, bilaterally. He also had elbow and arm/hand issues noted. Dr. Katz noted complaints of pain, rated "8/10" which was present "24/7." Dr. Katz performed an examination. He felt Petitioner had sustained a benign lumbosacral sprain; however, he did not have adequate records to review as he wished to see the MRI scan and notes from Dr. Eavenson. (RX 2, dep. ex. 2)

Petitioner underwent epidural injections at L3-L4 on May 7, 2014 and May 19, 2014 at L4-L5 with Dr. Boutwell (PX 4). Petitioner testified at trial that these injections gave him a couple of weeks of temporary relief with his pain symptoms.

Dr. Katz issued an addendum on May 21, 2014 after reviewing records from Dr. Eavenson and Therapist Voss, along with additional records from Dr. Gornet, a 3/17/14 lumbar spine film and a 2/25/14 MRI described as being of poor quality but showing multilevel degenerative changes. Dr. Katz felt the treatment by Dr. Eavenson and Mr. Voss was redundant billing as they were co-treating on the same day. He further stated that use of heat/cold/e-stim for more than two weeks after the onset of lower back pain was not reasonable and necessary treatment. His diagnosis of a benign lumbar spine strain remained unchanged. He felt Petitioner was at MMI after three months of rehabilitation and noted that both the chiropractor and therapist had noted improvement. He rendered a 0% impairment rating. In another addendum dated May 22, 2014 Dr. Katz stated Petitioner could work without restrictions. (RX 2, dep. ex. 2)

Petitioner continued with therapy and visits with Dr. Eavenson in June and July of 2014. (PX 2)

Petitioner returned to see Dr. Gornet on June 9, 2014. Petitioner reported that the injections helped but he still felt limited with increased activities, bending and lifting. Dr. Gornet wished to have him undergo work hardening at MultiCare five days a week. (PX 3, p. 24)

Following the injections, Dr. Gornet saw Petitioner on July 31, 2014 (PX 3, p. 23). Petitioner felt stronger and improved, and Petitioner wanted to do a "trial" of return to work full duty. (Id.). Dr. Gornet noted Petitioner was definitely not at maximum medical improvement yet as he still had significant disc pathology at L3-L4 and L4-L5, but Dr. Gornet was trying to manage him conservatively. (Id.).

Petitioner returned to full duty work for Respondent on August 1, 2014. (AX 1)

On August 21, 2014 Petitioner presented to Dr. Ajao's office, having last been seen December 19, 2012. Petitioner stated that he had hurt his back at work. The doctor wrote, "He was seen Dr. Everston? Then referred to Pain Management and then Dr. Garnett [sic]?" He had undergone physical therapy and injections, was offered surgery and tried to go back to work as a welder and his "back is killing him." His assessment was "physical exam, weight loss, and congestion." (RX 3, pp. 69-70)

Petitioner reported to Respondent's Dispensary on September 3, 2014 reporting left hand pain and swelling after pulling a cable that was stuck, resulting in his hand "flying" back and striking a casting. A cool compress was applied and 200 mg. of Ibuprofen was dispensed per Petitioner's request. Petitioner felt better upon discharge. (RX 4)

Petitioner presented to Respondent's Dispensary on September 16, 2014 for a contusion to his left fourth distal metacarpal which had been injured on September 3, 2014. Treatment was provided and an x-ray was offered, but declined. (RX 4)

Petitioner presented to Respondent's Dispensary on September 18, 2014 regarding his left eye after getting dust in it. His eye was flushed. (RX 4)

Dr. Gornet re-examined Petitioner on September 22, 2014. He had undergone a trial of full duty and while working was relying upon a back brace to tolerate his symptoms. His script for Meloxicam was renewed. He was also given a script for Flexeril. Dr. Gornet noted Petitioner had a disc herniation at L1-2 and some "disc pathology" at L3-4 and L4-5. He ordered a new MRI. (PX 3, p. 22)

Dr. Ajao re-examined Petitioner on October 2, 2014 regarding his diet and cholesterol. His back pain was to be further evaluated in follow up. (RX 3, pp. 73-74)

Petitioner presented to Respondent's Dispensary on October 9, 2014 regarding a spot burn at the base of the left side of his neck. The area was cleansed and gel provided. (RX 4)

Dr. Gornet met with Petitioner on October 30, 2014 noting that the new MRI "clearly" showed what the doctor felt was some progression of Petitioner's disc pathology at L3-4.

Petitioner felt his symptoms were worse and he explained that he had responded very well to injections in the past. Therefore, two injections were recommended. (PX 3, p. 21)

Petitioner underwent injections at L3-L4 and epidural injections at L3-L4 and L4-L5 on November 24, 2014 and December 8, 2014, respectively. (PX 4).

Dr. Katz, at the request of Respondent, on December 10, 2014, reviewed additional materials. He noted that Petitioner's back pain had "calmed down" at some point but still hurt. He had been returned to full duty work on July 31, 2014. Petitioner was examined by the doctor with the doctor concluding that he found neither the exam and MRI suggested surgical pathology. He felt Petitioner had degenerative changes but that his low back pain was primarily related to posture, noting very tight hamstrings and abductors of the hips. He felt Petitioner needed extensive strengthening and stretching and a regular exercise program outside of work. Dr. Katz did not believe Petitioner's low back pain was work related but believed it needed to be addressed with his primary care doctor as it strongly affected his quality of life. Dr. Katz noted there was scant evidence that epidural steroid injections were a reasonable treatment mode for degenerative spine disease and Petitioner had no acute radiculopathic syndrome. He, again, noted what he called the "redundant and unnecessary" treatment by Dr. Eavenson and the therapist. (RX 2, dep. ex. 2)

On December 25, 2014 Dr. Katz issued an addendum based upon his review of two recent MRIs. He concurred with the radiologist's impression stating, "Petitioner has multilevel degenerative disease and thus the hesitation to do surgery by Dr. Gornet. Clearly, this is a hereditary degenerative pattern" and not work-related. He did not feel Petitioner had any evidence of neurological low back pain. His symptoms and findnigs were more consistent with biomechanical problems. (RX 2, dep. ex. 2)

On January 12, 2015 Petitioner presented to Respondent's Dispensary regarding a non-occupational matter as he had undergone right hand surgery on January 9, 2015 and was off work through approximately March 9, 2015 per his surgeon, Dr. Beatty. Petitioner's case was described as "disputed." (RX 4)0

Following the injections, Petitioner was again seen by Dr. Gornet on January 15, 2015. Dr. Gornet noted that Petitioner experienced temporary relief only and that no further injections were warranted. A TENS unit was prescribed. (PX 3, p. 20) Dr. Gornet considered a fusion/disc replacement at L3-L4 and L4-L5, but also considering placing him on permanent bending and lifting restrictions to forego the fusion. Petitioner was still complaining of pain and was not at MMI. (Id.).

On March 16, 2015, Dr. Gornet again examined Petitioner noting that he was going to be off work for an upcoming carpal tunnel surgery. Although consideration could be given to surgery, the doctor noted he was trying to manage him conservatively if at all possible. He was going to manage him until his symptoms were so significant that he could not work and then restrictions would be imposed. The doctor felt all of Petitioner's symptoms were causally connected to his work injury. (PX 3, p. 19)

Petitioner presented to Respondent's Dispensary on March 27, 2015 with a release to return to work post bilateral carpal tunnel surgeries. He was released to return to work on March 30, 2015. A visit with the company doctor was scheduled for the next day, the 31st, and the visit took place. Petitioner was released to return to work post his carpal tunnel surgery. (RX 4)

Petitioner presented to Respondent's Dispensary on April 17, 2015 for a post-accident drug screen and "BAT." All results were negative. Petitioner advised he would be back the next day but was going home. It was noted that he had not been sent home by Medical. (RX 4)

Dr. Gornet re-examined Petitioner on September 10, 2015 for his low to mid-back pain and bilateral leg pain, having last been seen in March. His working diagnosis was discogenic pain emanating from L3-4 and L4-5. His exam was unchanged and Petitioner reported that his pain and symptoms were affecting all aspects of his life. Medications were dispensed. The doctor wanted a new MRI to make sure his problems were not progressing and Petitioner felt he might still require further treatment. As such, Dr. Gornet noted concern about placing him at maximum medical improvement (MMI). (PX 3, p. 18)

On that same day, September 10, 2015, Dr. Katz re-examined Petitioner regarding both his upper extremities and his low back. Petitioner was noted to be wearing a back brace. He denied any radiating pain or numbness or tingling in his legs. Sacroiliac biomechanics were markedly limited by his severe lumbosacral and hamstring tightness. Lumbar range of motion was markedly reduced in flexion, extension, lateral flexion, and rotation. Manual examination of the lumbar paraspinal musculature was unremarkable. In his report Dr. Katz commented on no signs of symptoms magnification or pain behaviors. His earlier diagnoses remained unchanged. He still believed Petitioner had sustained a lumbar sprain and nothing more. He had non-work-related degenerative changes in his back and would benefit from therapy for that. He did not think the injections were reasonable, necessary or work-related. Finally, Dr. Katz felt Petitioner was at MMI and needed no further treatment. He rendered an impairment rating of 5% of the spine. (RX 2, dep. ex. 2)

Petitioner presented to Respondent's Dispensary on September 16, 2015 complaining of a burn on his left leg sustained while welding. The area was cleaned and treated and Petitioner was sent back to work. (RX 4)

Petitioner presented to Respondent's Dispensary on September 23, 2015 for continued left eye irritation. He had been there the day before reporting there was something in his eye but no foreign body was noted and the eye was flushed three times before Petitioner was allowed to return to work. Again, his eye was examined with no evidence of a foreign body. It was flushed three times. Petitioner returned three hours later with ongoing irritation complaints and an appointment was scheduled with SureVision for later that day. After that appointment Petitioner returned to Respondent's Dispensary and reported he had no foreign body but was suffering from dry eyes with irritability due to scaring on the cornea of his eyes. Petitioner was advised that this was non-occupational. (RX 4)

Petitioner presented to Respondent's Dispensary on October 21, 2015 for a burn to his left cheek while cutting on a caster. (RX 4)

Petitioner underwent a random drug screen at Respondent's Dispensary on December 2, 2015. The results were negative. (RX 4)

On March 18, 2016 Petitioner presented to Respondent's Dispensary regarding his eyes. A small eye lash was removed from the right eye. His left eye was flushed with drops. (RX 4)

A radio frequency ablation at L3-L4, L4-L5, and L5-S1 was performed by Dr. Helen Blake on August 9, 2016 on the right side and on the left side on August 23, 2016. (PX 4 at 1-4).

Dr. Ajao examined Petitioner on August 30, 2016. No back complaints were voiced. (RX 3)

Following the rhizotomies, Petitioner was seen by Dr. Gornet on October 3, 2016. (PX 3 at 16). Dr. Gornet noted that he was seeing Petitioner for symptomatic back and buttock pain which affected his quality of life and most aspects of his life. Petitioner had failed his rhizotomies procedure. (Id.) He recommended a discogram at L3-L4, L4-L5 and L5-S1 CT Discogram. While the plant had been on shut down for the last few weeks Petitioner was still reporting significant pain affecting him and wished to move forward with some type of intervention that would relieve his symptoms.

Dr. Ajao examined Petitioner on November 16, 2016 regarding weight loss among other issues. No low back problems were noted as he denied any back pain. Nothing unusual was noted upon examination of his back. (RX 3, p. 79). (RX 3, pp. 76- 80)

The discogram was performed on November 21, 2016. Dr. Gornet noted a non-operative provocative disc at L5-S1, but a provocative disc at L4-L5. (PX 3; PX 6 at 16). The L3-L4 level was not tested given the appearance of the MRI being so similar to the L4-L5 level of MRI. (Id.). The MRI spectroscopy confirmed that there were objectively painful chemicals at the L3-L4 levels as well as L4-L5. (Id. at 18). No painful chemicals were noted at any other level. (Id.). Dr. Gornet recommended a disc replacement at L3-L4 and L4-L5. (Id. at 19).

Petitioner followed up with Dr. Gornet on November 21, 2016. They reviewed his discogram which was negative at L5-S1 but positive at both L3-4 and L4-5. Dr. Gornet felt a disc replacement at those levels would be best. Petitioner was working full duty and they discussed whether he should continue doing so but allowed him to do so noting Petitioner was "fairly adamant" that his pain and symptoms affect all aspects of his life and quality of life. (PX 3, p. 14)

Petitioner returned to see Dr. Gornet on February 9, 2017 who noted an IME with Dr. Chabot was pending. Dr. Gornet noted that Petitioner's real issue was his quality of life and Petitioner continued to believe his symptoms affected most aspects of his life and quality of life. Dr. Gornet felt a two-level disc replacement would provide Petitioner his best chance of improving his quality of life without disrupting his function and overall ability to work. Approval was pending. No exam appears to have been done. (PX 3, p. 13)

Petitioner was examined by Dr. Chabot on March 27, 2017. A written report issued thereafter. (RX 1, Depo Ex 2). Petitioner advised Dr. Chabot that he was working on 2/16/14 and had to pick up metal plates and stock them. The plates weighed between 30 – 35 lbs. He also had to pick up a chain. He reported that he began developing increasing back pain while performing those activities and he sought treatment at the facility's dispensary. At the time of the exam, he was working regular duty for Respondent. Petitioner's presenting complaints were a severe, aching, cramping pain. His symptoms appeared to worsen with more vigorous activities and improved with rest. He denied a limp or need for a cane/walker. His work duties require bending, twisting, and lifting. He reported that he had to wear a back brace at work. Dr. Chabot reviewed records from Dr. Ajao going back to 2003, Dr. Katz going back to 2006, Dispensary records going back to 2007, Dr. Beatty going back to 2013, Dr. Eavenson/Cory Voss going back to 2/24/14, Dr. Gornet going back to 3/17/14, and Dr. Boutwell and Dr. Blake going back to 4/21/14. On exam of the lumbar spine, Petitioner revealed no tenderness to palpation or spasm. He was able to bend forward greater than 90 degrees to remove his socks. His observed active range of motion was inconsistent with range of motion testing. Seated and supine straight leg raise testing was negative. Dr. Chabot reviewed a lumbar spine MRI dated 2/25/14, a lumbar spine MRI dated 10/30/14, a lumbar spine MRI dated 2/1/16, and a discogram CT study dated 11/8/16. Dr. Chabot concluded that the medical records clearly documented a prior history of long-standing back pain complaints pre-dating his injury. He noted that Petitioner had been previously referred to neurosurgeons for consideration of surgery but he never followed through. Dr. Chabot did not feel that Petitioner's advanced disc degeneration at L3-4 and L4-5 was related to his alleged work accident. The changes were chronic and progressive regardless of his activities. He saw no evidence of any acute changes on the MRI studies to indicate a disc injury. At most, he sustained a strain and the doctor concurred with Dr. Katz's earlier impressions regarding the type of injury sustained by Petitioner. Petitioner's sensory examination was diffuse, non-specific and didn't follow any specific dermatomal pattern. His observed flexion was inconsistent with testing results as when he flexed greater than 90 degrees to remove his socks but could only forward flex to seventy degrees when being tested. Dr. Chabot felt Petitioner had sustained a strain, was at MMI, and needed no further treatment or testing. He felt the treatment with Dr. Eavenson and Mr. Voss was excessive, stating "The inconsistencies with his LE muscle strength were not supported with his performance during PT, where at one point he was performing PT for greater than 4 hours. It is unlikely that an individual with global LE weakness as reported by Mr. Voss and RLE or LLE weakness as reported by Dr. Eavenson could have performed such physical endeavors if muscle strength weakness was present." (p. 20 of his report). He did not feel that additional treatment with Dr. Eavenson and Mr. Voss was necessary. He did not feel injections were warranted as there was no evidence of any neurologic changes to warrant them. He further added that Dr. Gornet consistently specified that Petitioner's complaints were associated with disc disease and the rhizotomies were performed when no test injections of those facets was undertaken to determine if they were a source of the pain. He also reported that MRI spectroscopy is an unproven diagnostic tool which has not been validated through the medical literature nor approved by the federal government. He concluded that if Petitioner proceeded with surgery it would be for chronic degenerative disease unrelated to his alleged work injury. (RX 2 to RX 1)

Petitioner returned to see Dr. Gornet on January 18, 2018. The doctor noted that Petitioner was having significant issues regarding his quality of life. He was continuing to work

but it was affecting him as he was continuing to have pain. Dr. Gornet was provided with a copy of Dr. Chabot's IME report from March of 2017. Dr. Gornet noted that the history provided to Dr. Chabot was "not in line exactly with the history provided" to him. He also noted that Dr. Chabot did not mention that Dr. Gornet had seen Petitioner approximately four weeks after the alleged injury. Dr. Gornet documented his discussion with Petitioner regarding his rationale for a discogram and the MRI spectroscopy. He further noted that he explained to Petitioner that the diagnosis of a simple lumbar strain was simply "illogical" as he was unaware of any patient in the entire world who has had a lumbar strain for four years. He wrote, "It is more likely that he injured his underlying degenerative discs at L3-4 and L4-5 making them more symptomatic." Petitioner requested more medicine to try to help him keep going. The doctor felt that was bad physiologically and that Petitioner should try and live with his symptoms as best he can. He noted Petitioner must stop working but is motivated to try and work, even though miserable. No examination was conducted at the visit. (PX 3, p. 1)

The deposition of Dr. Gornet, a board-certified orthopedic surgeon, was taken on June 4, 2018. Dr. Gornet testified consistent with his office notes. He further testified that Petitioner is suffering from discogenic pain which, while not causing severe neurologic dysfunction or abnormality, is nonetheless, painful and requires treatment. While he originally felt there was some involvement at L1-L2, he has currently focused his treatment at the L3-4 and L4-5 levels and the doctor is now recommending a two-level disc replacement or, possibly, a fusion instead. Based upon the history provided to him by Petitioner, Dr. Gornet felt Petitioner's symptoms and need for treatment were causally connected to his work accident. On cross-examination Dr. Gornet acknowledged that Petitioner denied any prior back problems of significance. (PX 6)

The deposition of Dr. Katz was taken on June 14, 2018. (RX 2) Dr. Katz testified consistent with his earlier reports. He is board certified in physical medicine and rehabilitation. On cross-examination, Dr. Katz acknowledged that he is a doctor of medicine and not a surgeon. He acknowledged that the lifting of plates could cause a lumbar disc herniation and could aggravate pre-existing degenerative disc disease. He also acknowledged that there is a sizeable number of people whose low back sprains do not resolve within six weeks. He reiterated that injections should not be used for degenerative disc disease or facet problems. He acknowledged that radiofrequency ablation can be used for a facet problem but not d.d.d. He also acknowledged that he hasn't seen Petitioner since September 10, 2015. He has not reviewed any additional records since that time.

The deposition of Dr. Chabot was taken on June 29, 2018. (RX 1) Dr. Chabot is a board-certified spine surgeon. He, too, testified consistent with his written report. (RX 1 at 4). Dr. Chabot specifically commented in comparing the MRIs of the lumbar spine from October 30, 2014 to February 1, 2016 that the changes were more pronounced on the latter study at L3-L4 and L4-L5. (Id. at 18). Dr. Chabot diagnosed Petitioner with advanced degeneration at L3-L4, L4-L5 and a history of a back strain. (Id. at 19). Dr. Chabot further opined that if surgical intervention was undertaken it should be at the L3-L4 and L4-L5 levels primarily to address chronic degenerative disease at those levels. (Id.).

Dr. Chabot admitted on cross-examination that he had not published any articles since 1997 and he is currently not participating in any FDA clinical trials. (RX 1 at 24). Dr. Chabot

conducts approximately six Section 12 exams per week. (Id.) He testified that the vast majority of his independent medical exams are for insurance companies. (Id. at 26). Dr. Chabot reviewed the records of Petitioner's primary care physician, Dr. Ajao, and agreed that no complaints of pain were made by Petitioner regarding low back pain since December 22, 2010. He acknowledged that Dr. Ajao referred Petitioner on January 5, 2011 to a specialist for neck pain, but never made any referral for back pain. (Id at 29). Dr. Chabot also opined that he did not operate on degenerative disc disease in the absence of a true radicular component, but that it is possible to permanently aggravate asymptomatic pre-existing degenerative disc disease. (RX 1 at 30). Dr. Chabot agreed that L3-L4 and L4-L5 were the levels with the most degeneration in Petitioner's spine. (Id. at 33).

The Arbitration Hearing

Petitioner's case proceeded to arbitration on a Petition for Immediate Hearing on July 18, 2018. The disputed issues were accident, causal connection, medical bills, temporary total disability, and prospective medical care. Petitioner was the sole witness testifying at the hearing.

Petitioner, who was 61 years old at the time of his hearing, testified that on February 16, 2014 he was employed by Respondent as a chainer helper. On that date, Petitioner was lifting a plate (a/k/a a pallet) weighing approximately 20 lbs. while twisting and he felt pain into his lower back. Petitioner agreed and testified that most of his pain was on the right side at the time of the accident.

Petitioner testified to receiving treatment from Dr. Eavenson, Dr. Gornet, and Dr. Boutwell. He further testified that the injections he received only helped for about two weeks. He also testified to undergoing physical therapy and work hardening with MultiCare Specialists.

Petitioner testified that he returned to work on August 1, 2014 as a welder inspector.

Petitioner testified that since he has been back at work, his back has been getting worse. He continues to wear his back brace and he wants to have the surgery that Dr. Gornet is proposing. Petitioner is still taking anti-inflammatory medication as well as pain medication prescribed by Dr. Gornet. He is having difficulties completing tasks at work, specifically bending and pushing castings down the rail. Occasionally, he has to stop performing completely and take a break. He did not have these complaints, have to wear a back brace, or take any medication prior to this injury for his lower back. Petitioner testified that he has a hard time with bending. He further testified that he asked for a back brace and Dr. Gornet provided it to him.

Petitioner denied any subsequent injuries. Petitioner did acknowledge that he had back issues before 2014 and that he did seek treatment from a doctor for back pain before the instant work accident. He also acknowledged that he had back pain that shot down his legs "off and on" before his work accident. Petitioner agreed that he was involved in a motor vehicle accident before 2014 in which he injured his low back. He could not recall if he had a history of a "slipped disc" in his back. Petitioner could not recall if he missed any time from work before the accident due to low back pain but he didn't think so. He also denied ever having to limit his activity before the accident or having to give up any activities before the accident. Petitioner

acknowledged that, at some point in time, he had a CNA license; however, he denied injuring his low back while working as a CNA. Petitioner also testified that his primary care physician, Dr. Ajao had never in the past referred him to a specialist for any lumbar spine complaints.

On redirect examination Petitioner testified that he would defer to histories and treatment as reflected in Dr. Ajao's records.

Petitioner presented the following medical bills into evidence:

MultiCare Specialists: $15,685.00
Dr. Gornet: $17,259.34
STL Spine & Orthopedic Surgery Center: $37,602.16
MRI of Chesterfield: $8,28000
Pain & Rehab Specialists: $6,600.46, $8,857.70 ($15,458.16)
CT Partners of Chesterfield: $2,240.00
Premier Anesthesia: $880.00
Orthopedic Ambulatory Surgery Center: $31,852.75 (PX 7)

The Arbitrator concludes:

ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner sustained an accident on February 16, 2014 that arose out of and in the course of Petitioner's employment by Respondent. Petitioner's testimony that he was injured while lifting and twisting a plate/pallet is supported not only by his testimony, but also by his initial statement and Respondent's Dispensary records.

ISSUE (F), IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Petitioner failed to prove that his current condition of ill-being in his low back is causally related to his February 16, 2014 accident.

At the outset, the Arbitrator notes concerns about Petitioner's overall credibility. First, he denied any history of significant back pain when presenting to Dr. Gornet. Dr. Ajao's records show otherwise. Petitioner has had back complaints since October of 2006 when Petitioner reported he hurt his back. In 2007 he had an episode at work. In January of 2008 Petitioner told the doctor he had hurt his back pulling a caster at work. He was also involved in a motor vehicle accident in 2008. When he presented for physical therapy in 2008a "significant medical history" for a "slipped disk" was noted. He explained that he had injured his lower back years earlier and had treated with exercise and therapy. Petitioner also related intermitted back pain rated a "5/10" at times for which he "self-treated." Petitioner, prior to this accident, had issues with getting out of bed, tying his shoes, kneeling, squatting, reaching forward, and trouble going to sleep. His lifting tolerance was 25 – 30 lbs. Petitioner continued to have back pain complaints in 2009 and

2010. On December 22, 2010 Petitioner saw Dr. Ajao regarding another back injury while working as a nurse. The injury included lower left leg radiculopathy for which Petitioner was prescribed prednisone and the doctor's notes indicate Dr. Ajao was going to look into a neurosurgical referral. Petitioner was referred to the neurosurgeon and a medical leave of absence followed. Petitioner did not follow up with the surgeon. While the Arbitrator is aware that there are no medical records showing any treatment to Petitioner's low back between 2011 and 2/16/14, the records that are in evidence clearly indicate a significant low back problem pre-accident which Petitioner failed to be upfront about.

Petitioner was also not completely honest and forthright at the hearing or to some of his other doctors. Petitioner told Dr. Eavenson he could "barely walk" the day after the accident. However, when seen at Respondent's Dispensary on February 18th, he made no reference to being barely able to walk and the note specifically states he had a normal gait. Similarly, Petitioner was not forthright with Dr. Eavenson regarding his history of back problems as the only problem he related to him was a back strain in the 1980s. Additionally, Petitioner testified that he was never referred to a neurosurgeon for his lower back complaints. However, a reading of Dr. Ajao's office note of December 22, 2010 suggests otherwise. The entire office note discusses Petitioner's lower back and radiating left leg complaints. There was a brief mention of severe stenosis of the cervical spine. At this same time he was taken off work for a low back injury. While it is true that Dr. Ajao's referral form states the referral is for neck pain and severe spinal stenosis the Arbitrator views the actual office note pre-dating the referral as more insightful as to the nature of the referral. More importantly, Dr. Ajao could have been deposed regarding this referral; however, he wasn't. At the arbitration hearing Petitioner testified that Dr. Gornet prescribed the back brace for him. Neither Dr. Gornet's records, testimony or his billing corroborate that testimony. Petitioner was also asked about prior lost time, difficulties with activities, the need to cease certain activities and medication usage. He essentially denied everything. Petitioner's attorney then attempted to rehabilitate his client's testimony by referencing Dr. Ajao's records at which point Petitioner acknowledged he would defer to whatever was contained therein. Either Petitioner was trying to mislead the Arbitrator with his original testimony or he had a very poor recollection of his medical history. Either way, it impacted his veracity in a negative way. In the end, Petitioner was not forthright with his doctors or the Arbitrator regarding his history of low back issues, thereby undermining his overall credibility.

It should be pointed out that Petitioner was not engaged in his usual job at the time of the accident. He had been moved to the area where he was hurt on February 16, 2014 as the department was short-handed. Thus, he was engaged in a job at the time of the accident that was not his usual job. Petitioner's back problems with lifting more than 25 – 30 lbs. goes back to 2008. Given his significant pre-existing low back issues, it would not be surprising that he might experience symptoms while engaged in lifting tasks which were not a part of his regular job. This, too, would be consistent with a strain as was his initial diagnosis and the diagnoses of Drs. Chabot and Katz. It is also significant that Petitioner told the Dispensary staff on February 17th that he didn't report the accident right away because the pain was not that severe. While Petitioner may have been involved in an accident on February 16th, the severity of the accident is questionable.

The only doctor who believes Petitioner's current condition of ill-being is causally related to the accident is Dr. Gornet. Unfortunately, Dr. Gornet's causation opinion is based upon Petitioner's history of no prior back problems of significance. Dr. Gornet never reviewed the records of Dr. Ajao. He acknowledged that Petitioner had pre-existing degeneration in his back that would be painful on occasion. This was one such occasion, at best. It cannot be overlooked that Petitioner returned to full duty work on August 1, 2014 and has continued to work on a full duty basis since that time. Since returning to work Petitioner has been seen at Respondent's Dispensary for other medical issues but he has never mentioned any ongoing issues with his back.

Petitioner's motivation herein is somewhat questionable and suspect. The record shows pre-existing low back problems which, at times, impacted Petitioner's ability to work. It is not unnoticed how quickly Petitioner retained counsel in this matter and filed his claim. Additionally, rather than return to the doctor who had treated him in the past for his low back and was familiar with his care, he initiated new treatment with doctors his attorney referred him to. To these doctors, he provided an incomplete and inaccurate history regarding his prior back issues.

Petitioner has failed to prove that his current condition of ill-being in his low back is causally related to his work accident of February 16, 2014. Petitioner failed to establish ongoing causation after July 31, 2014 when Petitioner returned to full duty work.

ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECSSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

The following medical bills were introduced into evidence:

MultiCare Specialists: $15,685.00
Dr. Gornet: $17,259.34
STL Spine & Orthopedic Surgery Center: $37,602.16
MRI of Chesterfield: $8,28000
Pain & Rehab Specialists: $6,600.46, $8,857.70 ($15,458.16)
CT Partners of Chesterfield: $2,240.00
Premier Anesthesia: $880.00
Orthopedic Ambulatory Surgery Center: $31,852.75

Consistent with her causation determination, the Arbitrator awards Petitioner those medical bills incurred prior to his return to work on August 1, 2014. Any medical bills incurred by Petitioner after that date are denied. The Arbitrator finds these bills are reasonable and necessary and ordered paid pursuant to the fee schedule. The Arbitrator awards Petitioner the medical bills from MultiCare Specialists for treatment through July 31, 2014. While Dr. Katz and Dr. Chabot may have referred to the services provided by the doctor and the therapist as "dual treatment" the Arbitrator notes that the records themselves show different treatment modalities being provided by the two providers. Additionally, Dr. Gornet felt the treatment there,

including work hardening, was appropriate. Respondent is to receive credit for any medical bills previously paid.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Consistent with her causation determination, Petitioner's request for prospective care as outlined and recommended by Dr. Gornet is denied.

ISSUE (L), WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner is awarded temporary total disability benefits from February 24, 2014 through July 31, 2014, a period of 22 4/7 weeks. Dr. Katz felt Petitioner could return to work on April 29, 2014. However, the work hardening provided by Mr. Voss, and ordered by Dr. Gornet, provided additional improvement and Petitioner was able to return to full duty work on August 1, 2014 and has remained in that capacity since then. Petitioner is awarded TTD benefits for the foregoing period of time.

****

STATE OF ILLINOIS	)
	) SS.
COUNTY OF COOK	)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael King,

Petitioner,

vs. No. 16 WC 36813

City of Chicago, **19IWCC0260**

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 the nature and extent of Petitioner's disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission agrees with the Arbitrator's determination as to the relative weight of each of the factors enumerated in section 8.1b(b) of the Workers' Compensation Act (the Act), except for factor (v). The Commission finds a lesser degree of disability than the Arbitrator found in weighing factor (v). Petitioner underwent conservative treatment and was released to return to work full duty. Petitioner credibly testified to residual pain and discomfort in his neck and right shoulder, which cause him to limit his activities at work and at home. The medical records corroborate Petitioner's testimony. Petitioner did not testify to any residual low back problems. Having carefully considered the entire record and weighed the evidence, the Commission finds the proper measure of disability is 7 percent of the person as a whole. All else is affirmed and adopted.

19IWCC0260

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 13, 2018, 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 $939.24 per week for the stipulated period of 70 3/7 weeks, from November 7, 2016 through March 14, 2018, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the medical bills itemized by the Arbitrator, pursuant to §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $775.18 per week for a period of 35 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 7 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.

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.

MAY 23 2019

DATED:
d-05/01/2019
SM/sk
44

Stephen Mathis

Douglas McCarthy

Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KING, MICHAEL
Employee/Petitioner

Case# **16WC036813**

CITY OF CHICAGO
Employer/Respondent

19IWCC0260

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:

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

0010 CITY OF CHICAGO DEPT OF LAW
LUCY HUANG
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)

) SS.
COUNTY OF **COOK**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Michael King
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **16** WC **36813**

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 **October 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. [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 **November 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 cervical and lumbar spine conditions of ill-being ***are*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**73,260.84**; the average weekly wage was $**1,408.86**.

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

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

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

Respondent shall be given a credit of $**37,839.97** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**37,839.97** .

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

ORDER

At the hearing, Respondent stipulated that Petitioner was temporarily totally disabled from November 7, 2016 through March 14, 2018. The parties further agree that Respondent is entitled to credit for the $37,839.97 in temporary total disability benefits it paid prior to the hearing. Arb Exh 1.

Respondent shall pay to the providers for reasonable and necessary medical services of $20,568.16 under Sections 8(a) and 8.2 of the Act for the following unpaid medical bills: Family Doctors Family Healthcare—$857.16; MRI Lincoln Imaging—$1,500.00; Stand up MRI of Deerfield—$12,000.00; Shirley Ryan Ability Lab—$2,186.00; Chicago Anesthesiology Pain Specialists—$1,280.00; Advocate Illinois Masonic—$2,745.00. Respondent shall receive a credit against the awarded bills for any payments previously made for that medical treatment. [See RX 1.] Respondent shall pay directly to Petitioner $117.50 for the following expenses paid out-of-pocket: Walgreens—DOS 11/23/16-3/29/18: $117.50.

Respondent shall pay Petitioner permanent partial disability benefits of $775.18/week for 50 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused a 10% loss of use of the whole person.

Respondent shall pay Petitioner compensation that has accrued from November 4, 2016 through October 19, 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.

19IWCC0260

Molly C Mason

Signature of Arbitrator

11/13/18

Date

ICArbDec p. 2

NOV 13 2018

Michael King v. City of Chicago
16 WC 36813

19IWCC0260

Summary of Disputed Issues

The parties agree Petitioner sustained an accident on November 4, 2016, while operating a vehicle for Respondent. At the hearing, Respondent also stipulated that Petitioner was temporarily totally disabled from November 7, 2016 through March 14, 2018, in exchange for Petitioner withdrawing a claim for penalties and fees. The disputed issues include causal connection, medical expenses and nature and extent. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified he was born on August 5, 1956.

Petitioner testified he worked as a motor truck driver for Respondent as of November 4, 2016. At that time, he was assigned to Respondent's traffic department. His duties included lifting heavy items such as barricades and stop signs and loading them into trucks.

Petitioner denied injuring his neck or back prior to the accident of November 4, 2016. On that date, a semi struck the truck he was operating for Respondent. [An accident report in PX 1 reflects Petitioner was transporting cones via a pick-up when he was sideswiped by a semi, causing him to "bounce around" and strike the driver's side door.] He testified he experienced an immediate onset of neck and back pain after the accident.

Petitioner testified he first sought treatment on November 7, 2016, at which point he went to MercyWorks at Respondent's direction. Records in PX 1 reflect Petitioner saw Dr. Stiso at MercyWorks on that date. The doctor noted complaints of left-sided low back pain, neck pain radiating up to the scalp, right arm pain and intermittent finger tingling. He described Petitioner's gait as slow. On examination, he noted discomfort bilaterally with straight leg raising to 75 degrees. He diagnosed cervicalgia with radiculitis of the right arm and "low back pain superimposed on chronic low back pain." He took Petitioner off work and referred him to Dr. Strugala, an orthopedic surgeon. PX 9. He discharged Petitioner from MercyWorks. PX 1.

On November 23, 2016, Petitioner saw Dr. Omiotek, his primary care physician. The doctor noted complaints of low back pain with spasm, neck pain, right hand pain and some paresthesias secondary to a work-related motor vehicle accident of November 4, 2016. She also noted that a workers' compensation facility referred Petitioner to Dr. Strugala and that Petitioner followed up on November 11th "but did not see M.D." On examination, she noted a normal gait, a decreased range of neck and back motion and pain and stiffness in the right hand when making a fist.

Dr. Omiotek prescribed lumbar and cervical spine MRI scans along with right hand X-rays. She released Petitioner to light duty with limited driving and no lifting over 19 pounds. PX 9.

Petitioner testified he presented Dr. Omiotek's restrictions to Respondent but was not accommodated.

On December 2, 2016, Dr. Omiotek prescribed a course of physical therapy for neck, back and right hand pain. PX 4. She continued the previous work restrictions. PX 9.

Bilateral hand X-rays performed on December 16, 2016 showed no acute abnormalities. PX 3.

On December 27, 2016, Petitioner presented to Windy City Orthopedics and saw Dr. Miller. At the doctor's request, Petitioner completed a questionnaire, describing the November 4, 2016 accident and indicating he was experiencing difficulty turning his head, lifting, manipulating objects and bending. PX 3.

A right hand MRI performed on December 28, 2016 showed no gross abnormalities. PX 2.

On January 5, 2017, Dr. Omiotek noted that the right hand MRI was negative. She also noted that Petitioner was still experiencing neck and back pain. She issued a letter indicating that Petitioner would be starting physical therapy the following day. She imposed restrictions of limited driving, no lifting over 20 pounds and no prolonged sitting due to low back pain. PX 9.

Petitioner began a course of physical therapy at Athletico on January 6, 2017. The evaluating therapist noted a history of the work accident. She documented complaints of neck and back pain, difficulty turning the neck and difficulty gripping with the right hand. She described Petitioner as right-handed. She noted that Petitioner's job involved lifting cones and barricades and constant driving. PX 4.

On January 17, 2017, Petitioner underwent several cervical spine MRIs at Upright MRI of Deerfield. MRIs performed in flexion-extension and the right and left lateral bending positions showed restriction of motion. An MRI performed in the neutral tilted position showed broad-based posterior bulges with osteophytes at C3-C4, causing mild stenosis, broad-based posterior bulges with osteophytes at C4-C5, causing moderate stenosis, broad-based posterior bulges with osteophytes at C5-C6, causing mild stenosis, and posterior osteophytes at C6-C7, causing mild to moderate stenosis. PX 5.

On January 17, 2017, Dr. Omiotek issued a note indicating Petitioner remained under her care secondary to the injuries he sustained on November 4, 2016. She indicated those injuries prevented Petitioner from driving or sitting for extended periods and lifting over 20 pounds. PX 9.

On January 18, 2017, Petitioner underwent brain and lumbar spine MRIs at Upright MRI of Deerfield. The brain MRI, performed without contrast, showed abnormal signal intensity foci raising the possibility of chronic white matter demyelination. The lumbar spine MRI performed in the neutral upright position showed mild or mild to moderate stenosis at L3-L4, L4-L5 and L5-S1 secondary to broad-based disc bulges and osteophytes at these levels. PX 5.

On January 23, 2017, Dr. Omiotek noted that Petitioner was still undergoing therapy and that his range of motion was improving. PX 2.

On January 31, 2017, Dr. Miller issued a note releasing Petitioner to light duty with no lifting over 20 pounds and no driving over one hour. PX 9.

An Athletico progress note dated February 6, 2017 reflects Petitioner reported improvement secondary to therapy but was still experiencing neck, back and right finger symptoms. PX 3.

On February 28, 2017, Dr. Miller wrote to Dr. Omiotek, indicating that Petitioner's pain was still interfering with his ability to work, drive and sleep. He prescribed therapy and medication. He issued a note indicating Petitioner could perform a "sedentary job only" until his next appointment on March 28, 2017. PX 3, 9.

An Athletico discharge summary dated April 3, 2017 reflects that Petitioner had attended twenty therapy sessions to date and was experiencing improvement of his neck and back symptoms. The therapist indicated that Petitioner was still experiencing right-sided neck pain, "cracking" sounds in the neck and right index finger pain. She recommended home exercises and indicated Petitioner might benefit from a neck injection. PX 4.

On April 18, May 2, May 30 and June 27, 2017, Dr. Miller issued notes releasing Petitioner to sedentary duty. PX 3, 9.

Petitioner began a course of physical therapy at the Shirley Ryan Ability Lab on June 30, 2017. The evaluating therapist noted a history of the work accident and subsequent care. She noted "chief complaints" of shoulder pain, neck pain radiating down the right arm and trigger finger. PX 3.

An upper extremity EMG performed by Dr. Matthew on July 20, 2017 showed no evidence of a right cervical radiculopathy or a right brachial plexopathy. PX 3.

On August 16, 2017, Dr. Miller wrote to Dr. Omiotek, informing her the EMG was negative and Petitioner's cervical spine examination was "completely normal." The doctor indicated he released Petitioner from care after discussing options of non-steroidal anti-inflammatory medication, modification of activities, referral to a pain clinic, home exercises and therapy. PX 3.

On October 20, 2017, Dr. Omiotek ordered chest X-rays and cleared Petitioner to undergo prostate surgery. She released Petitioner to restricted duty with no lifting of 10 to 25 pounds and "partial ability to operate machinery." PX 2, 9.

On January 4, 2018, Dr. Omiotek noted that Petitioner was undergoing radiation. She took Petitioner off work pending evaluation by Advocate Pain Management Clinic. PX 2, 9.

Petitioner saw Dr. Jani at Advocate Illinois Masonic Hospital's pain clinic on January 26, 2018. The doctor noted that Petitioner was undergoing radiation for prostate cancer and taking Norco and Codeine for groin and inguinal area pain per his urologist. He also noted complaints of low back pain and right-sided neck pain radiating down the right arm secondary to a 2016 work-related motor vehicle accident. He indicated that Petitioner "has had back pain for years but it was made worse with accident." On examination, he noted myofascial pain with trapezius trigger points and negative Spurling's signs bilaterally. He started Petitioner on Nortriptyline and scheduled him for right-sided trigger point injections. PX 7.

On February 2, 2018, Dr. Jani noted persistent complaints of neck pain radiating down the right arm, right arm weakness and difficulty grasping objects with the right hand. He also noted complaints of "chronic low back and groin pain . . . due to radiation therapy for prostate CA." He indicated that Petitioner had just started taking Nortriptyline and was experiencing some relief. On re-examination, he noted tenderness to palpation of the right trapezius, 4/5 hand grip, tenderness to palpation of the right

side of the lower back, positive straight leg raising on the right and negative Spurling's signs bilaterally. He administered trigger point injections and directed Petitioner to return in four weeks. PX 7.

On February 8, 2018, Dr. Omiotek issued a note indicating Petitioner was undergoing pain management and should remain off work until being re-evaluated on March 2, 2018. PX 2, 9.

On March 2, 2018, Petitioner returned to Dr. Jani and reported two weeks of relief following the February 2018 injections. He indicated his right-sided neck and trapezius pain then returned. He stated that certain movements such as dropping his shoulder tended to aggravate the pain. The doctor noted Petitioner was taking Norco and Codeine prescribed by his urologist. He administered additional right-sided trigger point injections. PX 7.

On March 7, 2018, Dr. Omiotek noted that Petitioner was better and planned to return to work the following week. She released Petitioner to resume full duty as of March 14, 2018. PX 2, 9.

Petitioner testified he resumed full duty thereafter but transferred from the traffic department to the sanitation department. His job in traffic services had involved lifting items such as cones and barricades. His job in streets and sanitation, which he was still performing as of the hearing, involves driving a garbage truck. He performs no lifting or carrying.

Petitioner last saw Dr. Jani on September 7, 2018. Petitioner reported experiencing five months of relief of his right-sided neck and right shoulder pain after the March 2018 trigger point injection. He also reported taking Codeine and Flexeril several times per week and Nortryptiline daily. The doctor adjusted Petitioner's medication and indicated he would consider repeating the right-sided trigger point injections. He directed Petitioner to return in four weeks. PX 7.

Petitioner testified his current garbage truck driver job requires him to look at the truck's mirrors to check the location of the laborers working behind him. When he turns his head to the right, he feels a strain in the top of his right shoulder and the right side of his neck. His current symptoms affect some of his non-work activities. He has difficulty lifting heavy items and has stopped participating in softball and football. He sleeps less soundly than he did before the accident. He now averages four to five hours of sleep per night. He takes medication to help him sleep on days when it is cold outside or he has experienced neck pain with activity.

Under cross-examination, Petitioner acknowledged being diagnosed with prostate cancer in July or August 2017. He underwent radiation but not surgery after being diagnosed. The cancer is not related to the work accident. He has not lost additional time from work due to neck or back pain since he resumed full duty in March 2018. He earns the same wages he earned before the accident. He had to lift heavy barricades and stop signs before the accident but now "just drives a garbage truck." He denied any pre- or post-accident neck or back injuries. He has no upcoming appointments for neck or back treatment. He takes Flexeril, a sleep-related medication and another medication prescribed by Dr. Jani. His pain makes it a little difficult for him to put his socks and shoes on. He drove to the Commission to attend the hearing. His injuries have affected his hygiene in the sense that he defers showering if he is in pain when he arrives home from work.

On redirect, Petitioner testified that Dr. Miller referred him to pain management. He is still classified as a motor truck driver.

No witnesses testified on behalf of Respondent. Respondent offered into evidence a print-out of the temporary total disability benefits and medical expenses it has paid to date. RX 1.

Arbitrator's Credibility Assessment

Petitioner did not overstate his complaints. None of his medical providers noted symptom magnification. Dr. Miller specifically described Waddell's signs as negative. PX 3.

Petitioner's testimony as to his pre-accident back condition was inconsistent with his records. He denied experiencing low back pain before the work accident but records in PX 4 reflect he underwent physical therapy for low back pain at Athletico in early 2016. One of Dr. Jani's notes reflects Petitioner described his low back pain as worsening after the accident. There is no evidence, however, indicating that Petitioner was disabled due to back pain before the accident.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between his undisputed work accident of November 4, 2016 and his claimed current conditions of ill-being?

The Arbitrator finds that Petitioner established causation as to his current cervical and lumbar spine conditions of ill-being. In so finding, the Arbitrator relies on the following: 1) the fact that, prior to the accident, Petitioner was successfully performing a traffic-related job that required substantial lifting; 2) Petitioner's credible account of the mechanism of injury; and 3) the treatment records, including but not limited to the cervical and lumbar spine MRI reports. The Arbitrator also notes that Respondent offered no evidence to support its causation defense.

The Arbitrator further finds that Petitioner established causation as to right hand and trigger finger injuries that required treatment but did not establish causation as to any current right hand or trigger finger conditions of ill-being. Right hand radiographic studies performed in late 2016 showed no abnormalities. PX 2. Petitioner did not testify to any ongoing right hand or finger complaints.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims various medical expenses as well as reimbursement of $117.50 in out of pocket prescription-related expenses. Arb Exh 1. PX 8.

The Arbitrator has reviewed the claimed medical expenses and compared the bills with the contemporaneous medical records and Respondent's payment print-out (RX 1). It appears that some of the claimed expenses were paid by a group carrier [Respondent seeks no 8(j) credit, Arb Exh 1] and others were paid by Respondent. It also appears that some bills, including the bill associated with the brain and lumbar spine MRIs performed on January 18, 2017, remain unpaid.

The Arbitrator has previously found that Petitioner established causation as to his current cervical and lumbar spine conditions of ill-being. The Arbitrator also finds that Petitioner established causation, as well as reasonableness and necessity, with respect to the treatment underlying the claimed medical expenses. Respondent did not offer any evidence, in the form of a utilization review or Section 12 examination report, calling the treatment into question.

The Arbitrator awards Petitioner the claimed medical expenses, subject to the fee schedule, and with Respondent receiving credit for the payments reflected in RX 1. The Arbitrator also directs Respondent to reimburse Petitioner for his claimed out of pocket expenses.

What is the nature and extent of the injury?

Because Petitioner's accident occurred after September 1, 2011, the Arbitrator looks to Section 8.1b of the Act for guidance in assessing permanency. This section sets forth five factors to be considered in determining nature and extent, with no single factor predominating. The Arbitrator views the first factor, i.e., any AMA 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 as of the accident. Petitioner resumed full duty, in terms of his job classification, after the accident but credibly testified his duties changed from a traffic-related job that involved significant lifting to a garbage truck assignment that involves only driving. Petitioner was 60 years old as of the 2016 accident. The Arbitrator views him as an older worker who is approaching retirement. He faces fewer years of persistent symptoms than a younger individual. The Arbitrator also assigns weight to the fourth factor, future earning capacity. Petitioner's duties changed after the accident but his earnings did not. He is still classified as a motor truck driver. As for the fifth and final factor, evidence of disability corroborated by the treating medical records, the Arbitrator notes the results of the various spinal MRI scans.

The Arbitrator, having considered the foregoing along with Petitioner's credible testimony as to his persistent symptoms and reduced range of neck motion, awards permanency equivalent to 10% loss of use of the person as a whole, representing 50 weeks of benefits under 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	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rudolph Lading,
Petitioner,

vs. NO: 09 WC 20439

City of Chicago ,
Respondent.

19IWCC0261

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 24, 2018, is hereby affirmed and adopted.

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

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

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

DATED: MAY 2 4 2019
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BNF/mw
045

Barbara Flores

Deborah Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LADING, RUDOLPH
Employee/Petitioner

Case# **09WC020439**
14WC034241
16WC017448

CITY OF CHICAGO
Employer/Respondent

19IWCC0261

On 10/24/2018, 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 2.42% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0059 BAUM RUFFOLO & MARZAL LTD
EDUARDO C SALGADO
33 N LASALLE ST SUITE 1710
CHICAGO, IL 60602

0010 CITY OF CHICAGO
D TAYLOR CHITTICK
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Rudolph Lading
Employee/Petitioner

Case # **09** WC **20439**

v.

Consolidated cases: **14WC34241 & 16WC17448**

City of Chicago
Employer/Respondent

19IWCC0261

An *Application for Adjustment 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 **09/21/2018**. 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. ☐ 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 **01/07/2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

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

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

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

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services. The parties agreed that, to the extent medical expenses are awarded, Respondent is authorized to negotiate directly with the providers.

Respondent shall be given a credit of $**0.00**for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0** for other benefits, for a total credit of $**0.00**.

Respondent failed to meet its burden of proving entitlement to credit under Section 8(j).

ORDER

Medical benefits
Respondent shall pay the reasonable and necessary medical services of Blue Cross Blue Shield in the amount of $1,230.22, subject to the fee schedule and the stipulation noted above, and shall reimburse Petitioner for out of pocket expenses in the amount of $286.29, as provided in Section 8(a) of the Act.

Permanent Partial Disability:
Respondent shall pay Petitioner permanent partial disability benefits of $664.72/week for 41 weeks, because the injuries sustained caused the 20% loss of the right hand, as provided in Section 8(e) of the Act.

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

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

Molly C Mason

Signature of Arbitrator

10/24/18
Date

OCT 24 2018

Rudolph Lading v. City of Chicago
09 WC 20439, 14 WC 34241 and 16 WC 17448 (consolidated)

Summary of Disputed Issues **19IWCC0261**

Petitioner worked as a painter for Respondent for eighteen years. He retired a few months before the hearing. His oldest claim, 09 WC 20439, involves a January 7, 2009 injury to his dominant right hand. This claim was the subject of a 2011 19(b) decision by former Arbitrator, now Commissioner, DeVriendt. The Arbitrator found causation as to the right hand condition and awarded medical expenses and prospective surgery. PX 1. Since neither party filed a review, the Arbitrator's findings are final, in accordance with the doctrine of the law of the case. Irizarry v. Industrial Commission, 337 Ill.App.3d 598, 606-607 (2003). As of the September 21, 2018 hearing, the disputed issues included medical expenses, nature and extent, whether Respondent is entitled to 8(j) credit and prospective care. Arb Exh 1. Petitioner's more recent claims, 14 WC 34241 and 16 WC 17448, involve his right shoulder. The disputed issues in both claims include causal connection, nature and extent and prospective care. Medical expenses are also at issue in 16 WC 17448. Arb Exh 2-3.

Arbitrator's Findings of Fact Relative to All Cases

Petitioner testified he worked as a painter for about thirty years. He began working in this capacity for Respondent in 2000. His job involved lifting 5-gallon buckets that weighed 70 to 90 pounds, erecting and using scaffolds, plastering and painting. He was on his feet all day and frequently worked overhead, with his arms extended upward.

Petitioner testified he injured his right hand on January 7, 2009, when he reached into his van to lift work materials. He reported the accident to his foreman, who sent him to MercyWorks. He saw Dr. Marino at this facility. The doctor noted complaints of right thumb and wrist pain secondary to lifting cans of paint. On examination, he noted tenderness along the radial side of the wrist, in the extensor tendon area and increased pain with thumb flexion. He obtained right wrist X-rays which showed "moderate degenerative joint space narrowing in the lateral carpus, most pronounced at the first carpometacarpal joint" with associated cysts and spurs. PX 2, p. 7. He diagnosed tenosynovitis of the right wrist. He prescribed Naprosyn and heat treatments. He released Petitioner to full duty and advised him to return in two weeks. PX 2, p. 2.

Petitioner returned to Dr. Marino on January 21, 2009 and complained of pain in the base of his right thumb. The doctor referred him to Dr. Heller, an orthopedic surgeon, and released him to full duty. PX 2, p. 2.

Petitioner first saw Dr. Heller on January 23, 2009. On initial examination, the doctor noted tenderness over the carpometacarpal joint of the right thumb with positive grind testing and pain with axial loading. He also noted visible evidence of tenosynovitis at the first dorsal compartment. He interpreted X-rays as showing relatively severe osteoarthritis at the thumb carpometacarpal [CMC] joint. He performed an intra-articular injection into the right thumb CMC joint and informed Petitioner he might eventually need surgery. He allowed Petitioner to continue full duty. PX 3, p. 9.

Petitioner returned to Dr. Heller on February 6, 2009 and reported relief secondary to the injection. The doctor advised Petitioner his symptoms would eventually recur. He released Petitioner to full duty and directed him to take anti-inflammatory medication as needed. PX 3, p. 11.

Petitioner returned to MercyWorks on February 11, 2009 and again saw Dr. Marino. The doctor noted improvement secondary to the injection but indicated Petitioner was still experiencing right thumb soreness at night. He directed Petitioner to take Aleve as needed and discharged him from care. PX 2, p. 2.

Petitioner next saw Dr. Heller on May 22, 2009. The doctor noted Petitioner was using his own insurance due to closure of his workers' compensation claim. He also noted "marked tenderness and grinding over the thumb CMC joint." The doctor recommended surgery and indicated Petitioner planned to try to reopen his claim. PX 3, p. 13.

Petitioner returned to Dr. Heller on June 12, 2009, again using his own insurance, and complained of right middle finger triggering as well as right thumb pain. The doctor injected the A1 pulley and the thumb CMC joint, noting Petitioner wanted to defer surgery. PX 3, p. 15.

Petitioner saw Dr. Breslow, an orthopedic surgeon affiliated with the Illinois Bone and Joint Institute, on September 28, 2009. The doctor noted an atraumatic onset of right hand swelling and pain since September 25, 2009. He also noted a history of psoriasis and psoriatic plaques on the dorsal aspect of the hand. On examination, he noted psoriatic plaques over the MCP joints dorsally of the fourth and fifth fingers and a palpable mass on the web space between the third and fourth fingers. He obtained X-rays which showed soft tissue swelling. He prescribed Celebrex and an MRI. PX 8, pp. 27-28.

The right hand MRI, performed without contrast on October 2, 2009, showed a mass that did not have typical MR characteristics of a ganglion cyst. It also showed severe osteoarthritis at the basilar joint with marked joint space narrowing, subchondral sclerosis and osteophytes along with moderate arthritis at the triscaphe articulation. PX 8, pp. 29-30.

On October 5, 2009, Dr. Breslow reviewed the MRI results with Petitioner. He suspected a psoriasis-related infection. He aspirated fluid from the area of the mass and started Petitioner on Keflex. He continued the Keflex at the next two visits. PX 8, pp. 33-36.

On December 1, 2009, Dr. Heller again injected the A1 pulley and thumb CMC joint. He advised Petitioner he would likely recommend surgery if the triggering and thumb symptoms recurred. PX 3, p. 17.

On January 14, 2010, Petitioner saw Dr. Beith, a chiropractor affiliated with Total Wellness. The doctor noted complaints relative to the right hand, fingers, wrist and elbow. She also noted Petitioner's painter occupation and the gradual onset of symptoms in January 2010. She indicated Petitioner had undergone three injections to date. She noted reduced grip strength in the right hand on Dynamometer testing. She recommended a thumb brace, an elbow brace and daily paraffin baths. She found Petitioner capable of working with no repetitive hand usage. PX 5.

Petitioner continued seeing Dr. Beith through January 29, 2010. At the last visit, the doctor noted that Petitioner wanted to see a hand surgeon and did not want to continue with chiropractic care. PX 5, p. 8.

Petitioner consulted Dr. Visotsky of Illinois Bone and Joint on February 9, 2010. On right hand examination, Dr. Visotsky noted underlying arthritic changes, specifically at the CMC and somewhat

throughout the DIP joint. He also noted tenderness at the CMC joint, positive CMC grind testing and tenderness along the A-1 pulley of the middle finger. He noted similar CMC findings but no triggering in the left hand. He obtained X-rays which showed CMC arthritis within both thumbs. He diagnosed CMC arthritis, right greater than left, right long stenosing tenosynovitis, right STT arthritis and left MP joint arthritis of the thumb. He discussed various treatment options and noted that Petitioner wanted to under a right CMC interposition arthroplasty with FCR tendon graft. PX 8, pp. 37-39.

Petitioner returned to Dr. Heller on August 13, 2010. Dr. Heller noted complaints of severe right thumb CMC pain, stiffness of the right middle finger and left thumb pain. On re-examination, the doctor noted marked tenderness of the right thumb CMC joint, residual stiffness and tenosynovitis of the right middle finger and evidence of CMC arthritis and early MP joint radial collateral ligament pain in the left thumb. He performed a fluoroscopy, which showed significant thumb CMC arthritis on the right and a "relatively normal" left thumb. The doctor injected the left thumb CMC joint and indicated he planned to seek authorization for a right thumb CMC arthroplasty and middle finger trigger release. PX 3, p. 18. He wrote a letter the same day outlining the recommended surgeries and indicating he felt Petitioner's right thumb and right middle finger conditions had been "accelerated beyond their normal progression" due to his painter duties. PX 3, p. 19.

On October 4, 2010, Dr. Heller noted that Petitioner remained symptomatic and was awaiting an independent medical examination. He injected the left thumb MP joint and indicated he was awaiting authorization for the previously recommended right-sided surgeries. PX 3, p. 20.

At Respondent's request, Petitioner saw Dr. Carroll for purposes of a Section 12 examination on October 28, 2010. In his report of the same date, the doctor indicated he was seeing Petitioner "only for his right hand." He described Petitioner as a right-handed painter and noted complaints of right middle finger stiffness and pain at the base of the right thumb. He noted Petitioner was contemplating a CMC arthroplasty. On right middle finger examination, Dr. Carroll noted some osteoarthritis and triggering. On right thumb examination, he noted arthritis at the base and a very prominent grind test. He measured Petitioner's grip strength at 30 pounds on the right and 60 pounds on the left. He obtained right wrist and hand X-rays, which showed significant osteoarthritis at the base of the thumb and some arthritis in the other digits, including the middle finger.

Dr. Carroll characterized the treatment to date as reasonable and necessary. He agreed with the need for an arthroplasty and indicated Petitioner could consider additional injections or surgery for the right middle finger triggering. He described the need for care as a "degenerative phenomenon." He did not view the job activities Petitioner described as aggravating his conditions but recommended that the ergonomics of his job "be further evaluated to look at pinching activities to see if any issue of aggravation could play a role." He found Petitioner capable of restricted duty. PX 4.

Former Arbitrator, now Commissioner, DeVriendt conducted a hearing in 09 WC 20439 on March 22, 2011. He issued a decision on April 6, 2011 finding, in reliance on Dr. Heller, that Petitioner established causation as to his right hand condition, awarding out of pocket expenses and directing Respondent to authorize and pay for the surgeries recommended by Dr. Heller. PX 1.

Neither party filed a review.

Petitioner returned to Dr. Visotsky following the hearing. On October 28, 2011, the doctor performed a right thumb CMC arthroplasty and tendon graft procedure.

Petitioner testified he continued seeing Dr. Visotsky postoperatively. He voiced left hand symptoms, secondary to overuse, on November 15, 2011, with the doctor recommending medication. Petitioner testified that, at this point, he was relying on his left hand to perform activities due to his right-sided symptoms and the surgery. At the doctor's recommendation, he began a course of occupational therapy at Illinois Bone & Joint in mid-November 2011. He also began wearing a brace, again at the doctor's recommendation. On December 13, 2011, Dr. Visotsky noted improvement. Petitioner was discharged from therapy on December 29, 2011. PX 8, pp. 124-125. On January 17, 2012, Dr. Visotsky released Petitioner to light duty, with no lifting over 10 pounds and brace usage. He noted Petitioner was undergoing a cervical spine work-up. On February 14, 2012, Dr. Visotsky found Petitioner to be at maximum medical improvement with respect to the right hand. He directed Petitioner to wean himself from the brace. He described CMC grind testing as "now negative." He released Petitioner to full duty with respect to the hand. PX 8, pp. 96-97. On June 12, 2012, Dr.Visotsky noted that Petitioner remained symptomatic, "having pain over the ECRB origin and hands with finger extension." He also diagnosed lateral epicondylitis. He recommended an injection. PX 8, p. 99.

Petitioner testified that, on November 1, 2012, he was painting a ceiling, using a roller, when he felt a "pull" in his right shoulder. He mentioned the incident to his foreman and continued working. On January 25, 2013, he returned to Dr. Visotsky and complained of right shoulder pain. The doctor injected his right shoulder, obtained X-rays, prescribed therapy and indicated he might need an MRI. PX 9, pp. 1-3.

Petitioner underwent a right shoulder MRI on February 7, 2013. This study, performed without contrast, showed degenerative rotator cuff tendinopathy, "complicated by a high-grade, Ellman Grade III, partial-thickness tear of the distal supraspinatus tendon, only sparing a few of its bursal fibers, without associated rotator cuff atrophy," and "chronic-appearing, partially detached posterior labral tear, appeared to have contiguously communicated with a SLAP lesion of the superior labrum." PX 9, pp. 8-9.

Dr. Visotsky operated on Petitioner's right shoulder on February 28, 2013, performing a right arthroscopic biceps tenodesis, an arthroscopic rotator cuff repair and an arthroscopic subacromial decompression. PX 9, pp. 11-12.

On March 6, 2013, Dr. Visotsky described Petitioner's incision site as "healing nicely." He obtained X-rays which showed "well-maintained suture anchors." He started Petitioner on a scar massage program and told him to continue wearing a sling. PX 9, pp. 18-19.

Petitioner underwent an initial physical therapy evaluation at Illinois Bone and Joint on March 7, 2013. After seven sessions, Petitioner's therapist noted improvement in range of motion. PX 9, pp. 22-23.

On March 27, 2013, Dr. Visotsky noted a "good arc of motion." He discontinued the sling and directed Petitioner to continue therapy. PX 9, p. 24.

Petitioner continued attending therapy thereafter. A therapy discharge summary of May 22, 2013 reflects that Petitioner remained symptomatic and had returned to work that day. PX 9, p. 29.

Petitioner returned to Dr. Visotsky on January 14, 2014. With respect to the shoulder, the doctor noted persistent tenderness along the biceps sheath. He started Petitioner on Mobic twice daily. PX 9, p. 30.

Petitioner testified he was loading 5-gallon containers on April 27, 2016, when he felt a pull in his right shoulder. He went to an occupational medicine facility, at Respondent's direction, and saw Dr. Punjwani, who prescribed a right shoulder MRI. The MRI, performed without contrast on May 23, 2016, was "sub-optimal" due to motion artifact and artifact related to the prior surgery. The radiologist noted defects involving the supraspinatus and infraspinatus tendons consistent with full-thickness, full-width tears. He also noted "maximal tendon retraction to the level of the superior glenoid rim," posterior-interior glenoid labral tearing and moderate joint effusion. PX 7, pp. 2-3.

Following the MRI, Petitioner resumed treatment with Dr. Visotsky.

On May 31, 2016, Dr. Visotsky noted pain on forward flexion and abduction along with some loss of glenohumeral motion. He described the MRI as "substantially limited due to the fact that [Petitioner] has implants in place." He recommended a CT arthrogram along with sling usage and medication. He imposed restrictions of no overhead work, pushing or pulling and no lifting over 10 pounds with the right arm. PX 10, pp. 29-32.

The CT arthrogram, performed on June 8, 2016, showed "large recurrent full-thickness rotator cuff tear with retraction of the torn tendon margin," posteroinferior and anteroinferior labral tearing, degenerative changes and evidence of the prior biceps tenotomy. PX 10, pp. 4-5.

On June 10, 2016, Dr. Visotsky reviewed the CT arthrogram with Petitioner. He noted the study revealed a full-thickness tear with retraction and mild atrophy. He recommended surgery and directed Petitioner to stay off work. PX 10, p. 33.

On June 21, 2016, Dr. Visotsky noted "marked weakness in supraspinatus" on examination. He again recommended surgery. PX 10, p. 36.

On July 11, 2016, Dr. Visotsky performed a right rotator cuff repair, an arthroscopic repair of the infraspinatus portion of the supraspinatus, subacromial and subcoracoid decompressions, a biceps tenolysis and an open acromioclavicular resection. In his operative report, he described the anchors as intact but noted that "the suture was seen pulled out of the cuff." He indicated that only portions of the supraspinatus and infraspinatus were reparable. PX 10, pp. 39-40. He prescribed an ice machine, therapy and Norco for pain. PX 10, pp. 44-46.

On July 15, 2016, Dr. Visotsky indicated he was "able to partially repair a portion of the tendon releasing the other sutures that have pulled out of the muscle." He described Petitioner as having a "muscle failure on implant failure." He directed Petitioner to remain off work and return in one week for suture removal. PX 10, pp. 47-48.

On July 20, 2016, Dr. Visotsky removed some sutures. He recommended that Petitioner continue wearing the sling and using the ice and CPM machines. He noted that Petitioner was meeting with his therapist the following day. He continued to keep Petitioner off work. PX 10, pp. 49-50.

On July 21, 2016, Petitioner's therapist noted Petitioner was still having difficulty reaching overhead "and when any type of weight is in his hand, such as a shampoo bottle." The therapist also noted that Petitioner was unable to lie on his right side for more than a couple of minutes. PX 10, pp. 124-125.

On August 23, 2016, Dr. Visotsky noted that Petitioner came to the appointment without the sling. He put Petitioner back in the sling and prescribed Naprosyn. He directed Petitioner to use the CPM and ice machines and avoid any resistance activities. PX 10, p. 52. He continued to keep Petitioner off work. PX 10, p. 53.

On September 27, 2016, Dr. Visotsky noted that Petitioner's range of motion was improving but that he was still having difficulty reaching overhead. He prescribed a strengthening program. PX 10, p. 56. He continued to keep Petitioner off work. PX 10, p. 57.

On November 22, 2016, Dr. Visotsky noted that Petitioner was having pain in the peritrapezial and perirhomboid areas. He referred Petitioner to a cervical spine specialist. He recommended additional shoulder therapy and released Petitioner to clerical work. PX 10, pp. 59-62.

On December 20, 2016, Dr. Visotsky noted that Petitioner was still weak, especially in forward flexion. He recommended continued therapy and prescribed Relafen. He released Petitioner to work with no overhead lifting and no lifting over 10 pounds. PX 10, pp. 63-65.

On January 17, 2017, Dr. Visotsky noted that Petitioner was plateauing in therapy. He recommended a functional capacity evaluation. PX 10, p. 67.

On January 24, 2017, Petitioner's therapist recommended discharge, noting that Petitioner's strength with sustained overhead usage and repetition with resistance motion "still remains poor." The therapist found it inappropriate for Petitioner to resume his regular job. PX 10, pp. 130-131.

Petitioner underwent a functional capacity evaluation on January 30, 2017. The evaluating therapist noted good effort. He rated the results as valid. He noted a "significant deficit" in the right shoulder versus the left. He indicated Petitioner required rest breaks and "favored his left upper extremity with all dynamic lifts." He noted that Petitioner reported being unable to install a smoke detector. He found Petitioner capable of performing at a medium physical demand level, noting that his painter job was rated as heavy. He recommended a work conditioning program. PX 10, pp. 70-90.

On February 14, 2017, Dr. Visotsky prescribed six more weeks of therapy followed by work conditioning. He directed Petitioner to resume using the ice and CPM machines. He found Petitioner capable of clerical work with no overhead lifting and no lifting over 10 pounds. PX 10, pp. 92-95.

Petitioner testified that, at Dr. Visotsky's recommendation, he underwent additional shoulder therapy in March 2017, while he was in Florida. Records from Bayonne Physical Therapy reflect Petitioner participated in eleven sessions between March 6 and March 30, 2017. The initial evaluation note identifies Dr. Visotsky as the referring physician. PX 6, p. 31. On March 27, 2017, the therapist noted that Petitioner felt his mobility had improved but was still experiencing pain traveling down the back of his shoulder. The therapist recommended additional formal therapy and home exercises once Petitioner returned to his permanent residence. PX 6, p. 6.

Petitioner resumed therapy in the Chicago area on April 4, 2017. The evaluating therapist noted the intervening therapy in Florida. She also noted ongoing complaints of weakness, with Petitioner expressing doubt that he could hold a roller overhead or transfer heavy items onto a truck, as required by his job. She recommended work conditioning. PX 10, pp. 134-136.

On April 11, 2017, Dr. Visotsky released Petitioner to work within the restrictions outlined in the functional capacity evaluation. He directed Petitioner to follow up in three months. PX 10, pp. 98-99.

On May 30, 2017, Dr. Visotsky noted complaints of persistent shoulder pain. On re-examination, he noted weakness on external rotation "indicative of atrophy of the muscle groups" and some crepitation in the subacromial space. He obtained new X-rays which did not show any displacement of the anchors. He found Petitioner to be at maximum medical improvement. He did not recommend any additional surgery. PX 10, pp. 101-102.

On June 30, 2017, Dr. Visotsky completed and signed a four-page Respondent questionnaire "for reasonable accommodation request" indicating Petitioner was subject to various lifting and climbing restrictions due to his right upper extremity impairment. The doctor characterized the right shoulder impairment as permanent. PX 10, pp. 103-105.

On July 19, 2017, Dr. Visotsky completed and signed a second, similar questionnaire outlining various restrictions relative to weights carried during ladder usage, carrying below shoulder level (50 pounds), pushing/pulling (40 pounds), reaching above and below shoulder level (15 pounds above shoulder level) and operating heavy equipment. He again characterized the right shoulder impairment as permanent. PX 10, pp. 110-114.

Petitioner testified he provided the completed questionnaires to Respondent.

Petitioner returned to Dr. Visotsky on August 18, 2017, due to "persistent shoulder pain." The doctor noted a good, well compensated range of motion but supraspinatus and infraspinatus weakness of 4/5. He prescribed another CT arthrogram to confirm arthritic and rotator cuff changes. He did not recommend additional surgery. PX 10, p. 115.

Dr. Visotsky's last note is dated September 5, 2017. In that note, he indicated the repeat CT arthrogram showed atrophy of the muscles of the supraspinatus and retraction and tearing in the supraspinatus "to the levels on the glenoid." He described the anterior and posterior labrum as intact. He indicated Petitioner had a "probable irreparable tear." He recommended against more surgery. He prescribed physical therapy, a structured rehabilitation program and Naprosyn. PX 10, p. 116.

Petitioner testified he is not certain whether he pursued Dr. Visotsky's September 5, 2017 recommendation of additional therapy.

Petitioner testified he resumed working as a painter for Respondent in September 2017, subject to the restrictions Dr. Visotsky imposed.

Petitioner testified he retired on March 1, 2018 because he could not tolerate working and wanted to avoid reinjuring his shoulder. As of the hearing, his shoulder felt "fine" pain-wise, so long as he avoided reaching overhead, but his strength remained limited. He believes he would not be capable of working as a painter.

With respect to his right hand, Petitioner testified his ability to grasp is limited. He experiences "phantom pain" and aching in the hand but not every day. His grip is weak. Of his injuries, his right shoulder is "worse" than his right hand.

Under cross-examination, Petitioner denied experiencing any right hand or wrist injuries prior to January 7, 2009. He resumed full duty as a painter after recovering from his right hand surgery. He also returned to work as a painter following his 2012 right shoulder injury. After his 2016 right shoulder injury, he resumed his painter job but subject to restrictions. He worked for about six months before retiring. He earned the same salary during this period. He was able to obtain accommodations due to his seniority and age. He was eligible for his pension as of his retirement.

In response to questions posed by the Arbitrator, Petitioner testified he is right-handed. When he resumed working, prior to his retirement, he would perform certain painter tasks that were within his restrictions. When it came to tasks outside those restrictions, his co-workers would step in.

No witnesses testified on behalf of Respondent. Respondent offered into evidence print-outs of the temporary total disability and medical expenses it has paid in Petitioner's claims. RX 1A-B.

Arbitrator's Credibility Assessment Relative to All Cases

Petitioner's lengthy tenure with Respondent weighs in his favor, credibility-wise. The Arbitrator found his testimony concerning his ongoing complaints very believable.

Arbitrator's Conclusions of Law

In 09 WC 20439, is Petitioner entitled to reasonable and necessary medical expenses? Is Respondent entitled to Section 8(j) credit?

In 09 WC 20439, Petitioner claims a Blue Cross/Blue Shield reimbursement of $1,230.22 and reimbursement of $286.29 in expenses he paid to Dr. Heller. Respondent claims Section 8(j) credit in the amount of $1,230.22. Arb Exh 1.

The Arbitrator finds the claimed expenses reasonable, necessary and related to the undisputed accident of January 7, 2009. Respondent stipulated to causation in this case (Arb Exh 1) and did not offer any evidence, in the way of utilization review or Section 12 reports, calling Petitioner's treatment into question. Dr. Heller was not a physician of Petitioner's selection. Rather, he was a referral from Respondent's selected facility, MercyWorks. The Arbitrator awards reimbursement of $1,230.22 and $286.29. The Arbitrator declines to award Respondent the claimed Section 8(j) credit. The Illinois Supreme Court has held that "the burden is upon the employer to establish the fact that it is entitled to credit under Section 8(j)." Hill Freight Lines v. Industrial Commission, 36 Ill.2d 419, 424 (1967). Respondent offered no evidence in support of its claim for credit.

In 09 WC 20439, what is the nature and extent of the injury?

This case is pre-amendatory, since the accident occurred prior to September 1, 2011. The accident resulted in a significant surgery involving Petitioner's dominant right hand. Petitioner was ultimately able to resume full duty but testified to ongoing grip weakness. Dr. Visotsky's records

document some left-sided complaints, secondary to overuse, but Petitioner did not testify to any current left hand problems. The prior 19(b) decision, which neither party reviewed, did not involve any findings relative to the left hand. PX 1.

The Arbitrator finds that Petitioner established permanency equivalent to 20% loss of use of his right hand, equivalent to 41 weeks of permanency under Section 8(e) of the Act.

Is Petitioner entitled to prospective care in 09 WC 20439?

The Arbitrator views Petitioner's claim for prospective care as inconsistent with his request for a permanency award. Petitioner is not seeking any specific future right hand care. Petitioner preserved his 8(a) rights by taking the case to arbitration.

In 14 WC 34241 and 16 WC 17448, did Petitioner establish causal connection?

The Arbitrator finds that Petitioner established a causal connection between each of his undisputed right shoulder injuries and his current, post-operative right shoulder condition of ill-being. In so finding, the Arbitrator notes that, with respect to both the 2012 and the 2016 injuries, Petitioner testified to an abrupt onset of right shoulder pain affecting his ability to continue working. There is no evidence indicating Petitioner was experiencing any disabling right shoulder symptoms prior to the November 1, 2012 accident. Following that accident, which necessitated a right shoulder surgery, Petitioner was able to resume full duty but suffered recurrent tearing due to the accident of April 27, 2016. This accident brought about the need for additional surgery. Petitioner was left with permanent restrictions following that surgery. The Arbitrator views Petitioner's current right shoulder condition as multi-factorial, with both injuries contributing to that condition.

The Arbitrator also notes that Respondent did not obtain a Section 12 examination or offer any causation-related opinion from a physician.

In 16 WC 17448, is Petitioner entitled to reasonable and necessary medical expenses?

In 16 WC 17448, Petitioner seeks an award of the expenses associated with services provided by Bayonne Physical Therapy ($602.31). The Arbitrator finds these services reasonable, necessary and related to the undisputed right shoulder injury of April 27, 2016. Bayonne Physical Therapy provided the services to Petitioner, per Dr. Visotsky, during a period in March 2017 when Petitioner was in Florida.

The Arbitrator has reviewed Bayonne Physical Therapy's itemized bill. PX 6. This bill shows various payments by "Florida Blue" (presumably a group carrier). It also shows a credit card payment by Petitioner in the amount of $293.19, various write-offs and a $0 balance. Respondent's payment print-out (RX 1B) does not show any payments for physical therapy services provided in March 2017.

Respondent did not offer any evidence, in the form of utilization review or Section 12 reports, calling any aspect of Petitioner's treatment into question.

The Arbitrator finds Respondent liable for the expenses associated with the care provided by Bayonne Physical Therapy, subject to the fee schedule. The Arbitrator directs Respondent to reimburse Petitioner for his out of pocket expenses totaling $293.19 and to pay/reimburse the remaining expenses

subject to the fee schedule. At the hearing, the parties agreed Respondent could negotiate directly with Petitioner's providers.

In 14 WC 34241 and 16 WC 17448, what is the nature and extent of the injury?

Both 14 WC 34241 and 16 WC 17448 involve undisputed right shoulder injuries. The Arbitrator has previously found that both these injuries played a role in Petitioner's current, post-operative right shoulder condition of ill-being. The Arbitrator elects to address permanency in 16 WC 17448. Because this case is post-amendatory, the Arbitrator looks to Section 8.1b of the Act for guidance in determining nature and extent. This Section sets forth five factors to be considered in assessing permanency, with no single factor to be afforded greater weight than any other. The Arbitrator gives the first enumerated factor, i.e., any AMA impairment rating, no weight since neither party offered such a rating into evidence. The Arbitrator assigns substantial weight to the second factor, i.e., Petitioner's occupation. Petitioner testified he worked as a painter for many years. While Petitioner was able to resume this trade following the accident in 14 WC 34241, he was left with a myriad of restrictions following the accident in 16 WC 17448. He was able to return to work, subject to those restrictions, but lasted only about six months before deciding to retire. He credibly testified he routinely obtained assistance from co-workers during that six-month period, with the co-workers performing the tasks that were beyond his restrictions. The Arbitrator views this case as involving a loss of trade. The Arbitrator also assigns weight to the third factor, Petitioner's age at the time of the accidents. Petitioner was 58 as of the 2012 accident and 62 as of the 2016 accident. He is an older worker who opted to retire in 2017 due to the difficulty he was experiencing performing his trade. As for the fourth factor, future earning capacity, the evidence shows that, while Petitioner was able to resume his painter job for a brief interval following the 2016 injury, he was not physically able to perform all of the aspects of that job due to his restrictions. His co-workers stepped in as needed and helped him along until he decided to take retirement. Petitioner credibly testified he does not believe he would be capable of resuming his trade at the present time. The Arbitrator assigns substantial weight to this. With respect to the fifth and final factor, evidence of disability corroborated by the treating medical records, the Arbitrator initially notes Dr. Visotsky's intra-operative findings. In the operative report dated July 11, 2016, the doctor indicated he was able to only partially repair the infraspinatus and supraspinatus tears. The Arbitrator also notes the valid results of the functional capacity evaluation performed on January 30, 2017. The evaluator noted "a significant deficit" in the right shoulder. He also noted that Petitioner tended to favor his left arm during all dynamic lifts. When Dr. Visotsky last saw Petitioner, in the summer of 2017, he indicated that a recent CT arthrogram showed atrophy of the infraspinatus and supraspinatus muscles, as well as tearing. He recommended against further surgery.

The Arbitrator has considered all of the foregoing. The Arbitrator has also considered that the deficits involve Petitioner's dominant right arm. The functional capacity evaluator noted that Petitioner reported difficulty with relatively routine overhead tasks, such as installing a smoke detector. PX 10, pp. 70-90. Petitioner credibly testified to persistent right shoulder weakness. His surgeon, Dr. Visotsky, characterized his current condition as "inoperable." In 16 WC 17448, the Arbitrator awards permanency equivalent to 32.5% loss of use of the person as a whole, representing 162.5 weeks of compensation under Section 8(d)2 of the Act.

Is Petitioner entitled to prospective care?

The Arbitrator views Petitioner's claim for prospective care as inconsistent with his request for a permanency award. Petitioner is not seeking any specific future care relative to the right shoulder. Petitioner preserved his Section 8(a) rights by taking the cases to arbitration.

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

Rudolph Lading,
Petitioner,

vs.

NO: 14 WC 34241
16 WC 17448

City of Chicago,
Respondent.

19IWCC0262

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 24. 2018, is hereby affirmed and adopted.

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

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

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

DATED: MAY 24 2019
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BNF/mw
045

Barbara Flores

Deborah Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LADING, RUDOLPH
Employee/Petitioner

Case# **14WC034241**

09WC020439
16WC017448

CITY OF CHICAGO
Employer/Respondent

19IWCC0262

On 10/24/2018, 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 2.42% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0059 BAUM RUFFOLO & MARZAL LTD
EDUARDO C SALGADO
33 N LASALLE ST SUITE 1710
CHICAGO, IL 60602

0010 CITY OF CHICAGO
D TAYLOR CHITTICK
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Rudolph Lading
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **14** WC **34241**

Consolidated cases: **09WC20439 & 16WC17448**

19IWCC0262

An *Application for Adjustment 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 **09/21/2018**. 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other

FINDINGS

On **11/01/2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**80,488.03**; the average weekly wage was $**1,546.89**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

The Arbitrator elects to address permanency in the decision in the third claim, numbered 16 WC 17448.

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

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

Molly C. Mason

Signature of Arbitrator

10/24/18

Date

OCT 2 4 2018

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

Raisa Ader,
Petitioner,

19IWCC0263

vs. NO: 09 WC 37078

United Parcel Service,
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, notice, permanent disability, temporary disability, spoilation, constitutionality 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 13, 2018, is hereby affirmed and adopted.

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

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

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

DATED: MAY 28 2019
o5/23/19
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0263

ADER, RAISA M
Employee/Petitioner

Case# **09WC037078**

09WC037079

UNITED PARCEL SERVICE
Employer/Respondent

On 2/13/2018, 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 1.65% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0863 ANCEL GLINK
W BRITT GLINK
140 S DEARBORN ST 6TH FL
CHICAGO, IL 60603

2461 NYHAN BAMBRICK KINZIE & LOWRY
MARTHA GELY-KRUTO
20 N CALRK ST SUITE 1000
CHICAGO, IL 60602

19IWCC0263

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

RAISA M. ADER,
Employee/Petitioner

v.

Case # **09** WC **37078**
Consolidated case: # **09** WC **37079**

UNITED PARCEL SERVICE,
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 **Brian T. Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **4/28/2017**, **5/2/2017** and **6/20/2017**. 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] 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: **Presumption that Subpoenaed Records Would Show 2006 Accident Report; Spoliation, & Constitutionality of Act as Applied to Petitioner**

Downstate offices: Collinsville 618/346-3450 Peoria 309/671-3019 Rockford 815/987-7292 Springfield 217/785-7084

FINDINGS

On **10/2/2006**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

In the year preceding the injury, Petitioner earned $**10,542.48**; the average weekly wage was $**202.74**.

On the date of accident, Petitioner was **23** years of age, ***single*** with 0 dependent children.

ORDER

Because Petitioner failed to prove by a preponderance of the evidence that she sustained accidental injuries arising out of her employment with Respondent on October 2, 2006, the Arbitrator denies her claim for compensation.

The Arbitrator finds that there is no presumption against Respondent that the subpoenaed records would have shown a 2006 accident report that was completed in October 2006, or that these records were prejudicial to Respondent. Petitioner's claim of spoliation is denied.

All other issues have been rendered moot.

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

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

Signature of Arbitrator

2-8-2018
Date

FEB 13 2018

19IWCC0263

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

RAISA M. ADER,)
Employee/Petitioner)
)
)
vs.) Case # 09 WC 37078
)
)
UNITED PARCEL SERVICE,)
Employer/Respondent)

FINDINGS OF FACT

Petitioner testified she was employed by UPS in the Northbrook facility from 2001 to 2009. As of October 2, 2006, she was a loader on B truck. She worked part-time from 5:00 p.m. to 10:00 p.m. every day, Monday through Friday. Petitioner testified she was required to load boxes inside a truck.

Petitioner testified she was supposed to lift up to 70 pounds but there were boxes from 50 pounds to 150 maybe 200 pounds. She would need assistance with the heavier boxes and those boxes were called bulk. Petitioner testified she was the fastest loader. She would lift 50 boxes per every 15 minutes (T. 14). However, in the span of an hour, she said she would lift 3,000 boxes (T. 15). Petitioner testified that she had a quota of lifting 1,000 to 1,500 packages per hour. (T. 15-16)

Petitioner testified that on October 2006 her truck was overloaded. A bunch of boxes "fell off on the ground in the truck" and she lifted about a 50 or 60-pound box. She testified that she turned, twisted to her left, and lifted it onto - - and her back went

out and shooting pain literally paralyzed her. The pain then shifted from left to right (T. 16). She also testified that when she felt the pain, she dropped the box. It was a sudden, sharp shooting pain down her leg. The shooting pain went down both legs.

Petitioner further testified she notified her supervisor and her supervisor told her manager Fidel. Petitioner did not know Fidel's last name. Fidel told her they had to fill out a report. When they went upstairs, nobody was upstairs so he radioed Ray Citko, who was the safety manager at the time (T. 19).

According to Petitioner, Mr. Citko met with her. Mr. Citko was writing up a report while she was telling him about the injury. She testified that Mr. Citko told her that she had to fill out a form. It was a piece of paper that she had to jot down the dates, the time, how it happened, what she was doing. (T. 20)

Petitioner testified that Mr. Citko called a taxicab to go to a clinic since UPS had a clinic. Petitioner also testified that Ray Citko went to the clinic with her but she did not remember the name of the clinic. According to Petitioner, Ray Citko told her the clinic they usually would go to was closed so they had to choose a different one. At the clinic, a nurse and a doctor looked at her back and prescribed Ibuprofen. After she was examined, Petitioner testified, they took a taxicab back to UPS. She did not work the rest of the night. Petitioner also testified that other than the 2006 low back injury, she did not have any other additional injuries in 2006 (T. 21-23).

According to Petitioner's testimony she had felt pain in her back in 1999 and 2000 and 2004. She used to do gymnastics in 1998 and she injured her back. She had therapy and acupuncture and the pain went away. In 2000, she went for therapy. She also got an MRI.

The October 9, 2000, MRI, without contrast, of Petitioner's lumbar spine was interpreted as showing an "L5-S1 central disc herniation causing moderate central stenosis." Such report indicates that the previous MRI showed a protrusion.(PX 6, p. 6)

Petitioner testified that the pain went away and that it was just inflammation. In 2004, Petitioner testified, she experienced "[j]ust inflammation, slight irritation" of her back (T. 25).

Petitioner testified that when she came to work in 2006 on or about October 2, 2006, she was fine, she was still loading. She got to work at 4:30 and was fine. She worked until 8:00 p.m. She had been working the prior week with no issues. According to Petitioner, the pain she felt in 2006 was a totally different pain. Her pain was shooting, paralyzing pain down her legs, shifting from left to right and making it hard to breathe.

On a referral from Julie Brandies, M.D., Petitioner saw Christopher Plastaras, M.D., at RIC Spine and Sports Rehabilitation Center for her injury of 2006. She saw Dr. Plastaras on November 6, 2006. (T. 27-30)

Upon examining Petitioner, Dr. Plastaras found, *inter alia*, a non-antalgic gait and was able to heel and toe walk without difficulty, no atrophy in the lower limb, straight leg test on the right and left that were normal, and femoral stretch on the right and left that were normal. After reviewing the November 6, 2006 x-ray images, and comparing them with the findings in a report that addressed x-ray images taken March 11, 2004, Dr. Plastaras made preliminary findings of mild disc space narrowing at L4-5. Dr. Plastaras' impression: L4-5 lumbar degenerative disc. (PX 6, pp. 116-118)

Petitioner testified that she would not dispute the impression in Dr. Plastaras' records that she had an L5-S1 lumbar disc protrusion, flared. (T. 30)

On March 16, 2007, after examining Petitioner, Dr. Plastaras offered the following impression of Petitioner's condition: right T10-11 thoracic zygapophysial joint pain related to T10-11 thoracic segmental dysfunction, and L5-S1 lumbar central disc protrusion, flared intermittently. (PX 6, pp. 164-165)

Petitioner testified that in 2009, Respondent offered her a light-duty job in Palatine as a small sort pre-loader. She testified that she did not take the job because the hours of the job were from 2:00 a.m. to 7:00 a.m., and there was no public transportation at that hour. Petitioner testified that she did not have a license, and that Respondent knew she did not have a car. (T. 67-68) She testified that she lived with her parents at 233 E. Walton Place, Chicago, and that she took a bus to work to the Northbrook, IL, facility. (T. 55, 72, 76, 111-112)

After she treated with Dr. Plastaras, Petitioner saw Dr. Natarajan of Chicago Primary Sports Medicine. She was also referred to Dr. Natarajan by Dr. Brandies. (T. 30)

Dr. Natarajan examined Petitioner's lower back in May 2010. MR images of her lumbar spine were taken on May 27, 2010 (T. 31).

After Dr. Natarajan, Petitioner was seen by Dr. Jain of Pain Care Specialists. (T. 31) Dr. Jain ordered a CT scan of the lumbar spine on October 8, 2010. Petitioner also testified that while seeing Dr. Jain she was also seeing a therapist, Dr. Brown, who noted pain about her back since the 2006. Dr. Jain essentially kept seeing Petitioner through July 19, 2011. She had been given 5 injections to her spine at L5-S1 and to her facet joints at L3-4, L4-5. Petitioner testified that the injections made the pain worse. Petitioner also testified that all her referrals were through Dr. Brandies (T. 32).

Petitioner testified she eventually came to see doctors at North Shore University Health System, particularly Mark T. Nolden, M.D. She was referred to Dr. Nolden by Dr. Malik (T. 33). Dr. Nolden first examined Petitioner's low back on June 8, 2011. At the time, she complained that the pain was chronic and severe with radiation into the buttocks.

In Dr. Nolden's June 8, 2011 letter to Dr. Malik, he states, in pertinent part, the following:

> As you know, she is a pleasant 28 year old woman who since 1999 has been suffering from intractable and severe back pain with radia-ation into the buttocks and thighs. The pain has waxed and waned and has been episodic and at times disabling. (PX 10, p. 57)

Petitioner testified that Dr. Nolden prescribed low back surgery and performed it on July 22, 2011 (T. 34).

Dr. Nolden's records indicate that such surgery included a posterolateral spine fusion L5-S1 with transforaminal interbody fusion, internal fixation by insertion of cage and bilateral pedicle screw instrumentation. (PX 10)

Petitioner testified that after the surgery, she had more pain and problems than before the surgery. She still had the shooting down her legs and she had difficulty bending. (T. 35)

Petitioner testified that even though she was following up with Dr. Nolden from September 8, 2011 through September 4, 2013, she had to go to a rehabilitation facility after the surgery (T. 36).

On February 20, 2014, Dr. Nolden testified via deposition. He testified that when he examined Petitioner on June 8, 2011, he found that she was neurologically intact,

but had a limited range of motion in all directions because of reported pain. (PX 19, p. 7) He also found that she had tenderness with palpation diffusely throughout her lumbar spine and that the rest of the exam was unremarkable. (PX 19, p. 7) Dr. Nolden reviewed the 2010 MRI and post-discographic CT scan from October 2010, which showed disc degeneration at L5-S1 with a provocative portion of the discogram that indicated that L5-S1 was the symptomatic disc. (PX 19, pp. 7-8) He testified, to a reasonable degree of medical and surgical certainty, that "the lifting and all that could aggravate her underlying condition of degenerative disc disease." The basis of his opinion is the diagnosis he was working with at the time. (PX 19, pp. 9-10) Dr. Nolden testified that the new MRI of June 22, 2011 revealed disc degeneration at L5-S1 with a posterior annular tear. (PX 19, p. 10) He further testified that all of Petitioner's back treatment has been related to the aggravation of her back problems caused by the regular lifting she was required to do while employed at UPS. (PX 19, p. 17)

On cross-examination, Dr. Nolden testified that there was not a big difference between the June 2011 MRI and the 2010 MRI. He further testified that he has not reviewed any MRIs prior to the 2010 MRI. (PX 19, pp. 18-19) Dr. Nolden testified that on December 15, 2011, he observed that Petitioner seemed very comfortable talking to him while she was standing, and on August 1, 2012, he stated: "It is not clear where her severe pain continues to emanate from." (Px 19, pp. 22-23) Dr. Nolden testified that he found no other pathology on imaging studies to which they could attribute her pain. (PX 19, p. 24) Dr. Nolden testified that he would be surprised to learn that there was about a 3-year gap in back treatment following her alleged work injury. (PX 19, pp. 24-25)

On redirect examination, he testified that it remains his opinion that Petitioner's condition of back pain is related to an aggravation caused by regular lifting done at work. (PX 19, p. 26)

Petitioner testified that Dr. Malik gave her several injections. He saw Petitioner from August 27, 2010 through September 25, 2012. This was all for treatment to her lower back. Dr. Malik also ordered CT scans of the lumbar spine and MRIs of the lumbar spine (PX 11).

Petitioner testified she was admitted to Manor Care Health Services through Hinsdale Hospital on July 27, 2011. She testified she was bedridden and unable to walk. She had to wear a back brace and use a wheelchair. She also attended occupational therapy. Petitioner was given a Medrol Dosepak, OxyContin, Ibuprofen, Flexeril, Hydrocodone and Ambien. Petitioner testified she was at Health Care Manor from July 27, 2011 until October 22, 2011. She also testified that when she was discharged from Manor Care, she did not feel better at all. Petitioner testified that the reason she had the surgery was to get rid of the paralyzing pain. However, 6 weeks after the surgery, the problem was still there but she was no longer bedridden and was able to walk out of the hospital and go home (T. 38).

On November 4, 2011 Petitioner had an emergency admission to LaGrange Hospital due to vomiting after a back surgery and pain medication. This was after she treated at Manor Care. Petitioner claimed she overdosed from all the medication she was taking. Petitioner testified she had been taken off work after her surgery. (T. 40-41)

Petitioner continued to have back pain and also hip pain. She testified that she was seen by Shane J. Nho, M.D., at Midwest Orthopedics at Rush. She first started

seeing Dr. Nho on October 2, 2012. Petitioner testified that Dr. Nho examined her bilateral hips. According to Petitioner she had a tear in her hip. It was a substantial tear. (T. 43) According to Petitioner, Dr. Nho advised her that she had a 50/50 chance of fixing her back due to the tear. The tear was in her left hip. On October 26, 2012, Petitioner underwent a CT scan of her left hip. At that time, she was suffering from left hip pain and joint pain. The CT scan showed impingement. Petitioner underwent hip surgery on January 23, 2013. The pre-surgical diagnosis was left hip labral tear. Petitioner underwent a left hip arthroscopy for a labral repair, a femoral osteochondroplasty, and a capsular plication. Petitioner also testified that Dr. Nho continued to see her through July 23, 2013 (T. 42; PX 14).

Petitioner then participated in physical therapy at Athletico from January 25, 2013 through May 29, 2015. After that, she went back to RIC to see Dr. Margulis. This was on the recommendation of Dr. Nolden. She was going to Dr. Margulis for pain management. Petitioner testified that she was still going to pain management at RIC once a month to obtain medication (T. 46). According to Petitioner, she takes Hydrocodone and Cymbalta 4 times a day.

Petitioner testified there was a gap in her medical treatment for her lower back between 2007 and 2010. According to Petitioner, it was because Dr. Plastaras had told her there was nothing more he could do and that she has to live with it. Petitioner testified that because the pain got worse over the years, she changed her mind (T. 48). Dr. Plastaras had recommended physical therapy and a couple of injections back in 2007.

Petitioner testified that the last time she worked for UPS was in 2009, but her medical treatment went beyond 2009 and her mother had to buy an insurance policy to

cover her medical care. Her mother also paid for COBRA premiums after UPS let her go (T. 49).

Petitioner testified that she was completely off work from July 22, 2011 through October 23, 2011. Petitioner testified that Dr. Nolden last saw her on September 4, 2013. He released her from medical care because there was nothing else he could do for her, but recommended that she see a doctor to help her control the pain. Petitioner testified that she has not followed Dr. Nolden's recommendations (T. 52-53).

Petitioner further testified that she is not currently employed because her back hurts. She has difficulty walking, sitting and standing. She also testified that she helps her neighbor, who has Alzheimer's Disease. She watches her once in a while. She also had a friend who died; she helps out with the children. Petitioner also testified that she has another friend for whom she processes mail and writes checks. Petitioner testified that after sitting for 15 minutes, her back starts to hurt and she is stiff. Her lower back hurts from the left side and then the right side and then the pain shifts from left to right. It helps her to stand up. Petitioner also testified that she lives with her parents at their home (T. 53-55).

She testified that she used to be very independent. She used to do sports. She used to be able to clean the house and help her parents. Now her parents help her a lot and she has difficulty socializing. Petitioner testified that the pain gets bad throughout the day. She gets paralyzing pain. She testified that 20-30 times a day, her back goes out (T.56).

According to Petitioner, before she had her back accident, she wanted to be a teacher. She received an Associate's Degree in Art from Harold Washington College and she wanted to finish her Bachelor's Degree, but had difficulty with the practicum.

She tried to continue her education, but her back was getting bad. She could not focus in school. She was going to be an early childhood teacher. Petitioner stated that she could not complete the 4-year degree to be an early childhood teacher because her back kept going out and she was always in pain (T. 60).

On cross-examination, Petitioner testified she took a bus to get to the Northbrook location when she worked as a loader in 2006. Petitioner testified that she reported her injury to a supervisor and further testified that she had gotten hurt lifting a box. According to Petitioner, she was in a lot of pain and it paralyzed her. She acknowledged that no ambulance was called. She confirmed that she did not know the name of the hospital or clinic that she went to that night (T. 73).

Petitioner testified that she continued to work for UPS. She clarified that she continued to work for UPS from October 2, 2006 all the way to December 27, 2007 when she injured her shoulders. (T. 74) According to her testimony, she injured her shoulders while working as a loader. As a result, she was given permanent restrictions. Petitioner testified that she was offered a position as a small sort sorter in 2009, but she did not show up for work on September 21, 2009, and again on November 2, 2009. (T. 76) Petitioner secured employment elsewhere as a teaching assistant in March of 2010. (T. 77)

Petitioner confirmed that she did not seek further medical attention for her back until she went to LaGrange Medical Center in May 2010 while working for a different employer. Her doctor referred her for a lumbar MRI, which was carried out on May 26, 2010 (T. 78).

Petitioner testified that her first evaluation with Pain Care Specialists was on November 8, 2010. Petitioner also testified that Dr. Brandies was her primary care

physician, and Dr. Brandies referred her to Dr. Nolden, who performed back surgery on her in 2011.

Petitioner testified that she was evaluated twice by Michael D. Kornblatt, M.D., on behalf of Respondent. The first exam was on December 20, 2010 and the second exam was on July 25, 2013. According to Petitioner, Dr. Kornblatt conducted a physical exam and asked her questions about her medical condition and how she got injured (T. 81-82).

On September 28, 2015, Dr. Kornblatt testified via deposition. When he examined Petitioner, he found, *inter alia*, that there was no neurological deficit. (RX 8, Dep., p. 7) Dr. Kornblatt testified that to a reasonable degree of medical and surgical certainty, Petitioner's work activities, specifically the alleged injury of October 1, 2006, did not cause, aggravate, or accelerate her pre-existing back problems. (RX 8, Dep., pp. 6, 12) He further testified that Petitioner had a spine fusion because she complained of back pain and had a diagnosis of degenerative disc disease, not because she had an injury at work or anywhere else. (RX 8, Dep., p. 18) Dr. Kornblatt also testified that Petitioner's inability to work without restrictions is not related to her activities or work at Respondent. (RX 8, Dep., p. 19)

On cross-examination, Dr. Kornblatt testified that he did not find that Petitioner was malingering. He testified that from 1999 to 2010, there was no physical or structural progression of Petitioner's disc disease. (RX 8, Dep., p. 25) He testified that a person with degenerative disc disease can be symptomatic with or without a traumatic event, and that Petitioner is symptomatic because she has degenerative disc disease, not because she had some episode of trauma. (RX 8, Dep., pp. 26-27)

Dr. Kornblatt testified that a person can lift a heavy weight and suddenly feel back pain with radicular symptoms that correlates with abnormal findings on exam. That would most likely be a traumatic event, like a herniated disc that occurred with a specific event. However, this scenario never happened to Petitioner. (RX 8, Dep., p. 42)

Dr. Kornblatt testified that he performs 99% of his independent medical examinations at the request of the defense. (RX 8, Dep., p. 44)

On redirect examination, Dr. Kornblatt testified that although he performs 99% of his independent medical examinations at the request of the defense, it does not mean that in all of these exams he finds no causal relationship between the work accident and claimant's current condition. (RX 8, Dep., p. 44)

Petitioner testified that at the time of trial, her back was still bad and went out. Petitioner testified that she has limitations with sitting and standing. (T. 82-83)

Petitioner testified that she met with Jayson Thomas of UPS on April 3, 2009. This was the ADA meeting. She confirmed that she discussed what type of job she wanted to do for UPS and what she felt she could do. According to Petitioner, she felt that she could do light-duty work (T. 83-84; RX 4).

Petitioner testified that she signed the accommodation checklist on April 3, 2009. She testified that she would like to be considered for a position in QC computer desk, air, soft small sort and air duct. Petitioner testified that the handwriting on page 5 of Respondent's Exhibit 4 was hers. (T. 86)

Petitioner testified as to the documents from the checklist meeting. After reviewing these documents, Petitioner testified, she greed that page 4 of RX 4 listed the essential job functions of the loader/unloader for UPS. She also confirmed that that it

showed numbers 1, 2 and 3. There were also the letters Y or N that represented yes or no, respectively (T. 84-87; RX 4). Petitioner read that when asked if she was able to continue to lift, lower, push, pull, and leverage and manipulate equipment and package weight up to, she answered no. Petitioner testified that page 5 of Respondent's Exhibit 4 displayed her explanation, in her handwriting, of what she could not do at that time (T. 88).

Petitioner testified that when she attended the ADA meeting, she was able to bend, stoop, crunch, squat, crawl, climb, stand, walk, and turn, pivot, part-time 3-5 per day. She marked that as a yes. Petitioner testified that at the time, that is, in 2009, she was able to bend, stoop, crouch, squat, crawl, climb, walk and turn and pivot.

Petitioner testified that she was terminated from UPS in 2009, but that her actual physical work at UPS ended in 2008. Petitioner testified that there was no medical treatment for her back from 2007 until 2010 (T. 89). Further, Petitioner testified that when she sought additional medical care for her back, she was working for a different employer (T. 90)

Petitioner testified she had had a prior shoulder injury in 2004. She confirmed that she settled that claim in 2007. Petitioner testified that she knew how to report a work injury. She testified she sought minimal treatment for her back. Petitioner also testified that by March 16, 2007, she had no physical restrictions and was able to go back to work. Petitioner read into the record the following portion of the March 16, 2007 medical record: "Activity as tolerated, no physical restrictions." (T. 92-93)

Petitioner testified she underwent back surgery on July 22, 2011 with Dr. Nolden. Petitioner also testified that on July 27, 2011, she presented to Manor Care with pain after taking a trip to Russia (T. 94-97).

On October 19, 2011, she presented for evaluation to Dr. Margulis. Petitioner testified that she told Dr. Margulis that she left UPS in 2008 and was working as a pre-school teacher in 2010. (T. 97-98)

Petitioner testified that she really enjoyed traveling. She testified she traveled to Russia, India, Mexico and Bulgaria. She had gone to Russia twice and to India twice (T. 98; RX 7). Petitioner testified that the flight to India takes 22 hours. She also testified that the flight to Russia takes 24 hours and that she did it twice. She stayed in India for 2 weeks and about 1 or 2 months in Russia when she traveled. Petitioner testified that when she traveled to India, Mexico and Russia, she was visiting friends and family. Mexico was a vacation. India was a vacation. Her fiancé lives there. In Russia, there is her family. She also traveled to Bulgaria to visit her family (T. 99-100).

Petitioner confirmed that a picture of her that shows her smiling and feeding ducks was taken in Russia (T. 101; RX 7). Petitioner testified that she cannot bend. However, she was shown another picture that was taken in Russia. Petitioner testified that she was crouching and smiling at the time the picture was taken (T. 102). Petitioner also testified as to another picture in her social media profile that was taken in Mexico. The picture was taken in 2015. Petitioner testified that in all those pictures, she was traveling but she could not work. She testified she was not able to work.

Petitioner testified that she currently helps with her godchildren. She helps them with their homework and she hangs out with them. She also helps with her neighbor, who has Alzheimer's Disease. She sits with her and watches TV. She testified that she spends 2-3 hours a day with her, once or twice a month. Petitioner also testified that she had a fiancé in India (T. 104).

Petitioner testified she had a gymnastics injury back in 1999. She was sent for medical care at that time. Petitioner confirmed that she had MR images of her lumbar spine taken in the year 2000. She has no reason to dispute that the MRI showed a herniated disc at the L5-S1 level. Petitioner testified that in May 2010, she had another lumbar spine MRI taken, and 10 years later, the MRI showed the same herniated disc at the L5-S1 level (T. 104-106). Petitioner testified the MRI from the year 2000 and the MRI from the year 2010 showed the same herniated disc (T. 109).

On re-direct examination, Petitioner testified that she has not had any new accidents. Her back was bad on April 3, 2009, but not as bad with the going out. It was not paralyzing her as frequently. Petitioner testified that she was willing to work at that point. She testified her pain got worse after the surgery, which was in 2011. Petitioner also testified that she had pain while she was traveling (T. 112-113). She went to India because she had a fiancé there. Petitioner met her fiancé in 2013. According to Petitioner, she was able to take this 22-hour flight with pain by using a wheelchair. She would stand up on the plane and would take medication. She was using the same medication she uses now. She was allowed to walk around the plane.

Petitioner testified she has had a hard time socializing. However, on re-cross examination, she testified that she did socialize and had a fiancé in India. Petitioner testified that she was released from medical care for her shoulders in 2008. She further testified that she has not received further medical treatment for her shoulders since that time. Petitioner also testified that she was released from medical care by Dr. Nolden.

Jacqueline Mary Ader:

Jacqueline Mary Ader, Petitioner's mother, testified on behalf of Petitioner. Mrs. Ader testified that she paid for COBRA premiums, and then premiums for the Illinois Chip Program, which is a program that accepts someone with a serious disability and pre-existing conditions. She paid co-pays and deductibles for Blue Cross/Blue Shield.

She testified that she compiled Petitioner's Exhibit #20, which is a list of medical bills that she paid. COBRA covered Petitioner from 2009 through 2010. I-Chip covered Petitioner from 2011 to 2013.

Mrs. Ader testified that they adopted Petitioner in 1994 when she was 11 years old. She has been living with them since. She further testified that after adopting Petitioner, they found out that Petitioner had family in Russia. The adoption agency wanted them to maintain contact. Mrs. Ader testified that Petitioner would go to Russia for maybe 3 or 4 weeks at a time; one time she went for 5 weeks.

Mrs. Ader testified that she received a phone call at home from Petitioner in 2006. She testified that Petitioner called her from work and said she had an injury and would not be coming home on time. She testified that they had taken her to the on-site clinic, but nobody was there so they had to take her off-site.

Mrs. Ader testified she has taken a lot of time off work to take Petitioner to different doctors to try to get second opinions.

Mrs. Ader testified that since Petitioner's accident in 2006, Petitioner's life has changed. She testified that, physically, Petitioner was not the person she used to be. She was very athletic. Mrs. Ader testified that Petitioner had to stop doing all of the activities that young people enjoy. Petitioner was not able to do it because of the pain.

(T. 127). Mrs. Ader also testified that Petitioner became more reclusive, reticent, and quiet, and was unable to sustain a full day of activity.

Jayson Thomas:

Mr. Jayson Thomas testified on behalf of UPS. He testified he is currently one of the global health and safety managers. He has been with UPS going on 19 years (T. 140).

Mr. Thomas testified that in 2009, he was the Metro Chicago District workforce planning manager. He was responsible for hiring and staffing for the Metro Chicago District, as well as for staffing any positions that fall under the ADA accommodation process.

Mr. Thomas testified that Ms. Raisa Ader was an employee at the UPS Northbrook facility, which was within the Metro Chicago District at the time. She applied for ADA accommodation due to a shoulder injury in 2007 (T. 141). Mr. Thomas explained that an ADA accommodation is an accommodation under the Americans with Disabilities Act.

Steven Simon:

Mr. Simon testified that he is an "operating investigative person." He first got in the industry in 1997. He received an undergraduate education in criminal justice and psychology at Illinois State University, and then attended graduate school where he studied psychology. He began working for a private investigator in Chicago and then began his own investigative firm in 2000-2001.

Mr. Simon testified that he conducted a social media investigation. He found an online profile for Petitioner. Mr. Simon testified that authored a report in which he summarized his findings of the investigation he conducted on Petitioner (RX7).

Mr. Simon testified that he located or discovered the social networking profile that he believed is associated with Petitioner's online account. Within that profile, there was activity that included around 200 photographs of Petitioner. There were a number of friends and associates listed on the profile, many of whom appear to be of Russian descent. Also, Petitioner entered "posts" and "likes" throughout the profile. Mr. Simon began capturing the information in the profile and the profile numbers in the hundreds of pages. Mr. Simon indicated that there were a lot of "selfie" photos. There were images of Petitioner standing outside in various places. He recalled a photo of her next to a lake in which she was in a squatting position.

Mr. Simon testified that Petitioner's social media profile was not in English. It was in Russian. He utilized Google Translate to basically translate the entire page. To ensure proper translation, he testified, he inquired throughout his network of associates for someone who could translate the information from Russian to English.

On cross-examination, Mr. Simon testified that he could only speak to what he saw in the photos. He saw Petitioner smiling, sitting and squatting. There were no photos of her running and no photos of her lifting. There were photos of her with children. Mr. Simon testified that he did not see any videos of Petitioner.

He further testified that from the 200+ pictures he saw, he concluded that he was looking at a normal young woman. Mr. Simon testified that he wanted to do surveillance but because of the logistics of the property around Petitioner's residence,

he did not recommend it. With such a building, he did not feel that surveillance would be productive.

Mr. Simon testified that he drafted a report that contains pictures he found as a result of his investigation (T. 181). Mr. Simon further testified that the URL of the site was Okay.ru and the name of the site was Odnoklassniki. The photos in the report are photos from that website; that was the information contained in the report. He completed the report on January 16, 2017. He conducted this social media investigation between November 8 and January 16, 2017.

Iryna Aniushkevich:

Ms. Aniushkevich testified that she is from Belarus but lives in Austin, Texas. She has been in the United States for 5 years. She further testified that she is a full-time biochemistry student at University of Texas. She works at the computer lab part-time and occasionally provides supportive services to private investigation companies. By that she means she translates documents. She translates documents from Russian to English. She testified that her first language is Russian.

Ms. Aniushkevich testified that Steve Simon contacted her to review a profile that he found on a social media network. She commented on her observations. She further confirmed that he had properly translated from Russian to English.

On cross-examination, she testified that she confirmed that the translations in the profile were properly translated from Russian to English. Those translations were of captions beside the photos that she saw. She also testified that there were captions around the wall page that were also properly translated.

Raymond Citko:

Mr. Citko testified that he is a part-time health and safety supervisor for UPS. He testified that he now works out of the Franklin Park location, but in 2006 he worked out of the Northbrook facility.

Mr. Citko testified that he knew Petitioner from his time in Northbrook. He did not recall Petitioner notifying him of a work accident regarding Petitioner's back. He did recall an injury to her shoulders. Mr. Citko further testified that he did not recall getting in a taxicab with Petitioner and taking her to a clinic. He did testify that if he had called her a cab, she would have gone to the clinic by herself (T. 22).

Mr. Citko testified that it was his job to fill out an accident report if there was a report of injury. He would complete the report immediately, or at least before he left for the day. If an injured worker required medical attention, he would provide assistance first, and then complete the report.

On cross-examination, he testified that he worked as a part-time supervisor for about 10 years out of Northbrook. He investigated less than 100 accidents during his tenure (T. 31). He would document the accident reports with the injured worker. The report would go in a binder and then would be thrown in the garbage after several years. Mr. Citko also testified that the name Fidel sounded familiar, but without a last name, he was not sure.

On re-direct, Mr. Citko testified that it was company policy to contact Liberty Mutual after an accident was reported and a report was completed. He would make a phone call and report what had happened.

Petitioner's Rebuttal Testimony:

Petitioner testified that when she injured her back, she told her supervisor who told Fidel, the full-time supervisor. Ray Citko had to be called and he filled out the accident report. She further testified that Mr. Citko also helped her fill out accident reports for her shoulder injuries. She went to a clinic in a cab with Mr. Citko, but she did not remember the name of the clinic. At the clinic, they provided her with Ibuprofen. After visiting the clinic, she went back to UPS and got a ride home. She could not recall who drove her home that night.

Petitioner further testified she remembered Mr. Citko putting the report in a file in a metal drawer. She then testified that a nurse from UPS came to Dr. Plastaras' office with her.

On cross-examination Petitioner testified she did not know the name of the nurse who went with her to Dr. Plastaras' office and she did not know the name of the clinic to which she was taken on October 2, 2006.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that on October 2, 2006, she sustained an accident that arose out of and in the course of her employment by Respondent.

The aggravation of a pre-existing disease may be an accidental injury and compensable if it meets the requirements that the occurrence is traceable to a definite time, place, and cause. *Riteway Plumbing v. Indus. Comm'n*, 67 Ill. 2d 404, 367 N.E.2d 1294, 10 Ill. Dec. 528 (1977).

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

In the Application for Adjustment of Claim, which she filed on September 8, 2009, Petitioner alleged that on "10-1-06," she sustained a permanent injury to her back and right shoulder that arose out of and in the course of her employment. (PX 2)

The Arbitrator takes judicial notice that October 1, 2006 was a Sunday.

In the Amended Application for Adjustment of Claim, which she filed on March 24, 2017, which was 7-1/2 years later, Petitioner alleges that on "10-2-06," she sustained a permanent injury to her back and right shoulder that arose out of and in the course of her employment. (PX 2)

Petitioner testified that on October 2, 2006, she suffered a work injury to her lower back while lifting a box from floor to waist level. She testified that the box weighed 50-60 pounds, and that she twisted her body when she lifted the box. (T. 16-17) According to Petitioner, the pain was "sudden, quick, sharp shooting pain down my leg." She further testified that "it was a reaction in which [I] had to drop the box." She then testified that the shooting pain went down *both* legs. (T. 18) Petitioner described the pain she felt in this 2006 accident as a totally different from the back pain she experienced in 2000 and 2004. She described the pain she felt in the 2006 accident as

"shooting, paralyzing pain down my legs" that shifted from left to right. She further testified that "it's difficult to breathe when my back goes out," and that "it literally paralyzed me." (T. 26)

Petitioner further testified that she notified her supervisor, who told her manager, Fidel, who radioed Ray Citko. (T. 19) According to Petitioner, Fidel told her to go upstairs to fill out a report. She testified that Ray Citko, the safety manager, asked her to sit down and tell him what happened. She testified that he filled out an accident report, called a taxicab, and join Petitioner in the taxi to a clinic. (T. 20-21) She testified that Ray told her that the clinic they usually take employees to was closed, so he had to choose a different clinic. (T. 21) At the clinic, Petitioner testified, she saw a nurse and a doctor, who examined her. She testified that the doctor prescribed Ibuprofen 500 mg. Petitioner testified that after she received treatment that day, "we" took a taxicab back to UPS, and she did not work the rest of the night. (T. 22) Petitioner testified that she continued to work for Respondent from October 2, 2006 to December 27, 2007, when she injured her shoulder. (T. 74)

Mr. Citko testified that he did not recall an accident to Petitioner's lower back. He denied that he got in a taxicab with Petitioner and took her for medical treatment. Mr. Citko testified that he did, however, assist Petitioner with the reporting of a shoulder injury.

The Arbitrator notes that despite her claim of paralyzing pain in her back and legs at the time of the alleged accident, she was able to climb the stairs at work shortly thereafter and did not require an ambulance.

The Arbitrator finds it noteworthy that Petitioner did not know her supervisor's name, did not know Fidel's last name, and could not recall who drove her home from

UPS on the night of October 2, 2006. Significantly, Petitioner failed to produce any medical documentation supporting her claim that she received treatment on October 2, 2006, and did not even know the name of the clinic to which she was taken that evening, or the city it was in, even though (1) she allegedly rode in a taxicab to such clinic, and (2) she had been working at this UPS facility in Northbrook since 2001.

The Arbitrator notes that the first documented treatment Petitioner received following the alleged accident was on November 6, 2006 at RIC.

In the November 6, 2006, RIC record, Christopher Plastaras, M.D., a physiatrist, wrote the following History of Present Illness:

> Raisa Ader is a 23 year old female with complaints of bilateral low back pain. The pain is rated 10/10 in intensity. It is dull, aching, stabbing, tingling, cramping, tight in quality. It is in the bilateral low back radiating to the right posterior thigh. This is worsened with working at UPS, lifting and bending over, walking. It is better with sitting. It began insidiously in 1998. It has followed a fluctuating course. Workup has included MRI, x-ray. For treatment, she has tried physical therapy. The patient has had pain at night. She has stable asthma. The patient has weakness in the low back with pain. She has numbness/tingling in the right leg sometimes. The patient has not noticed fevers, weight loss, bowel incontinence, bladder changes. (RX 6, p. 116)

The Arbitrator reasons that if the type of pain she experienced at the time of the October 2, 2006 alleged accident was "paralyzing" and was "totally different" from the back pain she had previously experienced, surely, she would have reported this acute, traumatic injury to Dr. Plastaras and would have given him at least an approximate date of such injury. There is no evidence that she did so.

At the November 6, 2006 visit, Dr. Plastaras ordered x-rays and physical therapy, prescribed Naproxen, recommended application of ice packs, and restricted her from repetitive lifting, bending, and twisting. (PX 6, p. 118)

Dr. Plastaras' January 24, 2007 record indicates a 50% improvement in Petitioner's low back symptoms, but also indicates complaints of stabbing, sharp, right central mid-back pain rated 5/10 in intensity, which began suddenly on January 20, 2007. No history of a specific work accident was provided then either. (PX 6, p. 133)

On March 16, 2007, Petitioner was released from medical care without restrictions. (PX 6, p. 166)

Petitioner continued to work as a loader for Respondent until her shoulder injuries in December of 2007, which was more than a year after the alleged lower back accident. Furthermore, after March 16, 2007, Petitioner did not seek medical treatment for her lower back until May 2010, when she was working for a different employer.

In an August 27, 2010 note from Dr. Malik at Northwestern Medicine, he records a history in which Petitioner's symptoms started after she lifted a heavy load while she was a UPS employee. (PX 11, p. 65) In a November 9, 2010 note from Pain Care Specialists, a history is given "of low back pain since 2006 after a work-related injury. She states that she worked at UPS, and as she was lifting a 50 lb. to 60 lb. box, she felt a sharp pain in her lower back." (PX 9, p. 68) Dr. Nolden wrote a note that includes the following: "[s]he has been suffering from significant and disabling low back pain since 2006. Her back pain history dates back to 1999. She recalls that her pain took a substantial turn for the worse while working for UPS and doing regular heavy lifting in 2006 ... New MRI reveals L5-S1 disc degeneration and desiccation with appositive annular tear and associated broad-based disc herniation at L5-S1." (PX 10, p. 51)

The Arbitrator has carefully reviewed the records and gives much more weight to the documented histories (or lack thereof) that were taken shortly after the alleged accident than he does to the documented histories taken 3-1/2 years later, or to the testimony given more than 10-1/2 years later.

The Arbitrator gives little weight to the testimony of Jacqueline Mary Ader. Mrs. Ader is Petitioner's mother, and did not testify as to a date in 2006 on which Petitioner allegedly phoned her at home to report her alleged work injury.

The Arbitrator notes that Petitioner indicated to Dr. Plastaras on November 6, 2006 that her back pain began insidiously in 1998, but reported to Dr. Nolden on June 8, 2011, that she began experiencing low back pain after a gymnastics-related injury in 1999/2000.

With regard to the back problems she had in 2000, Petitioner testified that it consisted of inflammation with throbbing and aching pain; she did not have shooting pain or radiating pain. (T. 115) She characterized her 2004 symptoms as "[j]ust inflammation, slight irritation" of her back. However, the October 9, 2000, RIC record shows that she had a history of left leg numbness and tingling (PX 6, p. 6), and the March 11, 2004, record shows that she has intermittent "left thigh sharp pains associated with her back." (PX 6, p. 40)

The June 11, 2004, FCE that Petitioner underwent for a 2004 left shoulder injury revealed that Petitioner demonstrated numerous inconsistencies and pain-focused behaviors throughout the evaluation. Such inconsistencies indicated variable effort that would place in question the validity and consistency of Petitioner's performance. (PX 6, p. 77)

In both the Application for Adjustment of Claim and the Amended Application for Adjustment of Claim, Petitioner alleged that in October 2006, she not only injured her low back, but her right shoulder. However, there are no documented complaints of right shoulder pain until December 2007.

The Arbitrator finds that Petitioner spoke and understood English with no problem.

The Arbitrator finds that Petitioner is not credible.

Based on the foregoing, the Arbitrator finds that Petitioner failed to prove that on October 2, 2006, she sustained accidental injuries to her low back.

O. Presumption that subpoenaed records would show 2006 accident report; Spoliation

The Appellate Court addressed the recordkeeping issue in *Chidichimo v. Indus. Comm'n*, 278 Ill. App. 3d 369, 662 N.E.2d 611 (1996). Therein, in August and December of 1983, the claimant served subpoenas on the employer seeking decedent's employment records. The employer responded to both subpoenas, and noted that the materials provided "are the only records in my/our possession or control relating to the [subpoena]." In February 1984, claimant served another subpoena, which specifically asked for "employee daily time tickets." The employer objected to the subpoena on the basis there is no Commission rule that provides for pre-trial discovery. At trial, it was revealed that all daily time tickets were sent to the accounting department where the information was loaded into a computer. The employer would keep the records on a computer for 2 years and then destroy them. In accordance with this procedure, decedent's March 18, 1983, time records had been destroyed prior to the

1988 arbitration hearing but after the February 1984 subpoena. Throughout the hearing, the claimant asserted a claim for a presumption that the time sheets would show decedent worked with heavy materials on the date he died. The arbitrator denied the request, as did the Commission:

> The Commission concludes [claimant] is not entitled to a favorable presumption and [employer] is not subject to sanctions based on destruction of documents. [Claimant] failed to take necessary steps to protect the existence of documents from routine deletion. *Chidichimo, 278 Ill. App. 3d at 373.*

On appeal, the court affirmed and stated: "Had claimant believed the time records were crucial to her claim, she could have obtained a court order to obtain the records at the hearing or have had a subpoena issued pursuant to section 16 of the Act (820 ILCS 305/16 (West 1994)). Instead, claimant allowed four years to pass before she raised employer's noncompliance with the subpoena as an issue. By that time, the records had long been destroyed pursuant to routine procedure." *Chidichimo*, 278 Ill. App. 3d at 374. The court further emphasized that there is no discovery under the Act and therefore civil sanctions for discovery violations are inapplicable:

> However, workers' compensation cases are governed by the Act and do not allow for pretrial discovery. Further, assuming *arguendo* that employer knew decedent's time sheets or production records were of import in the case, the Commission found no evidence that the destruction of the records was anything other than routine procedure. The fact that employer did not destroy the records until more than one year after it received the third subpoena suggests there was no bad faith in the destruction. Had employer immediately purged the records upon receiving the subpoena (prior to the routine two-year period), it may have raised suspicion as to

> the contents thereof. However, in this case, claimant did not seek enforcement of the subpoena for over four years and failed to take necessary steps to protect the records from routine deletion. *Chidichimo*, 278 Ill. App. 3d at 375.

The Arbitrator finds that like the claimant in *Chidichimo*, Petitioner failed to take the necessary steps to protect the existence of documents from routine deletion. Petitioner claims a date of injury of October 2, 2006. However, it took Petitioner 10½ years to issue a subpoena for her employment file. (PX Group Exhibit 4)

Pursuant to federal and Illinois law, UPS is only required to keep employment records for 3 years. The subpoena in question was not issued until 2017.

It is ludicrous to now argue a presumption against the employer for Petitioner's own failure to secure records she deemed necessary to prove her case.

Furthermore, the Arbitrator notes by its very nature, the Act mandates a duty of due diligence. *Contreras v. Indus. Comm'n*, 306 Ill. App. 3d 1071, 1076, 715 N.E.2d 701 (1999).

Petitioner's argument of the missing evidence rule is equally inapplicable. The missing evidence rule holds where a party fails to produce evidence in its control, a presumption arises that evidence would be adverse to that party. The presumption is not applicable, however, where evidence shows a reasonable excuse for failure to produce evidence and that missing evidence was equally available to other side. *REO Movers, Inc. v. Indus. Comm'n*, 226 Ill. App. 3d 216, 223, 589 N.E.2d 704 (1992).

Here, the personnel file was equally available to Petitioner via a simple Commission subpoena.

For reasons only Petitioner knows, she delayed issuing such a subpoena for 10½ years. Furthermore, Respondent offered to bring a witness to testify regarding UPS' record keeping policy and eventual purging of records. Instead of allowing Respondent's witness to testify, Petitioner objected to the re-opening of proofs to allow the testimony of Mr. Raymond Citko and Mr. Frank Barre.

Based on the foregoing, the Arbitrator finds there is no presumption against Respondent that the subpoenaed records would have shown a 2006 accident report that was completed in October 2006.

With regard to the allegation of spoliation, Petitioner argues that as she filed her Application for Adjustment of Claim on September 3, 2009, Respondent had a duty to preserve Petitioner's 2006 personnel records.

It is indisputable that Petitioner's employment file was equally available to Petitioner via a simple Commission subpoena. Yet, Petitioner delayed issuing such a subpoena for 10½ years.

There is no evidence that a 19(b) Petition for case # 09 WC 37078 ever proceeded to trial.

Once again, the Arbitrator cites the Court's holding in *Chidichimo v. Indus. Comm'n*, 278 Ill. App. 3d 369, 662 N.E.2d 611 (1996). (ARBITRATION DECISION, pp. 27-28)

As already stated above, the Act mandates a duty of due diligence.

The Arbitrator notes that a UPS Keeper of Records did not testify, and that there was no direct evidence of the records retention policy or destruction policy for employee documents and personnel files. Although the Respondent's attorney argues that such a records retention policy was in place at UPS, no direct evidence, either

testimonial or documentary, was admitted at trial about the UPS records retention policy, if there is one.

Nevertheless, the Arbitrator finds it unreasonable to expect Respondent to hold onto records indefinitely.

Furthermore, Petitioner was given the opportunity to cross-examine Mr. Barre, the UPS Keeper of Records, but declined.

Based on the evidence presented at trial, the Arbitrator denies Petitioner's claim of spoliation.

Compensation is hereby denied. All other issues have been rendered moot.

Brian T. Cronin
Arbitrator

2-8-2018
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 WILLIAMSON	)	☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☒ Modify: Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RICHARD HOLLEY,

Petitioner,

19IWCC0264

vs.

NO: 16 WC 20685

STATE OF ILLINOIS – DEPARTMENT OF TRANSPORTATION,

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner worked for Respondent as a highway maintainer. He alleged repetitive traumatic injuries to his wrists and elbows bilaterally. Petitioner came under the care of Dr. Mirly. Dr. Mirly diagnosed bilateral carpal tunnel and cubital tunnel syndromes. On January 8, 2016, Dr. Mirly performed right carpal tunnel release and ulnar nerve transposition for right carpal tunnel syndrome and cubital tunnel syndrome. On February 3, 2016, Dr. Mirly performed left carpal tunnel release and ulnar nerve transposition for left carpal tunnel syndrome and cubital tunnel syndrome.

On February 26, 2016 Petitioner first filed an accident report indicating that he suffered "ulnar nerve and carpal tunnel damage from repetitive work" "shoveling – operating equipment – etc. heavy lifting." This was the first notice Petitioner provided to Respondent that he believed these conditions of ill-being were related to his work activities.

The Arbitrator found that Petitioner proved a repetitive traumatic accident causing current conditions of ill-being and of his hands and arms bilaterally manifesting themselves on January 7, 2016. He awarded Petitioner 6&6/7 weeks of temporary total disability benefits, "reasonable and necessary" medical expenses submitted into evidence, and 101.25 weeks of permanent partial disability benefits representing loss of 10% of each hand and 12.5% of each arm. The Arbitrator also found notice was adequate, even though it was not within the 45 days required by the Act, because the Arbitrator found that Respondent was not prejudiced by the delay.

The Commission notes that Petitioner established that his job involved considerable repetitive motion of his hands and arms, as well as forceful gripping and vibration. Therefore, the Commission affirms the Decision of the Arbitrator regarding the issues of accident and causal connection.

However, the Commission has concerns about the finding of the Arbitrator on the issue of notice. In this case, Petitioner did not notify Respondent that he believed his conditions were related to his work activities or that he contemplated filing a workers' compensation claim until his treatment was completed and he was back at work at full duty. In our opinion, an employer may be prejudiced by such delay of notice because the employer cannot adequately mount any defense or dispute the necessity or reasonableness of medical treatment before it was provided.

Specifically, Petitioner had an NCV in 2011 which was consistent with right carpal tunnel syndrome and Dr. Mirly treated the condition conservatively. Petitioner returned to Dr. Mirly on July 24, 2015 reporting worsening symptoms bilaterally. At that time, Dr. Mirly offered Petitioner another NCV or surgery. Dr. Mirly performed the surgeries without the benefit of any additional nerve conduction studies. Therefore, in this case Respondent was prejudiced because it was not even provided the opportunity to order testing to confirm Dr. Mirly's diagnoses.

However, while the first surgeries were performed more than 45 days before Petitioner provided Respondent notice, the second surgeries were within the 45 days required under the Act. Therefore, the Commission affirms the Decision of the Arbitrator and awards associated with Petitioner's left carpal tunnel and cubital tunnel syndromes and the ensuing surgeries performed on February 3, 2017. In addition, the Commission reverses the Decision of the Arbitrator and associated awards regarding Petitioner's right carpal tunnel and cubital tunnel syndromes and ensuing surgeries performed on January 8, 2017.

Accordingly, because of Petitioner's failure to provide adequate notice, the Commission vacates the awards associated with his right carpal tunnel syndrome and cubital tunnel syndrome.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $938.18 per week for a period of 3&3/7 weeks, that being the period of temporary total incapacity for work under §8(b).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay medical expenses associated with treatment of Petitioner's conditions of ill-being of left carpal tunnel syndrome and cubital tunnel syndrome under §8(a) of the Act, subject to the applicable medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION, that the award for medical expenses associated with treatment of Petitioner's conditions of ill-being of right carpal tunnel syndrome and cubital tunnel syndrome is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION, that Respondent pay Petitioner $755.22 per week for 51.675 weeks because the injury sustained caused the loss of the use of 10% of the left hand and 12.5% loss of the use of the left arm.

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

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

DATED: MAY 28 2019

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
O-5/9/19
46

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

HOLLEY, RICHARD
Employee/Petitioner

Case# **16WC020685**

IDOT
Employer/Respondent

19IWCC0264

On 6/6/2018, 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 2.07% 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:

4075 FISHER KERKHOVER COFFEY ET AL
JASON COFFEY
1300 1/2 SWANWICK PO BOX 191
CHESTER, IL 62233

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

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

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

1430 CENTAL MGMGT SERVICES
WORKERS' COMPENSATION MAGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUN 8 - 2018

19IWCC0264

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Richard Holley
Employee/Petitioner

v.

IDOT
Employer/Respondent

Case # 16 WC 20685

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on April 12, 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. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On January 7, 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 $73,177.96; the average weekly wage was $1,407.27.

On the date of accident, Petitioner was 47 years of age, single with 1 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services, as provided by Sections 8(a) and 8.2 of the Act subject to the fee schedule. Respondent shall be given a credit for amounts paid for medical bills 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 $938.18 per week for six and six-sevenths weeks commencing January 8, 2016, through February 25, 2016, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $755.22 per week for 101.25 weeks because the injury sustained caused the 10% loss of use of the right hand, 10% loss of use of the left hand, 12 ½% loss of use of the right arm and 12 1/2 % loss of use of the left arm, as provided in Section 8(e) of the Act.

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

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

William R. Gallagher, Arbitrator

June 3, 2018
Date

JUN 6 - 2018

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained a repetitive trauma injury arising out of and in the course of his employment for Respondent. The Application alleged a date of accident (manifestation) of January 7, 2016, and that Petitioner sustained "Repetitive stress/trauma" to "Bilateral hands/wrists" (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident, notice and causal relationship. In regard to temporary total disability benefits, Petitioner claimed he was entitled to payment of temporary total disability benefits of six and six-sevenths weeks, commencing January 8, 2016, through February 25, 2016. Respondent agreed Petitioner was disabled during that period of time, but disputed its liability for payment of temporary total disability benefits (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a highway maintainer, and he became employed by Respondent in May, 2010. Petitioner testified at length regarding his job duties which varied considerably from one day to another. Petitioner stated he worked eight hours a day, 40 hours per week. Petitioner's work required the repetitive use of his upper extremities for at least 50% of the time at work. At trial, Petitioner reviewed a "Position Description" of his job that was prepared by Respondent. He agreed that it was accurate (Petitioner's Exhibit 1; Deposition Exhibit 3).

Petitioner testified his job involved operating heavy equipment, specifically, a backhoe. When Petitioner operated the backhoe, he sat in a chair and used both hands to operate the joysticks to move/manipulate the backhoe. Various devices would be attached to the backhoe depending on the task that was being performed. Most of the time, either a bucket or concrete breaker was attached to the backhoe. The concrete breaker was similar to a jackhammer and when it was used, it caused Petitioner to experience vibration in both of his upper extremities.

Petitioner would also cut grass adjacent to the highways. He would drive a tractor and use a weed eater when he performed this task. When he used the weed eater, it caused a vibration in both of his upper extremities.

Petitioner would also patched holes in the roads and work on culverts. Petitioner used a shovel when he patched roads and he had to forcefully grip the shovel with both of his hands.

During the winter months, Petitioner would spread salt and remove snow. Petitioner initially used a piece of equipment to load the salt on to a truck and would then drive the truck to spread the salt. Petitioner would also drive a truck to plow/remove snow. Obviously, the extent to which Petitioner performed these tasks depended on how severe the winter weather had been.

Petitioner previously sought medical treatment for bilateral hand symptoms sometime in 2011 from Dr. Nancy Birner, his family physician (her medical records were not tendered into evidence). Dr. Birner ordered EMG/nerve conduction studies which were performed on August 1, 2011. The studies were limited to the right hand and were consistent with right carpal tunnel syndrome (Petitioner's Exhibit 1; Deposition Exhibit 2).

Petitioner was subsequently seen by Dr. Harvey Mirly, a hand surgeon, on September 23, 2011, because of bilateral hand symptoms, more on the right than left. Dr. Mirly examined Petitioner and noted Petitioner had been experiencing bilateral hand symptoms for a number of years. He opined Petitioner had carpal tunnel syndrome (he did not state whether it involved both hands) and prescribed a wrist splint for nighttime wear (Petitioner's Exhibit 1; Deposition Exhibit 2).

Petitioner next sought medical treatment on July 24, 2015, when he was again seen by Dr. Mirly. Petitioner still had complaints of bilateral hand numbness. At that time, Dr. Mirly noted Petitioner had a motorcycle accident and had undergone several ankle surgeries. Petitioner complained of numbness of his entire hand in both the median and ulnar distribution. Petitioner did advise that he had the ulnar nerve symptoms when he rode his motorcycle and the median nerve symptoms while at work. Dr. Mirly indicated that he discussed surgery with Petitioner with the surgical procedure being both a carpal tunnel and cubital tunnel release. Dr. Mirly's medical record of that date did not specifically state whether the condition he diagnosed was bilateral; however, his reference to Petitioner's upper extremity findings on examination were stated in the singular, not plural (Petitioner's Exhibit 1; Deposition Exhibit 2).

Petitioner testified that his hand symptoms gradually worsened, but he continued to work. Sometime in January, 2016, Petitioner contacted Dr. Mirly's office and advised he wanted to proceed with surgery. At trial, Petitioner stated he informed Respondent that he needed time off from work and completed some paperwork.

Dr. Mirly performed surgery on January 8, 2016, and the procedure consisted of an open right carpal tunnel release and an anterior transposition of the right ulnar nerve. Dr. Mirly subsequently performed surgery on February 3, 2016, and the procedure consisted of an open left carpal tunnel release and anterior transposition of the left ulnar nerve. Dr. Mirly saw Petitioner following the surgeries. He released Petitioner to return to work without restrictions on February 26, 2016 (Petitioner's Exhibit 1; Deposition Exhibit 2).

At trial, Petitioner testified he thought his upper extremity symptoms may have been work-related either just prior to or after undergoing surgery. He was not certain; however, Petitioner noted his symptoms worsened while he was working.

Petitioner stated he notified Respondent by telephone of the fact he was claiming his upper extremity conditions were work-related on February 26, 2016 (the date Petitioner was authorized to return to work). Petitioner tendered into evidence an "Employer's First Report of Injury" dated February 26, 2016, completed and signed by Petitioner. According to that report, Petitioner sustained an injury on January 7, 2016, as a result of repetitive work/performing daily duties and that Petitioner sustained "ulnar nerve and carpal tunnel damage" (Petitioner's Exhibit 1).

Respondent tendered into evidence and "Employer's First Report of Injury" dated February 26, 2016, prepared by Sandra Riley. According to that report, Petitioner claimed a date of accident of January 8, 2016, and Petitioner sustained an injury as a result of shoveling, heavy lifting and operating equipment which caused him to get carpal tunnel and ulnar nerve injuries in both elbows (Respondent's Exhibit 1).

Respondent tendered into evidence an "Employee's Notice of Injury" dated March 21, 2016, completed and signed by Petitioner. In this document, Petitioner indicated a date of accident of January 7, 2016, and that he sustained an injury as result of operating equipment (Respondent's Exhibit 2).

Respondent also tendered into evidence a "Supervisor's Report of Injury or Illness" dated March 21, 2016, prepared and signed by Mark Gard, which indicated "unknown" for both the date and description of the accident (Respondent's Exhibit 3).

At the request of Petitioner's counsel, on May 27, 2016, Dr. Mirly prepared a narrative medical report in which he addressed the issue of whether Petitioner's upper extremity conditions were related to his work duties. In addition to information about Petitioner's job duties provided to him by Petitioner's counsel, Dr. Mirly also reviewed a description of Petitioner's job that was prepared by Respondent. Dr. Mirly opined that Petitioner's various job duties would have caused an exacerbation or aggravation of Petitioner's carpal tunnel and cubital tunnel syndrome (Petitioner's Exhibit 2; Deposition Exhibit 2).

At the direction of Respondent, Petitioner was examined by Dr. Anthony Sudekum, a hand surgeon, on March 21, 2017. In connection with his examination of Petitioner, Dr. Sudekum reviewed medical records provided to him by Respondent. Dr. Sudekum also obtained information regarding Petitioner's job duties from Petitioner at the time of his evaluation. On examination, Dr. Sudekum did not find any objective evidence of either cubital tunnel or carpal tunnel syndrome. He did note Petitioner had significant arthritis affecting both wrists and elbows (Respondent's Exhibit 5; Deposition Exhibit 2).

In regard to causality, Dr. Sudekum opined that Petitioner's job duties as a highway maintainer were an aggravating factor in the progression of bilateral carpal tunnel syndrome. However, Dr. Sudekum opined that Petitioner's job duties as a highway maintainer did not cause or aggravate his bilateral cubital tunnel syndrome. He opined that condition was related to other nonwork factors including arthritis in both elbows and Petitioner's motorcycle riding (Respondent's Exhibit 5; Deposition Exhibit 2).

Keith Boyce testified on behalf of Respondent at trial. Boyce was employed by Respondent as an Operations Supervisor. On direct examination, Boyce testified that Petitioner's description of his job duties was accurate. However, he did state that the number of hours Petitioner spent performing those job duties may have been a little high. He said that many times the highway maintainers did not actually leave the yard until 7:30 AM even though they were supposed to leave the yard at 7:15 AM.

Boyce confirmed that Petitioner's job duties varied from one day to another. In regard to Petitioner's operating the backhoe, Boyce testified that Petitioner did not do this every day, but that he was the best backhoe operator that Respondent had.

Angela Blackburn also testified on behalf of of Respondent at trial. Blackburn was a safety and claims manager for Respondent. Blackburn testified she became aware of the fact Petitioner was claiming to have sustained a work-related injury when she received a Form 45 report of injury on February 26, 2016. She did not have any personal contact with Petitioner.

Dr. Mirly was deposed on January 27, 2017, and his deposition testimony was received into evidence at trial. In regard to his diagnosis and treatment of Petitioner's bilateral carpal tunnel and cubital tunnel syndrome conditions, Dr. Mirly's testimony was consistent with his medical records. In regard to causality, Dr. Mirly testified that he reviewed a position description prepared by Respondent. He testified that Petitioner's job duties could have aggravated his bilateral upper extremity conditions. While he noted Petitioner had symptoms on September 23, 2011, he stated they were not severe enough at that time require surgery. It was when Petitioner was seen in 2015 that the symptoms were more severe (Petitioner's Exhibit 2; pp 20-23).

When questioned about other contributing factors, Dr. Mirly also noted that Petitioner had arthritis in both elbows which he opined would have been a contributing factor for cubital tunnel syndrome, but not carpal tunnel syndrome. While Petitioner was a little overweight, he was not obese. Further, Petitioner did not smoke and did not have any type of thyroid condition. On cross-examination, Dr. Mirly agreed the exposure to vibration while riding a motorcycle would also contribute to the development of carpal tunnel and cubital tunnel syndrome (Petitioner's Exhibit 2; pp 23-24, 35).

Dr. Sudekum was deposed on October 26, 2017, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Sudekum's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Dr. Sudekum testified Petitioner informed him of his job duties and he had no reason to doubt Petitioner's description of them. He testified Petitioner's work activities could have been an aggravating factor of his carpal tunnel syndrome (Respondent's Exhibit 5; pp 18-19, 28).

Dr. Sudekum stated Petitioner's cubital tunnel syndrome was not related to his work activities and opined it was related to arthritis and Petitioner's motorcycle riding. He also opined Petitioner would have developed cubital tunnel syndrome regardless of his work activities (Respondent's Exhibit 5; pp 29-30, 39-40).

On cross-examination, Dr. Sudekum agreed Petitioner's work duties would involve at least moderate forceful use of his upper extremities. He also conceded Petitioner's job duties could also cause vibration (Respondent's Exhibit 5; p 35).

At trial, Petitioner agreed he had been released to return to work without restrictions and was able to perform all of his job duties. Most of Petitioner's symptoms resolved following surgery, but Petitioner stated he still has aches and pains in both upper extremities that usually progress during the course of a workday.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner sustained a repetitive trauma injury arising out of and in the course of his employment for Respondent that manifested itself on January 7, 2016, and that Petitioner's current condition of ill-being is causally related to same.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony regarding the repetitive nature of his job duties was unrebutted. Respondent's witness, Keith Boyce, confirmed that Petitioner's testimony regarding his job duties was accurate. He only questioned the amount of time Petitioner spent performing his repetitive activities stating that Petitioner usually left the yard at 7:30 AM, not 7:15 AM.

There was no question Petitioner had upper extremity symptoms that predated the manifestation date of January 7, 2016; however, over time the conditions progressed to the point that Petitioner required surgery on both wrists and elbows.

The determination of the date of manifestation of a repetitive trauma injury is the date in which the injury manifests itself meaning the date in which both the fact of the injury and its causal relationship to repetitive trauma would be plainly apparent to a reasonable person. Peoria CountyBellwood Nursing Home v. Industrial Commission, 505 N.E.2d 1026 (Ill. 1987). The date of manifestation can be (1) the date the employee actually becomes aware of the physical condition and its relationship to work through medical consultation; (2) the date the employee requires medical treatment; (3) the date on which employee can no longer perform work activities; or (4) when a reasonable person would have plainly recognized the injury and its relationship to work. Durand v. Industrial Commission, 862 N.E.2d 918, 929 (Ill. 2006).

In the instant case, Petitioner continued to work up until the day he underwent the first surgery on January 8, 2016.

There was no dispute Petitioner's bilateral carpal tunnel syndrome condition was related to Petitioner's work activities because both Petitioner's treating physician, Dr. Mirly, and Respondent's Section 12 examiner, Dr. Sudekum, opined Petitioner's work activities aggravated that condition.

In regard to Petitioner's bilateral cubital tunnel syndrome, Dr. Mirly credibly testified the condition was aggravated by Petitioner's work activities, although he acknowledged that there were other nonwork related factors as well, including Petitioner's motorcycle riding.

Dr. Sudekum's opinion that Petitioner's work activities aggravated his bilateral carpal tunnel syndrome condition, but not his bilateral cubital tunnel syndrome condition seems inconsistent. Further, while Dr. Sudekum opined the vibration of motorcycle riding contributed to Petitioner's bilateral cubital tunnel syndrome, he also acknowledged Petitioner was subject to vibration activities performed during the course of his work duties.

Based upon the preceding, the Arbitrator finds Dr. Mirly's opinion to be more persuasive than that of Dr. Sudekum in regard to causality.

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

The Arbitrator concludes Petitioner gave notice to Respondent as required by Section 6(c) of the Act.

In support of this conclusion the Arbitrator notes the following:

Petitioner worked through January 7, 2016 (the date of manifestation alleged in the Application) and underwent the first surgery the following day, January 8, 2016.

There was no dispute that Petitioner informed Respondent on February 26, 2016 that his upper extremity conditions were work-related because the Employer's First Report of Injury was prepared on that date. Further, Angela Blackburn, Respondent's safety and claims manager testified that on February 26, 2016, she became aware that Petitioner was claiming to have sustained a work-related injury.

The date of February 26, 2016, was not within the time period of 45 days for an employee to give notice to an employer of his having sustained a work-related injury; however, Section 6(c) of the Act provides in relevant part: "No defect or inaccuracy of such notice shall be a bar to the maintenance of proceedings on arbitration or otherwise by the employee unless the employer proves he is unduly prejudiced in such proceedings by such defect or inaccuracy."

Obviously, the notice provided by Petitioner to Respondent in this case was defective; however, Respondent's interests were not prejudiced. The aforestated provision of the Act has been liberally construed, but limited to the extent of protection of the employer against unjust or fraudulent claims. McLean Trucking Co. v. Industrial Commission, 381 N.E.2d 245, 247 (Ill. 1978).

In the instant case, Respondent was not prejudiced by Petitioner having given a defective notice. Respondent was able to fully investigate the claim and exercised its right to obtain a Section 12 examination of Petitioner.

There was no evidence that Petitioner's claim was fraudulent. As noted herein, Respondent's Section 12 examiner, Dr. Sudekum, opined Petitioner's job duties were an aggravating factor of his bilateral carpal tunnel syndrome.

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

The Arbitrator concludes that all the medical treatment provided to Petitioner was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for amounts paid

for medical bills that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of services for which Respondent is receiving this credit, as provided in Section 8(j) of Act.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of six and six-sevenths weeks, commencing January 8, 2016, through February 25, 2016.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner was temporarily totally disabled for the aforestated period of time.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 10% loss of use of the right hand, 10% loss of use of the left hand, 12 ½% loss of use of the right arm and 12 ½% percent loss of use of the left arm.

In support of this conclusion the Arbitrator notes the following:

Neither Petitioner nor Respondent tendered an AMA impairment rating. The Arbitrator gives this factor no weight.

Petitioner worked as a highway maintainer and his job required the repetitive use of both upper extremities for at least 50% of his time at work. The Arbitrator gives this factor significant weight.

Petitioner was 47 years old at the time of the injury. Petitioner will have to live with the effects of this injury for the remainder of his working and natural life. The Arbitrator gives this factor moderate weight.

There was no evidence that the injury had any effect on Petitioner's future earning capacity. The Arbitrator gives this factor no weight.

Petitioner sustained repetitive trauma injuries to both upper extremities which aggravated bilateral carpal tunnel and cubital tunnel syndrome conditions. Petitioner ultimately underwent surgeries on both wrists and elbows. While Petitioner experienced a resolution of many of his symptoms, he still has complaints consistent with the injuries he sustained. The Arbitrator gives this factor moderate weight.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)		
) SS.	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
COUNTY OF ROCK ISLAND)	☒ 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

Mirna Castillo,
Petitioner,

vs. No. 16 WC 25665

19IWCC0265

Petersen Health Care, Inc., d/b/a
Rock River Gardens,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary 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. So that the record is clear, we have considered the record in its entirety. We had reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all of the testimony of the witnesses, exhibits, pleadings and arguments submitted by the parties.

The underlying facts of this claim were well laid out in the Arbitrator's Decision, incorporated herein. Petitioner, a 44-year-old cook, sustained injury on July 18, 2016 while walking down basement steps at work to retrieve a can of pop for a resident's lunch. Petitioner slipped on a step and fell, sustaining a bimalleolar fracture to her right ankle. She underwent surgery, and after her recovery she returned to her usual job with no restrictions.

The Commission agrees with the Arbitrator that, in walking down the stairway, Petitioner was exposed to a risk qualitatively greater than that faced by the general public. However, the Commission disagrees that Petitioner proved she was exposed to a quantitively greater risk. There was no testimony as to the number of times each day Petitioner traversed the stairway, and that number cannot be logically deduced without factual support, which is absent from the record. Accordingly, the Commission strikes paragraph 5 of page 8 of the Arbitrator's decision, in which the Arbitrator concluded that Petitioner's risk on the subject stairway was quantitively greater than that faced by the general public.

The Commission, in affirming the Arbitrator's denial of a disfigurement award pursuant to Section 8(c) of the Act, notes the clear language of that section which states in relevant part, "no compensation is payable under this paragraph where compensation is payable under paragraphs (d), (e) or (f) of this Section." 820 ILCS 305/8(c). Here, Petitioner's injury was to her right ankle, and she received a permanency award for that injury under Section 8(e) of the Act. The scar on Petitioner's leg, for which she seeks a disfigurement award, was the result of her surgery for that ankle injury. Petitioner cannot receive benefits under both Section 8(c) and 8(e) for the same injury.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner 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 $88,400.00. 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: MAY 29 2019

o-04/08/19
sm/mcp
44

Stephen Mathis

D. Douglas McCarthy

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CASTILLO, MIRNA
Employee/Petitioner

Case# **16WC025665**

PETERSEN HEALTH CARE INC D/B/A ROCK RIVER GARDENS
Employer/Respondent

19IWCC0265

On 12/20/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.48% 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:

0021 REESE & REESE
TODD S REESE
979 N MAIN ST
ROCKFORD, IL 61103

1337 KNELL LAW LLC
LLIR IMERI
504 FAYETTE ST
PEORIA, IL 61603

STATE OF ILLINOIS)SS. **19IWCC0265**

COUNTY OF Rock Island)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Mirna Castillo
Employee/Petitioner

v.

Peterson Health Care, Inc. d/b/a Rock River Gardens
Employer/Respondent

Case # **16** WC **25665**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Rock Island**, on **7/14/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] 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 **7/18/16**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**17,492.80**; the average weekly wage was $**336.40**.

On the date of accident, Petitioner was **44** years of age, ***single*** with **1** dependent child.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $67,505.90, as set forth in Petitioner's exhibits 3 - 6, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $253.00/week for 23 6/7 weeks, commencing 7/19/16 through 1/1/17, 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 $**253.00**/week for a further period of **58.45** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **35% loss of use of the right foot**.

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

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

Michael K. Nowak, Arbitrator

12/18/17
Date

DEC 20 2017

FINDINGS OF FACT

Although there are multiple issues listed as in dispute on the request for hearing form in this case, the seminal inquiry is whether Petitioner sustained and accident which arose out of her employment. The entirety of the evidence in this matter indicates that the injuries which Petitioner sustained are causally related to her fall down Respondent's stairs on 7/18/16. Further, Respondent does not dispute the reasonableness or necessity of treatment provided or the period of temporary total incapacity, but only its liability to pay benefits based on the issue of accident, as well the nature and extent of permanent disability.

Petitioner, 44 year old female, worked for Respondent as a cook. Her job responsibilities included cooking, cleaning the kitchen, restocking inventory and preparing food for the residents at her facility. Supplies required for her various tasks were located in the basement of Respondent's facility. On the morning of 7/18/16, Petitioner was in the course of her duties when she needed to go to the basement of the facility to obtain a drink for one of the resident's meals. The resident was waiting to be provided their lunch before being taken to work.

Petitioner testified that she had to go downstairs for the soft drink so she grabbed her keys and headed downstairs. There is a door at the top of the stairs to the basement, which she needed her keys to unlock. She opened the door to the basement steps, put the keys around her left wrist and then proceeded downstairs. She was using the hand railing on her right as she descended the steps. She testified that when she got to the third step her foot got stuck on the rubber mat/runner of the step and she began to fall forward. She testified that the railing was loose and she was unable to stop herself from falling down the stairs. She then called out for help and her coworker, Eileen Arreola, came to her and ultimately sought help from other employees.

Petitioner testified that the stairway is very dark, that the railing was loose, that the stairs are steep and small, that they are old, that they are not in good condition, and that the stairs were dirty. She testified that the black rubber/mat or runner that goes down the stairs moved when her foot got stuck on it. She said that that rubber mat or runner was not secure to the stairs and that it was also lifted up or curling at the edge. She testified that the stairs are not open to the general public, but only used by the employees. She further testified that because of the steepness of the stairs she has to hunch forward to hold the railing and proceed down the stairs.

Petitioner offered into evidence photographs of the stairwell, contained in Petitioner's Exhibits 11 - 29. Petitioner testified that the stairs were dark and the only light was at the top of the stairs (PX 11), that the lights in the basement were off at the time of the accident and the switch to turn them on is actually in the basement at the bottom of the steps. (PX 12) The lights at the top of the stairs always remained on and the switch did not work. (PX 13-16) She testified that the stairs were in a deteriorated condition. (PX 17-18) She further testified that the handrail on the right side was loose and had been repaired numerous times. (PX 20, 29) She testified that the black rubber mat or runner going down the stairs was loose and that the mat/runner was raised up as well.

On 7/18/16, Petitioner was taken by ambulance to CGH Hospital emergency department. The ambulance report relates that Petitioner was complaining of right ankle/lower leg pain and tenderness to her right hip, right side and her rib cage. Petitioner related that she was walking down the steps at work when she

caught her toe on one of the steps causing her to fall to the bottom of the steps. The emergency department performed x-rays, which revealed a complex ankle fracture with fibular tibial fractures as well as 100% displacement of the talotibial joint. Disruption of the ankle ligamentous mortise was also suggested. The findings were compatible with severe disruption of the ankle mortise and ligamentous injury.

On 7/19/16, Petitioner was still in the hospital at CGH Medical Center and she underwent surgery to the right ankle by Dr. Shawn Hanlon. Dr. Hanlon performed an open reduction internal fixation of the right ankle.

On 8/2/16, Petitioner was seen post-operatively by Dr. Hanlon at the CGH Medical Center. The staples were removed and a new short-leg cast was applied. X-rays revealed a well-aligned bimalleolar ankle fracture. Internal fixation was in good position and the ankle mortise was well maintained. The plan for treatment was that she continue non-weight bearing and return in three weeks for cast removal and further x-rays. Petitioner was prescribed refill medication of Norco and instructed to remain non-weight bearing.

On 8/24/16, Petitioner returned for follow-up care with Dr. Hanlon. She was now five weeks post-surgery. X-rays revealed an anatomically aligned bimalleorar ankle fracture consisting of lateral malleolus fracture and a posterior malleolus fracture. Internal fixation remained in good position. She was placed in a fracture boot and allowed fifty-percent weight bearing.

On 9/6/16, Petitioner followed-up with Dr. Hanlon and x-rays showed internal healing changes and no displacement of the fractures. She was upgraded to full weight bearing and advised that she may take the boot off for sleeping at night. She was to continue to work on range of motion exercises diligently and she would be seen again in three weeks for recheck and further x-rays.

On 9/28/16, Petitioner was seen by Dr. Hanlon and it was noted that she was still having pain with walking in the boot. X-rays revealed that her ankle swelling had diminished some in comparison to her previous visit and her range of motion had improved a little bit. Dr. Hanlon indicated that he would like her to go without the brace while at home, and then in two weeks to discard the brace and use regular shoe wear. She was to follow up in four weeks.

On 10/27/16, Petitioner returned to Dr. Hanlon. She was still having some pain and swelling with the right foot. X-rays revealed a healing bimalleolar right ankle fracture, but there was a slight shift in position of the distal tibia fracture in comparison to the previous x-ray. Dr. Hanlon felt that it was okay for her to continue weight bearing as tolerated, but continued her off-work status and refilled pain medications.

On 11/23/16, Petitioner had her last appointment with Dr. Hanlon. It was noted that she was improving and was wearing shoes for all of her walking, but that she still had some swelling and discomfort. X-rays revealed a healing bimalleolar fracture consisting of a healing distal fibular fracture and healing posterior malleolus fracture of the distal tibia. Internal fixation remained in good position and interval healing changes were noted in comparison to previous x-rays. Petitioner was instructed in activities as tolerated and to anticipate gradual improvement over time. Petitioner was given a return to work on 1/2/17 with no restrictions and released from treatment.

Respondent called Travis Ashlin to testify. Mr. Ashlin was Director of Maintenance for Respondent until June of 2016. He testified he daily goes down the steps in question and does not recall that the railing was loose. He says that the matting on the steps was nailed down and he recalls seeing nails in some of them. Mr. Ashlin reviewed the photo of Petitioner's Exhibit 12 and he indicates that is an accurate picture to his recollection. He said that there were no defects in the stairs or railing prior to the accident and that no repairs were done to the stairs or railing either before the accident or after the accident. He testified that he inspected the stairs and railing and found no defects, although, he did not have his glasses with him. He testified that he did have to use the flashlight on his cell phone as he examined the stairs and railing.

Respondent called Jeffrey O'Brien to testify. He indicated that he was a maintenance supervisor from March of 2016 through June of 2017. He said that he inspected the stairs after the accident and that he did not find any defects with the stairs or the railing and that both were secure. He testified that the lights at the top of the stairs worked. He further testified that no repairs to the stairs or the railing had been done before or after Petitioner's accident. He indicated that the rubber matting/runner on the stairs was nailed down on most of the stairs, but he could not identify which stairs had the nails or how many nails they had. He also testified that the light switch at the top of the stairs operated the lights in the basement.

Respondent called Eileen Arreola to testify. She testified that she works in the kitchen with Petitioner and that she was the first to respond to Petitioner after she had fallen down the stairs. Mrs. Arreola sought help from other staff. She said that Petitioner did not tell her how the accident occurred, but that Petitioner had told the nurse how she fell.

Respondent called Brian Russel to testify. He is one of the CNAs at the facility and he attended to Petitioner after the accident. He indicated that he did not believe there were any defects with the stairs, but he did not personally examine or inspect the stairs or the railing. He testified that his main focus was helping Petitioner after the accident.

Respondent called Angela Mehlbreck to testify. She is the administrator for the facility. She testified that there were no defects in the stairs or the railing and that there had been no repairs to either before or after the accident. She further testified that Petitioner was wearing approved footwear and that the building is very old. She testified that she believed that the lights at the bottom of the stairs were turned on by a switch at the top of the stairs. She testified that the stairs are not open to the general public, but are limited to use by the employees. Respondent offered into evidence the report of Mrs. Mehlbreck (RX 1). She indicates that Petitioner was going down the stairs and her foot caught on a step, causing her fall. Mrs. Mehlbreck also completed a second report, identified as RX 2. In this report, it is reported that Petitioner indicated that her shoe caught on the stair, that she was wearing approved footwear, and that the stairs are covered with rubber mats for slip resistance. A third report was signed by Mrs. Mehlbreck (RX 3) and indicated that Petitioner was going down basement steps and claimed her shoe caught a step causing her to fall.

Respondent offered into evidence the witness statement of Cindy Shoulders (RX 4). She did not testify at trial. Her report indicates that Petitioner was going down to the basement steps and was a little ways down and her foot went forward and her shoe fell off as she fell.

Respondent called Sharon Bonanno as a witness. She is the adjuster or the claims specialist for Argent, the workers' compensation insurance company. She testified that she took a statement from Petitioner on 7/21/16. The statement was offered into evidence as respondent's exhibit 10. Mrs. Bonanno testified she used an interpreter and her interview was conducted by telephone. She did not speak with Petitioner directly but through the interpreter. She confirmed that Petitioner indicated several times that she was on the third step when she caught her foot on the step and slipped. Mrs. Bonanno did not ask if Petitioner was currently on any medication for the interview and she did not know what medications Petitioner was currently on for her injuries. She did confirm that Petitioner advised that the handrail to the stairs was broken/loose and that Petitioner was using the handrail when she went down the steps. She also testified that she was aware that Petitioner had undergone surgery two days prior and had just been released from the hospital the day before the interview.

Petitioner recalled Eileen Arreolla back to the stand for further testimony. She testified that her duties are the same as Petitioners and that she works with Petitioner in the kitchen on a regular basis and that she uses the same stairs in question to retrieve needed items. She testified that she is familiar with the steps and that the railing was loose on those steps. She testified that the lights in the basement are turned on by a switch in the basement and not at the top of the stairs. She testified that the switch at the top of the stairs does not turn on the lights in the basement. She further testified that the stairs are steep and one has to hunch or lean forward to use the railing when going down the stairs.

Petitioner testified that the hardware from surgery remains in her right ankle and she notices stiffness and lack of mobility with the right ankle. In the morning, before shoe goes to work, she has to warm her right ankle up or stretch and massage it before she goes to work or it cramps. Her ankle feels stiff most days. She does have swelling after a full 8-hours of work. She has difficulty going up and down stairs and she has to go slow. She says her foot doesn't feel the same as it did prior the work accident and she has to take her time with any type of walking, being careful with the ground she is walking upon. Petitioner testified that she has trouble walking and demonstrated the rocking from heel to toe movement that that's very difficult. Uneven ground is difficult because her foot feels weak and uneasy. She does not take any prescription medications, but she does take Ibuprofen every five to six hours for inflammation and pain.

CONCLUSIONS

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

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

The claimant in a workers' compensation case has the burden of proving, by a preponderance of the evidence, all of the elements of his claim, including proof that he suffered an accident which arose out of and in the course of his employment. 820 ILCS 305/2 (West 2008); *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013, 944 N.E.2d 800, 348 Ill. Dec. 559 (2011). 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, 546 N.E.2d 603, 137 Ill. Dec. 658 (1989).

Injuries sustained at a place where a claimant might reasonably have been while performing his work duties are deemed to have been received in the course of his employment. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57, 541 N.E.2d 665, 133 Ill. Dec. 454 (1989). In this case, it is undisputed that the Petitioner's injuries were sustained in the course of her 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. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. There are three general types of risks to which an employee may be exposed: (1) risks that are distinctly associated with the employment: (2) risks that are personal to the employee; and (3) neutral risks that do not have any particular employment or personal characteristics. *Potenzo v. Illinois Workers' Compensation Comm'n*, 378 Ill. App. 3d 113, 116, 881 N.E.2d 523, 317 Ill. Dec. 355 (2007) (citing *Illinois Institute of Technology Research Institute*, 314 Ill. App. 3d 149, 162, 731 N.E.2d 795, 247 Ill. Dec. 22 (2000)).

In this case, the Petitioner caught her foot and fell down a flight of steps on Respondent's premises. There is no evidence in the record tending to show that the she suffered from some physical condition which caused her to fall. Thus this is not a risk personal to Petitioner. Nor, under the current state of Illinois law, is the risk associated with traversing a steps a risk distinctly associated with employment. Unless, however it can be shown that the injury occurred as a result of the condition of the employer's premises.

In this case Petitioner testified that her right foot caught on defective rubber matting or runner that was on the stairs, the railing was broken/loose and unable to stop her from falling, and that the stairwell was dark and poorly lit. Respondent's witness, Travis Ashlin, testified that he had to use the flashlight on his cell phone to examine the stairwell. Respondent's witness, Eileen Arreola, testified that the lights to the basement were controlled by a switch in the basement and that the stair railing was loose. Petitioner's photographs (PX 11-29) show that the hand railing has been repaired numerous times and that the black rubber matting or runner is raised above the stair steps. The Arbitrator also notes that the stairs in question are not open to the general public. The Arbitrator further notes that the witness statements and testimony, as well as the medical records, all reflect that Petitioner indicated that her foot caught on the stairs. The two maintenance supervisors, whose responsibility it was to maintain the stairway, testified that there had been no repairs to the stairs or the railing either before or after the fall. The photographs entered into evidence clearly show that the railing had been repaired. Further, Respondent's witnesses offered conflicting testimony with regard to whether the switch which controlled the lights in the basement were at the top of the stairs or at the bottom, as Petitioner testified. In addition, one of Respondent's witnesses testified that the rubber runners had been nailed down and secured since he began his employment with Respondent years before. However, the Arbitrator notes the nails holding the runner into place in the photograph of Respondent look new. The Arbitrator finds Petitioner's testimony and medical records more persuasive than the testimony of Respondent's witnesses.

The Arbitrator, based on the totality of the evidence, finds that Petitioner's fall on the stairs arose out of her employment due to a risk distinctly associated with her employment. However, despite any defects in the stairs that caused Petitioner to fall, the Arbitrator finds that Petitioner's fall is compensable under the Neutral risk analysis as well.

Injuries resulting from a neutral risk do not arise out of the employment and are not compensable under the Act unless the employee was exposed to the risk to a greater degree than the general public. *Illinois Institute of Technology Research Institute*, 314 Ill. App. 3d at 163. The increased risk may be either qualitative, that is when some aspect of the employment contributes to the risk; or quantitative, such as when the employee is exposed to the risk more frequently than the general public. *Metropolitan Water Reclamation District of Greater Chicago*, 407 Ill. App. 3d at 1014.

The appropriate application of the neutral risk analysis requires comparison of the hazard of peril faced by Petitioner at this location to be compared to the risk faced by the general public at large in descending stairs in general and not simply these stairs. *Illinois Institute of Technology Research Institute v. Ind. Commn.*, 314 Ill App. 3rd 149, 731 N.E. 2d 795 (1st Dist., 2000)

In this case Petitioner works in a kitchen for Respondent and is required to use the stairs in question to obtain items needed for her duties, including cleaning supplies, food supplies, and soft drinks. The stairs are not open to the general public. The stairs are old and in a deteriorated condition. The stairs are steep and narrow. The stairway is not well lit. The hand rail has been repaired numerous times and was loose on the date of the work accident.

In assessing whether the Petitioner faced a risk qualitatively greater than the general public at large one need simply view the photographs of the stairs on which Petitioner fell and compare those, for example, to the stairs which the public at large traverses within the James R. Thompson Center, wherein the Commissions headquarters is located. Clearly the hazard faced by Petitioner in descending the stairs on Respondent's premises was greater than that faced by the public at large.

Further, the Arbitrator notes that both Petitioner and her coworker testified that many of the supplies required for them to perform their duties are located in the basement. Although there was no testimony as to the exact number of times each day Petitioner was required to traverse the stairs the Arbitrator can logically deduce that numerous trips up and down were required by Petitioner's employment.

The Arbitrator therefore finds that Petitioner was exposed to a risk greater than that faced by the general public. Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner sustained injuries which arouse out of and in the course of her employment with Respondent.

The Arbitrator, having found that Petitioner sustained an accident that arose out of and in the course of her employment with Respondent, finds that Petitioner's injuries are causally related to the work accident on 7/18/16.

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

The Arbitrator incorporates his above findings with respect to the Respondent's liability for medical bills. Respondent's only dispute with regard to medical bills was one of liability based on the issue of accident. Having found in Petitioner's favor on the issue of accident, the Arbitrator finds that Petitioner is entitled to payment of medical expenses.

Respondent shall pay reasonable and necessary medical services of $67,505.90, as set forth in Petitioner's exhibits 3 - 6, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator incorporates his above findings. Respondent's only objection to temporary total disability was one of liability based on accident. Respondent does not dispute the TTD period. Accordingly, the Respondent is liable for TTD payments for a period of 23-6/7 weeks from 7/19/16 through 1/1/17.

Respondent shall pay Petitioner temporary total disability benefits of $253.00/week for 23 6/7 weeks, commencing 7/19/16 through 1/1/17, as provided in Section 8(b) of the Act.

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

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 is to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of §8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that 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 is a cook, which requires her to be on her feet for her entire work shift. Petitioner is also required to use stairs, carry items needed for her job and kneel/squat. Petitioner's duties include her to be on her feet and put more stress to her affected right ankle. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 44 years old at the time of the accident. Because the Petitioner has an extended period of work life left and has to deal with the ongoing disability, and the hardware that remains in her ankle, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no direct evidence of reduced earning capacity contained in the record. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. Petitioner sustained a right bimalleolar ankle fracture consisting of lateral malleolus fracture and a posterior malleolus fracture. Petitioner underwent an open reduction internal fixation of the fractures and the hardware remains in her ankle to this day. The Arbitrator

finds that the evidence of disability is corroborated by the treating medical records. The Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 35% loss of use of the right foor pursuant to §8(e) of the Act.

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

Amy Eitutis,

Petitioner,

vs. NO: 15WC 15664

Andy Skoog, LaSalle County Circuit Clerks Office,

Respondent.

19IWCC0266

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causation, 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 21, 2017, is hereby affirmed and adopted.

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

19IWCC0266

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: MAY 29 2019

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DDM/jrc
052

Douglas McCarthy

Stephen Mathis

DISSENT

As the Supreme Court of Illinois 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 her condition is work-related. Therefore, I respectfully dissent.

Petitioner testified she works for Respondent as an administrative assistant with additional supervisory responsibilities and has performed such duties since her hire in April of 2006. T. 10-11. Petitioner testified her job requires her to perform data entry into a computer six and a half to seven hours out of an eight-hour day and the remainder of her day "writing out their time sheets and turning them in, a lot of file stamping, pulling of court files, assembling of court files." T. 20. As part of her payroll duties, Petitioner assembled three-ring binders utilizing a three-hole punch. T. 21.

Respondent offered into evidence a video depicting Petitioner's job duties with such duties being performed by Ms. Diane LeBeau Gerber, Petitioner's supervisor. RX4. Petitioner viewed the video and testified the speed at which the job tasks were performed were approximately 80% slower than the pace Petitioner performed her job duties. T. 37. Petitioner also took issue with the short duration of the video. T. 30. Petitioner reiterated these two concerns with the video on cross-examination. T. 54.

Ms. Gerber was called to testify on Respondent's behalf. Ms. Gerber testified she was employed by Respondent as the chief deputy officer and was familiar with the duties of a court clerk supervisor. T. 75-76. Ms. Gerber described such duties to include data entry, assembling of three-ring binders, signing checks, and pulling files. T. 78. Ms. Gerber confirmed she was depicted in RX4 performing the job tasks. T. 83. On cross-examination, Ms. Gerber conceded the video due to its short duration was not a complete picture of Petitioner's job duties as well as the speed in which she performed the task depicted was slower than performed by Petitioner. T. 96-97.

The medical records evidence Petitioner sought treatment from Dr. Rhode on September 1, 2016 complaining of bilateral wrist pain with numbness and tingling. Petitioner provided a history of "10 year exposure to dad a [*sic*] and file management. This includes approximately 6 hours per day of typing as well as pulling files and writing." Dr. Rhode subsequently recommended surgical management. PX3.

On the referral of Dr. Rhode, Dr. Freedberg evaluated Petitioner on March 21, 2017. Petitioner provided a consistent history of pain with numbness and tingling as well as a

description of her job duties which included "writing and typing and handling of files." Dr. Freedberg provided treatment options and referred Petitioner back to Dr. Rhode for ongoing care and treatment. Additionally, Dr. Freedberg memorialized in his records as follows: "I have reviewed the patient's history of injury in great detail. It is my opinion that within a reasonable degree of medical and orthopaedic certainty that her condition of ill being is causally connected to her work based off a repetitive basis." PX5.

At Respondent's request pursuant to Section 12 of the Act, Dr. Carroll performed a records review and provided his evidence deposition on May 22, 2017. RX1, RX5, RX6. Dr. Carroll testified Petitioner suffered from bilateral carpal tunnel syndrome, but such condition was neither caused nor aggravated by her work duties. RX6, p. 12. In formulating his opinions, Dr. Carroll relied on Petitioner's medical records, the job description as well as the video of Petitioner's job activities. Dr. Carroll explained he identified the tenets of force, repetition, and posture as the causes of carpal tunnel syndrome. RX6, p. 13.

I believe Dr. Carroll's opinions should be afforded greater weight than those of Drs. Rhode and Freedberg. Dr. Carroll possessed a better understanding of Petitioner's job duties as he reviewed both the job description as well as the video depicting Petitioner's job duties. Both Petitioner and Ms. Gerber testified that the video was only a fraction in duration of Petitioner's work day, but it stands to reason, Dr. Carroll could certainly surmise in reviewing a video lasting several minutes, such video did not purport to be a movie of an eight-hour work day but merely representative of the same. Moreover, Petitioner's testimony that the video did not represent the speed in which she performed her work tasks has no bearing on Dr. Carroll's ultimate opinion as to causation. As Dr. Carroll explained, the salient components of job tasks which result in carpal tunnel syndrome are force, repetition, and posture. Petitioner's varied job tasks such as typing, writing, and file management fail to satisfy any of the three criteria. Dr. Carroll testified Petitioner's work station appeared ergonomically correct.

In contrast, both Dr. Rhode and Dr. Freedberg provided no bases in support of their ultimate conclusions. Both physicians refer to Petitioner's "repetitive" job duties but fail to define what precisely is repetitive regarding Petitioner's job. Is it the typing or the file

management or both? Drs. Rhode and Freedberg merely provide conclusory statements without explanation. Moreover, to the extent the majority relied on causation opinions offered by Drs. Rhode and Freedberg, I believe such is error as Respondent's objection based upon hearsay should have been sustained and the records redacted accordingly.

As the Court noted in *RG Construction Services v. Illinois Workers' Compensation Commission*, "[t]he provisions of Section 16 at issue in this appeal assist in accomplishing that goal by easing the *foundational requirements* for the admission of a treating physician's records. *Shafer v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100505WC, ¶ 50, 976 N.E.2d 1 (stating the 2005 amendments to section 16 were meant 'to ease the *foundational requirements* for the admission of medical bills and records')." (Emphasis added). 2014 IL App (1st) 132137WC, ¶ 39. The amendments to Section 16 of the Act were undertaken to allow the admission of medical records in a more efficient fashion <u>not</u> to shield objectionable hearsay statements.

Certainly, treating physicians' records "are likely to contain medical opinions relating to a variety of aspects in the care, treatment, and evaluation of the employee." *RG Construction Services* at ¶ 39. Such opinions are offered as part and parcel of the care and treatment of a patient. An opinion offered relating to a causal relationship between an accident and a claimant's resulting condition of ill-being is neither necessary nor relevant to the diagnosis or treatment provided by a doctor. Such statements are hearsay and do not qualify under the exception defined in the Rules of Evidence- Rule 803(4)- Statements for Medical Diagnosis or Treatment. *Illinois Rules of Evidence*- Rule 803(4) (2011).

Again, as the Court noted in *RG Construction Services*, "'under certain circumstances the probability of accuracy and trustworthiness [of a document] may serve as a substitute for cross-examination under oath.' *United Electric Coal Co. v. Industrial Commission*, 93 Ill. 2d 415, 444 N.E.2d 115, 117 (1982)." 2014 IL App (1st) 132137WC, ¶ 42. The Court went on to explain the Supreme Court's holding in *United Electric Coal Co. v. Industrial Commission*, wherein, the Supreme Court allowed a hearsay causation opinion into evidence despite the employer's objection to the same. The Court reasoned that the opinion testimony offered by the treating

physician was, in part, based upon the opinions provided by the employer's examining expert physician. In such circumstances, the Court reasoned the opinions offered were trustworthy.

Dr. Rhode's records contain the following statement: "The patient demonstrates evidence of work-related bilateral carpal tunnel syndrome." PX3. Dr. Freedberg's records go a step further and incorporate the legal foundational requirement stating: "It is my opinion that within a reasonable degree of medical and orthopaedic certainty that her condition of ill being is causally connected to her work based off a repetitive basis." PX5. Such statements are hearsay and do not qualify as an exception under Rule 803(4) as the statements were not made for the purposes of diagnosis or treatment. These opinions were offered presumably for use at hearing. Further, unlike *United Electric Coal Co. v. Industrial Commission*, there is nothing in the record which indicates these opinions are inherently trustworthy. These causation opinions should have been redacted from the record.

Petitioner suffers from bilateral carpal tunnel syndrome which was neither caused nor aggravated by her work duties. Petitioner failed to prove the manner and method of her work duties- typing and file management were sufficiently repetitive to lead to the development of carpal tunnel sundrome. Therefore, I respectfully dissent.

L. Elizabeth Coppoletti

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

EITUTIS, AMY
Employee/Petitioner

Case# **15WC015664**

SKOOG, ANDY LaSALLE COUNTY CIRCUIT CLERKS OFFICE
Employer/Respondent

19IWCC0266

On 9/21/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1097 SCHWEICKERT & GANASSIN LLP
SCOTT J GANASSIN
2101 MARQUETTE RD
PERU, IL 61354

0263 HERBOLSHEIMBER DUNCAN ET AL
WILLIAM P HINTZ
PO BOX 539
LaSALLE, IL 61301

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSalle)

- [ ] 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)

Amy Eitutis,
Employee/Petitioner

v.

Andy Skoog, LaSalle County Circuit Clerks Office,
Employer/Respondent

Case # 15 WC 15664

Consolidated cases: n/a

19IWCC0266

An *Application for Adjustment 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 **Ottawa, Illinois**, on **August 24, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

D. [ ] What was the date of the accident?

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

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

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

K. [x] Is Petitioner entitled to any prospective medical care?

L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD

M. [x] Should penalties or fees be imposed upon Respondent?

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On the date of accident, **January 23, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$43,056.00**; the average weekly wage was **$828.00**.

On the date of accident, Petitioner was **40** years of age, *married* with **2** dependent children.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $3,341.58 to Dr. Donald Mammano, $2,385.20 to Orland Park Orthopedics, $1,413.00 to RX Compliance Laboratories, Inc. and $225.00 to Suburban Orthopedics Ltd and Respondent shall pay an additional $458.42 to Petitioner's group insurance for the bill of Dr. Mammano it paid or pay Dr. Mammano directly for the services he rendered Petitioner and which he shall then he required to address repayment of the Petitioner's group insurance she has through her spouse which originally paid said money, as provided in Sections 8(a) and 8.2 of the Act.

Pursuant to Section 8(a) of the Act, the Respondent shall provide direct and ancillary reasonable and necessary treatment related to Petitioner's bilateral carpal tunnel condition including surgery and physical therapy.

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

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

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

Signature of Arbitrator

9/20/17
Date

ICArbDec19(b)

SEP 21 2017

19IWCC026

FINDINGS OF FACT:

Amy Eitutis, Petitioner in this matter, was employed by Respondent, Andy Skoog, LaSalle County Circuit Clerk's Office, on January 23, 2015. Petitioner remains employed with the LaSalle County Circuit Clerk's Office where she continues to work since April of 2006. The first three months of her employment she served in a part-time role and, thereafter, has been a full-time employee of Respondent. When Petitioner began her employment in 2006, she performed data entry, computer and clerical work. At the end of this three-month period, she became full-time.

Petitioner testified she remains a full time, forty hour a week, employee of Respondent for over eleven years. Petitioner testified that as a full-time employee, she performs continuous, repetitive data entry work for about seven hours of her eight-hour day where she entered information on Circuit Court cases and placed employee time into the computer system during her shift. Petitioner testified she became a supervisor in July of 2006. As a supervisor, she reports not only doing her normal job of repetitive work on the computer, estimating her time on the computer entering information to be seven or more hours of each of her eight-hour work days. During her normal work week, up to four times, Petitioner also worked through breaks and lunch because of her need to keep up with her data entry tasks. As a supervisor, her job was not any less repetitive. She would receive and distribute information from the court, handle employee payroll and pull files needed for court. She reports her tasks included constant use of her hands.

Petitioner testified that in 2015, her job was transferred from the downtown Ottawa courthouse to Respondent's Etna Road facility which is located at the LaSalle County Criminal Justice Center in Ottawa, Illinois. She reports performing the same job at that location. Petitioner conveyed that after developing pain in both hands, which had gradually worsened in the last year or year and a half before her alleged accident date of January 23, 2015, she sought medical attention.

On January 23, 2015, Petitioner presented to Dr. Donald Mammano, a chiropractor, with complaints that she first developed right hand and wrist pain in the first three fingers of her hand with accompanying numbness and tingling. She explained after first noting it in her right hand, she started to notice the same develop in her left hand. (PX 2) Petitioner testified that as the pain becoming gradually worse and by January 23, 2015, she decided to see Dr. Mammano with complaints in both. Petitioner stated that when she first saw Dr. Mammano, she had pain in both hands with pain going up the forearm to the elbow along with pain in the top and bottom of each hand. Also noted was numbness in her fingers, both the pointer and middle along with her thumb. Petitioner testified Dr. Mammano explained that she may require surgery but said she could first try electronic therapy/stimulation and exercise. She underwent this therapy along with laser therapy as well. (PX 2) When asked why she didn't want to go on to get an initial surgical assessment, Petitioner testified she had a fear of surgery and that she would prefer to try the less invasive techniques suggested by Dr. Mammano. She had treatment from January 23, 2015 through and including April of 2015. (PX 2)

Petitioner testified the initial care from Dr. Mammano significantly decreased the symptomology experienced. She reported getting relief and discontinued her initial treatment with Dr. Mammano on April 8, 2015 when the doctor opined he felt she was as good as she would be through his care. (PX 2) During the entire time she treated with Dr. Mammano, Petitioner remained at work performing her full duty position.

Petitioner testified that the symptoms she previously experienced gradually returned. Petitioner returned to Dr. Mammano in August 29, 2016. Dr. Mammano referred her to an orthopedic surgeon, Dr. Blair Rhode. In

his referral letter dated August 31, 2016, Dr. Mammano noted Petitioner experienced recurrent and persistent symptomology and that she was suffering from repetitive injury syndrome as a result of her work. (PX 2)

Petitioner presented to Dr. Rhode on September 1, 2016. Dr. Rhode recorded a history that Petitioner had developed bilateral palmer wrist pain with numbness and tingling in the thumb, index and long finger. He wrote Petitioner performed the duties of a data entry specialist in a government position for the last ten years. He explained Petitioner developed symptomology in approximately June of 2014 and previously treated for these symptoms. She was taught exercises but had no prior injections or bracing. He wrote Petitioner performed significant amounts of data entry and types six hours a day. She also pulls a significant amount of files and describes a pinching mechanism in the hand while doing the same. Following an examination, Dr. Rhode assessed wrist pain and carpal tunnel syndrome. The doctor provided that Petitioner had evidence of work related bilateral carpal tunnel syndrome. He indicated she had continuous complaints of numbness and tingling in the thumb, index and long fingers and demonstrated a positive Tinel's and Phalen's maneuver bilaterally. Dr. Rhode noted Petitioner continued to work full duty employment and suggested she follow up after an EMG. (PX 3) Petitioner testified that Dr. Rhode initially discussed surgery as a form of treatment. She also testified that she was not able to get an EMG as suggested by Dr. Rhode because Respondent failed to approve the same.

Petitioner testified that due to continued symptomology, she followed up again with Dr. Rhode on February 2, 2017. Petitioner reported that she tried night braces but her symptoms continued to worsen. Dr. Rhode again reported Petitioner had work related bilateral carpal tunnel syndrome and discussed bilateral carpal tunnel surgery as a form of treatment. Petitioner was then referred by Dr. Rhode for a second opinion with Dr. Howard Freedburg, an orthopedic surgeon. (PX 3)

Petitioner presented with Dr. Howard Freedburg of Suburban Orthopedics on March 21, 2017. Dr. Freedburg noted Petitioner presented with a chief complaint of bilateral hand pain that was worse on her right when compared to the left. He noted the onset of her symptomology began approximately January of 2014 and that by the time of her visit with him, she had a couple years of symptoms due to the repetitive use of her hands at work. The doctor noted Petitioner reported no trauma of any type to her hands other than repetitive work. She also reports having initially sought chiropractic treatment for her carpal tunnel issue which provided good initial relief; however, that therapy no longer helped. (PX 5) Petitioner reported frequent achy bilateral hands with weakness. She had pain radiating up her forearm and felt occasional numbness and tingling in her bilateral hands with numbness awakening her at night. She reported pain at a 7 to 8 out of 10 and expressed taking aspirin as needed for pain. The doctor noted she had not undergone an EMG. Dr. Freedburg wrote that the cause or mechanism of Petitioner's injury was overuse at work. He explained Petitioner had worked with LaSalle County for eleven years where she experiences extensive repetitive use of her hands for approximately eight hours a day, five days per week. He explained her job requires typing, computer entry, file assembly and handling. She also repetitively grabs three ring binders from an overhead shelf, opening and placing papers within and then closing the same which is forceful activity. He performed a physical examination and following this examination, which included x-rays, he opined Petitioner had bilateral carpal tunnel syndrome and discussed the etiology and severity of her carpal tunnel syndrome along with treatment options and the pros and cons of each. He stated it was his opinion, within reasonable degree of medical and orthopedic certainty, that Petitioner's bilateral carpal tunnel condition was causally related to her repetitive work. He felt the treatment she had undergone was necessitated by the work she performed for the last eleven years. He then referred her back to Dr. Rhode for further care and treatment. (PX 5)

Respondent introduced a physical job description created by On Call Medical Management Services, LLC ("On Call"), as well as a video, also created by On Call, which purported to depict the job duties performed by Petitioner. (RX 3, RX 4) Petitioner testified that she did not take part in any preparation of the job description or the preparation of the videotape. Petitioner testified she had the opportunity to review both the physical job description and the videotape. When asked about both, Petitioner testified that the video

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demonstrated tasks performed at a pace that was approximately 80% slower than the actual speed it is typically done. The video itself did not contain Petitioner but instead showed Ms. Diane LeBeau-Gerber, Petitioner's supervisor. Petitioner noted the video was only a few minutes in length while she works eight hours a day and explained the tasks reflected, such as data entry were done at a much slower speed then performed by her. She also indicated that it does not show her issuing three to four hundred checks she is required to do, among other tasks. As to the physical demands reported in Respondent's job description, Petitioner explained she has to perform repetitive motor skill tasks up to two-thirds of her day. Respondent's Exhibit 3, also reports Petitioner performs frequent clerical tasks up to two-thirds of the day as well. According to the job description, all other physical demands of the job not involving use of the hands, arms, or shoulders are all listed at zero.

Also testifying in this matter was Petitioner's co-worker, Ms. Marsha Perez. She testified to being a current employee of Respondent that has worked with this employer for nine years. Ms. Perez indicated Petitioner is her supervisor and indicated their job duties were about the same. Ms. Perez explained Petitioner spends 90% of her day typing on a keyboard with the other portion of her day is spent pulling files and placing documents into them.

Respondent called Ms. Diane Lebeau-Gerber as a witness in this case. Ms. Diane Lebeau-Gerber indicated she is the Chief Deputy and office manager for the Circuit Clerk's Office. Ms. Leabeau-Gerber testified she is Petitioner's supervisor. as well as Ms. Marsha Perez. She agreed with a good portion of the job description created by On Call Medical Management Services LLC in Respondent's Exhibit 3. However, she testified the job description does not describe each job, the time frame for the tasks or how often each task is performed.

Ms. Lebeau-Gerber testified that up until the job change in July of 2015, Petitioner performed data entry documents, time off requests for co-employees, prepared three ring binders, served as a second signature on checks and assembled files, among other things. She described Petitioner's job as clerical. When asked about the video (RX 4), Ms. Lebeau-Gerber testified the video does not show the full eight hour work day. She was also uncertain if the video demonstrated most of Petitioner's work activities as she never saw the completed version. When asked by Respondent's counsel what she did for the video, Ms. Lebeau-Gerber replied she could not recall. She was only able to recall pulling of three ring binders and stated that was a task performed by Petitioner multiple times a day. Ms. Lebeau-Gerber also explained there would be data entry. When asked to describe the work station of Petitioner, she could not recall the make-up of Petitioner's desk but believed the keyboard was adjustable along with the chair and screen.

On cross examination, Ms. Lebeau-Gerber testified Petitioner's present job as a supervisor is similar to her prior work for Respondent. She described Petitioner as an active employee who uses her hands all day except when going physically into a courtroom. She further testified Petitioner performs her job after 2013 at the Etna Road Circuit Clerk's Office while this witness instead works at a separate office in downtown Ottawa. However, they did work near one another for a while when Petitioner was employed at the downtown Ottawa courthouse. Ms. Lebeau-Gerber indicated that when Petitioner worked near her, she always worked with her hands and performed repetitive tasks. The supervisor expressed Petitioner was never a person she had to ask to pick up the pace. She explained Petitioner performs on the front line of their office and has done well. Ms. Lebeau-Gerber described Petitioner as a good, hard working employee who is very active with her hands. She describes Petitioner as performing typing tasks most of the day. Ms. Lebeau-Gerber described the video and stated it is an incomplete picture of what Petitioner does for her eight hour shift. She further discussed the speed of tasks depicted in the video being at a lesser rate than what Petitioner would perform. She expressed this was, in part, due to Ms. Lebeau-Gerber trying to explain the tasks while doing them in the video.

At Respondent's request, Dr. Charles Carroll performed a records review pursuant to Section12 of the Act. D r. Carroll authored two reports dated April 14, 2016 and September 25, 2016 respectively. The doctor

also testified via deposition in this matter. Dr. Carroll testified that he is an orthopedic surgeon with a subspecialty in hand surgery. He limits his opinions to areas concerning the upper extremities, elbow, shoulders, wrists and hands. The doctor provided that he reviewed Petitioner's medical records, job descriptions supplied by Respondent (RX 3) and a job video (RX 4). After reviewing the records of Dr. Mammano, Dr. Rhode and Dr. Freeberg, as well as the job description and job video, Dr. Carroll assessed Petitioner with suffering from bilateral carpal tunnel syndrome. However, he did not find her carpal tunnel syndrome to be work related. Dr. Carroll opined that Petitioner's carpal tunnel syndrome was due to non-occupational factors such as her age, sex, and being overweight. The doctor noted that at the time of her medical treatment, Petitioner was 5'-2-1/2" tall and weighed 229 pounds. He felt Petitioner's work station appeared to be ergonomically appropriate, and that Petitioner's work activities, including using the "Monster" would not cause or aggravate her carpal tunnel syndrome. He testified that work activities involving the use of force, repetition and postures can cause carpal tunnel syndrome. He gave an example of a jackhammer operating using force and vibration. He noted that some assembly jobs use high force and high repetition and some jobs involve awkward positioning where a wrist is chronically flexed in an extended, awkward position like a mechanic. The doctor added that while there have been studies back and forth over last number of years regarding keyboard use, the type of work duties that would cause carpal tunnel syndrome on a repetitive basis involve heavy forces or heavy vibration and not excessive keyboard use. Dr. Carroll also stated that while Petitioner does a significant amount of typing and data entry, the job activities varied and as such he did not see any connection or cause between her condition of ill-being and carpal tunnel and possible cubital tunnel with her work duties. (RX 1, RX 5, RX 6)

On cross examination, Dr. Carroll agreed that he had no contact with Petitioner including the opportunity ask questions or perform a physical examination. He further testified that if the job description and/or video of the claimed job tasks was inaccurate, this might or could affect his opinions on the issue of causal connection. (RX 6)

At trial, Petitioner testified that she was still working full time for Respondent. She still has pain and numbness in her hands and her right elbow. This pain, numbness and tingling occurs while she is at work.

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

Petitioner, Amy Eitutis, by January 23, 2015, had worked approximately nine years for Respondent, Andy Skoog, LaSalle County Circuit Clerk's Office. At the time of the hearing in this matter, August 24, 2017, Petitioner has now been employed with Respondent for over eleven years. During her initial three months of her job with the Circuit Clerk's Office, she worked part time performing data entry, computer and clerical work. At the end of this three months, Petitioner became a full-time employee working forty hours a week and typically performing continuous data entry and repetitive work. Testimony of Petitioner and her supervisor, Ms. Diane Lebeau-Gerber, was essentially the same. Each explained Petitioner rose to the level of a supervisor after only three months on the job. Although she became a supervisor, her job obligations essentially remained the same with the work remaining repetitive with continuous keyboard use for seven or more hours a day with the last hour being consumed with other repetitive work, such as executing hundreds of checks, creating files and filling three ring binders. Her testimony about repetitive, continuous and quickly performed tasks was unrebutted. It was also noted that Petitioner, when she became a supervisor eleven years ago, no longer took regular lunches, missing three to four a week due to the demand of her job that required her to stay at her desk and perform continuous and repetitive movement. She estimated her time on the computer doing this work was seven or more hours out of her eight-hour day.

Petitioner's testimony on the repetitive nature of her work activities indicated these repetitive tasks were performed at a fast and consistent pace throughout the day was unrebutted. Petitioner's testimony on the subject was further supported by Ms. Marsha Perez, a coworker, as well as by Petitioner's supervisor, Ms. Diane Lebeau-Gerber, who indicated Petitioner was a good employee and very active with her hands throughout the shift. This supervisor described Petitioner as performing computer entry work most of her work day. She testified
to also being unaware of any task outside the job Petitioner performs that is repetitive in nature.

Petitioner demonstrated that her hand movements experienced throughout the day required for the opening of files, data entry and placement of documentation in three ring binders. Petitioner demonstrated her hands and arms were involved in continuous flexion, extension and rotation. The type of movement demonstrated by Petitioner and its rapidity, was supported through the testimony of Respondent's witness, Ms. Diane Lebeau-Gerber and Ms. Marsha Perez, a coworker. Ms. Diane Lebeau-Gerber indicated that Petitioner was an honest individual who is a fast working employee who is continuously working.

On behalf of Respondent, On Call Medical Management Services, LLC, prepared both a written job description and a video. Petitioner reported she was not consulted on the written job description, nor did she take part in the claimed video of her job tasks. However, she reports viewing each of these exhibits prior to the hearing in this matter. Petitioner explained the video was only a few minutes in length as compared to her eight-hour work day and that the video was wholly inaccurate as it did not properly address the type, nature and speed of her data entry work. It also failed to show her efforts in issuing three to four hundred checks weekly. Petitioner also testified the claimed video showed some of the work activities performed by her, but expressed the speed of the tasks performed was approximately 80% slower than reality.

After reviewing job description prepared by On Call, Petitioner explained the same was wholly inaccurate as it failed to describe all her tasks properly. However, of note, under "Physical Demands of the Job," on page 3 of said exhibit, indicates she performs her tasks using Repetitive Motor skills 34-66% of her day and Clerical Tasks 34-66% of her day.

Ms. Lebeau-Gerber, Respondent's own witness and Petitioner's supervisor, reported that the job video presents an incomplete picture of what Petitioner does for an eight-hour shift. Although Ms. Lebeau-Gerber was the person doing the tasks in the video, she admitted to being unable to testify to the accuracy of the video, explaining she had never seen a completed copy. She further testified the tasks performed by her while doing the video did not provide an accurate description of the speed Petitioner performs them, admitting the tasks performed in the video were completed at a slower rate than in reality.

The Arbitrator reviewed the video. Petitioner testified in an unrebutted manner that the video is performed at a rate approximately 20% of normal. This was uncontradicted by Petitioner's supervisor, Ms. Diane Lebeau-Gerber.

Petitioner further testified she began noticing symptomology about one to one and a half years prior to January 23, 2015, first in her right hand and fingers, followed shortly thereafter by similar left hand symptomology. On January 23, 2015, she reported her bilateral hand problems to her supervisor. Ms. Diane Lebeau-Gerber, Petitioner's supervisor, agreed that on or about that date, Petitioner notified her of the bilateral hand injury. On this same date Petitioner reported the injury, she visited Dr. Donald Mammano, a chiropractic physician.

Dr. Mammano diagnosed Petitioner with bilateral carpel tunnel syndrome related to repetitive work activities. Petitioner then underwent treatment for palpatory pain and tenderness over the volar aspect of both wrists accompanied by paresthesia into the second, third and fourth digits on both hands. By April 8, 2015,

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Dr. Mammano reported a significant decrease in Petitioner's bilateral wrist pain and finger paresthesia, reporting symptomology that would now only occasionally rise to a level of one out of ten. Petitioner reported she was capable of performing her repetitive work activities. Although Dr. Mammano discharged her at that time, he wrote that should she experience any exacerbation of symptomology, Petitioner was to return to the office. Petitioner explained she had a good response to the chiropractic manipulation procedures, electrical stimulation and the exercise taught to her by Dr. Mammano. However, as she continued working, her condition slowly progressed and worsened to the extent she was required to see him again on August 29, 2016. At that time, she reported to Dr. Mammano and he indicated she was present for repetitive injury syndrome as a result of her work injury. She sustained bilateral carpel tunnel syndrome. Because of persistence and recurrent symptomology, he referred her to Dr. Blair Rhode, an orthopedic surgeon.

Petitioner presented with Dr. Rhode on September 1, 2016. Dr. Rhode noted Petitioner had a work related wrist injury, developing bilateral carpel tunnel syndrome which had led to pain with numbness and tingling to the thumb, index and long fingers. She also developed palmer wrist pain with numbness. Dr. Rhode reviewed her job and indicated she performed data entry and had been a specialist in this category for ten years. He noted she developed symptomology in 2014 and attempted chiropractic care and exercise. His examination demonstrated positive Tinel and Phalen's maneuvers bilaterally and determined that Petitioner's ten-year exposure to her data entry tasks and file management for Respondent caused this condition. Although Dr. Rhode recommended an EMG, same was not approved by Respondent.

Petitioner continued to follow with Dr. Rhode on February 2, 2017. The doctor noted she had the same symptomology even though she used night braces. Dr. Rhode again reported Petitioner experienced work related bilateral carpal tunnel syndrome. He addressed the need for bilateral carpal tunnel releases and reported that he was waiting for approval from Respondent. He also noted, that despite her symptomology, Petitioner continues to work full duty. Dr. Rhode also recommended an additional opinion by an orthopedic surgeon. He referred Petitioner to Dr. Howard Freedburg.

Petitioner presented to Dr. Freedburg on March 21, 2017. He noted Petitioner experienced repetitive hand use on her job with Respondent. He reported that chiropractic care did provide Petitioner with some relief. He also wrote that at his examination that Petitioner reported pain in both hands that now also included a portion of the left forearm. She also expressed occasional numbness and tingling in her hands due to the same condition. Dr. Freedburg went on to state Petitioner had bilateral carpel tunnel syndrome with the cause or mechanism of the injury being overuse of these limbs through her employment with Respondent. He wrote Petitioner had been working for Respondent for eleven years and experienced extensive repetitive use of her hands for approximately eight hours a day, five days a week. Dr. Freedburg also indicated the medical care Petitioner had received was necessitated by her work injuries. She was referred back to Dr. Rhode for further care and treatment, including surgery.

Respondent obtained the services of Dr. Charles Carroll who testified in this matter via evidence deposition on May 22, 2017. Dr. Carroll performed a records review. He did not examine or interview her regarding the nature of her employment, the level of activity or repetition alleged by her. After reviewing Petitioner's treating records as well as the job description and the video of Petitioner's purported job tasks, Dr. Carroll testified it was his opinion Petitioner had a diagnosis of bilateral carpal tunnel syndrome. The doctor further stated that Respondent's employment neither caused or aggravated the same. Dr. Carroll opined that Petitioner's carpal tunnel syndrome was due to non-occupational factors such as her age, sex, and being overweight. The doctor noted that at the time of her medical treatment, Petitioner was 5'-2-1/2" tall and weighed 229 pounds. He felt Petitioner's work station appeared to be ergonomically appropriate, and that Petitioner's work activities, including using the "Monster" would not cause or aggravate her carpal tunnel syndrome. Dr. Carroll admitted his opinions could be affected on the issue of casual connection if the job description or the video of the claimed job tasks was not accurate. Of note, testimony regarding the claimed

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video and job description demonstrated by both the video and job description lacked accuracy. Petitioner indicated the work activity in the video was performed at a rate of 80% slower than normal. Her supervisor, Ms. Diane Lebeau-Gerber, agreed and stated the tasks in the video are also slower than normal as she tried to explain the job she was performing while participating in the film. She further indicated she could not testify to the accurateness of the video because she never viewed the same after completion.

Following consideration of the testimony and evidence presented, the Arbitrator finds that an accident did occur that arose out of and in the course of Petitioner's employment with Respondent due to the repetitive nature of her employment with the date of accident being January 23, 2015, her first physician appointment regarding this matter. This finding is further based upon and consistent with Peoria County Belwood Nursing Home v. Industrial Commission 138 Ill.App.3d880 (1995). It is also found that timely notice of this accident of January 23, 2015 was provided to Respondent, as on the same day, Petitioner reported the same to her supervisor, Ms. Diane Lebeau-Gerber.

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

Dr. Donald Mammano, Dr. Blair Rhode and Dr. Howard Freedburg each indicate Petitioner suffered bilateral work related carpal tunnel syndrome. Each described Petitioner's work related tasks as repetitive work and this caused the development of her injury which required the care each physician provided. Each physician was able to develop their opinions after visits with Petitioner and the job description provided personally by her to the physicians. Further, medical records of Petitioner appear consistent with the job description provided during the hearing by Petitioner, Ms. Marsha Perez and Petitioner's supervisor, Ms. Diane Lebeau-Gerber. The only evidence providing an opposing viewpoint was that of Dr. Charles Carroll, who only performed a records review that included both an inaccurate job description and inaccurate video representation of Petitioner's job tasks.

Based on the above, the Arbitrator finds Petitioner established that her diagnosed bilateral carpal tunnel syndrome that is casually related to her repetitive work of January 23, 2015.

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

Petitioner sought initial care and treatment with Dr. Mammano, a chiropractic physician. His records note Petitioner suffers from work related bilateral carpal tunnel syndrome. His records demonstrate that in under three months, the symptomology was greatly reduced through chiropractic manipulation, exercise and electronical stimulation therapy. Records also demonstrate, along with Petitioner's testimony, that after obtaining substantial initial symptom relief, the symptoms slowly returned, causing Petitioner to return to Dr. Mammano in August of 2016. At this visit, Dr. Mammano indicated Petitioner should see an orthopedic surgeon. She was referred to Dr. Rhode who referred Petitioner to Dr. Freeburg for a second opinion. Both Dr. Rhode and Dr. Freedburg examined Petitioner and obtained a history. Each physician recommended an EMG, denied by Respondent, and bilateral carpal tunnel releases.

The medical bills of Petitioner, pre-fee schedule, total $7,364.78 (Dr. Mammano: $3,800.00; Orland Park Orthopedics: $2,385.20; RX Compliance Laboratories, Inc: $1,413.00; and Suburban Orthopedics Ltd.: $225.00).(PX 1) Of this amount, $458.42 was paid by Petitioner's third party insurance unrelated to her employment.

Following consideration of the testimony and evidence presented, including the testimony and a review of records, the Arbitrator finds the medical services provided Petitioner were reasonable and necessary to treat her work related injury. Respondent shall pay all bills noted herein and at Medical Fee Schedule rates as provided by the Workers' Compensation Act.

With respect to K.) Is Petitioner entitled to prospective medical care, the arbitrator finds as follows:

Pursuant to Section 8(a) of the Act, Petitioner has sought prospective medical care in the form of reasonable and related treatment for her diagnosed condition of bilateral carpal tunnel syndrome. Having found the requisite casual relationship, the Arbitrator finds that Respondent shall authorize the bilateral carpal tunnel releases and ancillary treatment as recommended by both Dr. Rhode and Dr. Freedburg.

With respect to M.) Should penalties or fees be imposed upon the Respondent, the arbitrator finds as follows:

The Arbitrator finds that a legitimate dispute existed in this matter and as such, the request for penalties are hereby denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Moustafa Cisse,
Petitioner,

vs. No. 16 WC 04035

19IWCC0267

Tyson Fresh Meats, Inc.,
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 accident, temporary total disability, causal connection, medical expenses, prospective 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. 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, other than as stated above, the Decision of the Arbitrator filed September 29, 2017, 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.

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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 removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $8,200.00. 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: MAY 29 2019

Marc Parker

mp/wj
05-23-19
68

Barbara N. Flores

Deborah L. Simpson

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

CISSE, MOUSTAPHA
Employee/Petitioner

Case# **16WC004035**

TYSON FRESH MEATS INC
Employer/Respondent

19IWCC0267

On 9/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.17% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0714 WARNER & ZIMMERLE
HOWARD ZIMMERLE
423 17TH ST SUITE 201
ROCK ISLAND, IL 61201

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

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STATE OF ILLINOIS)
)SS.
COUNTY OF Rock Island)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Moustapha Cisse
Employee/Petitioner

v.

Tyson Fresh Meats, Inc.
Employer/Respondent

Case # **16** WC **4035**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Rock Island**, on **7/13/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

D. [ ] What was the date of the accident?

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

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

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

K. [x] Is Petitioner entitled to any prospective medical care?

L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD

M. [x] Should penalties or fees be imposed upon Respondent?

N. [ ] Is Respondent due any credit?

O. [ ] Other ____

FINDINGS

On the date of accident, **4/17/15**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$23,012.08**; the average weekly wage was **$442.54**.

On the date of accident, Petitioner was **53** years of age, *married* with **3** dependent children.

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

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

Respondent is entitled to a credit of **$2,481.50** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $10,546.36, as set forth in Petitioner's exhibit 4, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $2,481.50 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for prospective medical care as recommended by Dr. Berry and Dr. Sundar, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Michael K. Nowak, Arbitrator

9/26/17
Date

ICArbDec19(b)

SEP 29 2017

Petitioner testified in English during the Arbitration hearing. Although English is not his native language, he seemed to be able to understand and communicate well during these proceedings. Petitioner was advised through counsel and by the Arbitrator to only speak English if he was 100% sure of what was asked and 100% sure that he could answer adequately in English. A French interpreter was present and sitting next to Petitioner throughout the hearing, although she was not needed.

The Arbitrator found Petitioner's testimony to be forthright and credible in all regards.

FINDINGS OF FACT

Petitioner Moustapha Cisse is a now a 55 year old man who has been working at Tyson for nearly 17 years. During the period of time in question, his main job was using the "whizzard knife" to cut meat. However, he would occasionally fill in on a line which he called the "XF fat" but in Tyson's records this is referred to as the XF Vat Loading job.

At the XF Vat line, there were two moving conveyor belts. The Petitioner described one belt as being approximately 3.5 feet high, while the other belt was at his eye level. Petitioner stated that he was either 6 foot 1 or 6 foot 2. His job at the XF fat line was to hook and pull fat from the conveyor belt in front of him, then twist to put the fat into a vat to his left. Each vat would end up with at least 1,600 pounds of fat. This was a non-stop job that required constant twisting.

Petitioner testified that he worked on this line on Wednesday, April 15th and again on Friday, April 17th. On April 17th, he worked for five hours, filling up 8 vats. He testified that this was a faster pace than normal. He did not complain of any pain or difficulty at work that day.

He testified that after work on the 17th, he returned home, took a shower, and sat down. It was at this point that he began to experience pain in his right shoulder, the right side of his back, and into his right leg.

On April 20, 2015, Petitioner presented to his family doctor, Dr. Brian Anderson. (PX3, pg. 5). At that point, he described his pain as "right shoulder pain that radiates down his back into right leg after working on Friday." (PX3, pg 5). He described this pain as being severe and starting after he showered and sat down on Friday after work. (PX3, pg 5). Dr. Anderson referred Petitioner for an MRI.

The MRI was done on April 21, 2015. (PX3, pg 18). It showed, among other things, a prominent disc bulge at the L3-4 level. (PX3, 19). After the MRI, Petitioner returned to Dr. Anderson on April 22. (PX3, pg 7). At that point, his shoulder felt "much better" but the back pain was described as severe with numbness down the right leg. (PX 3, pg 7). Dr. Anderson referred Petitioner to a neurosurgeon, released him from work pending the neurosurgical appointment, and "stressed need to inform employer pain could be related to work environment." (PX3, pg 8).

On that same day, July 22, 2015, Petitioner reported the injury to Tyson. (PX 2). Petitioner's statement of injury clearly indicates an accident date of April 17, 2015. On May 8, 2015, he was seen by Tyson's on-site physician, Dr. Robert Gordon. At that time, his shoulder was doing well. (PX3, pg 22). The history he gave Dr. Gordon was consistent with his prior medical records and his testimony at hearing. (PX3, pg 22). Dr. Gordon recommended physical therapy and a light duty job. (PX3, pg 23).

Petitioner continued to treat with Dr. Gordon and work a light duty job. On July 6, 2015, Dr. Gordon mentioned in his medical record that "[b]ased upon my jobsite evaluation, this is not a work-related condition" but did not provide any explanation or reasoning for that opinion. (PX3, pg 32).

On August 27, 2015, Petitioner saw orthopedic surgeon Dr. Michael Berry. Although Dr. Berry's notes refer to a date of injury of April 22, 2015, this is obviously in error. (PX 3, pg 42). Dr. Berry reviewed Petitioner's history and MRI. He noted that there was a "very large right paracentral herniated nucleus pulposus at L3-4" with a "significant amount" of caudal migration "causing quite severe lateral recess and canal stenosis." (PX3, pg 42). Dr. Berry also noted that Petitioner's radiating symptoms were consistent with an L4 distribution. (PX3, pg 42). He noted that Petitioner was a candidate for a L3-4 microdiscectomy. (PX3, pg 43).

Respondent sent Petitioner to a Section 12 exam with Dr. Kern Singh on November 4, 2015. Dr. Singh performed a records review and examined Petitioner (RX1). Dr. Singh was apparently under the impression that the date of injury was April 22. His conclusion was that, because the April 20 visit to Dr. Anderson and the April 21 MRI pre-date April 22nd, that Petitioner's condition was not work-related. Dr. Singh did not opine on the potential for an injury of April 17th.

Petitioner was referred to Dr. Sanjay Sundar, a pain specialist, on February 29, 2016. At that point, Petitioner's pain was still located in the right lumbar area, radiating down the right leg "in an L4 fashion" with associated numbness and tingling. (PX3, pg 127). Dr. Sundar opined that Petitioner was suffering a herniated disc at the L3-4 level which was causing his symptoms. (PX3 pg 129).

Dr. Sundar performed epidural steroid injections on March 2 and March 14, 2016. Petitioner returned to Dr. Sundar's office on March 28th, at which time he was prescribed Gabapentin. Petitioner continued to see Dr. Sundar periodically for checkups and refills on Gabapentin and Tramadol. On December 20, Petitioner underwent a third epidural steroid injection (PX3, 71). Dr. Sundar last saw the Petitioner prior to hearing on April 19, 2017.

Petitioner still works at Tyson, albeit now in a light duty position. He testified that his back pain has essentially remained the same since April 17, 2015 and that he still experiences numbness and tingling going down his right leg. If surgery is still an option, he testified that he would like to pursue it.

CONCLUSIONS

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

Petitioner testified about his work activities of April 17, 2015. As stated above, his job that day involved a great deal of movement, including bending down and twisting. He testified that his pain started after taking a shower right after work that day. Contemporaneous medical records from April 20, 2015 and an injury report from April 22, 2015 support his testimony. The Arbitrator finds that there was an accident arising out of and in the course of Petitioner's employment on April 17, 2015.

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

Petitioner's back and right leg symptoms have been present consistently since April 17th, 2015. As stated above, an MRI showed a large, right-sided disc herniation at the L3-4 level, which all physicians seem to agree is causing his pain and radiating symptoms.

Dr. Berry testified that pulling, bending and twisting at work "could have accelerated or contributed to his low back pain" and radiating symptoms. (PX5, pg 10). He further testified that pulling, lifting, bending and twisting were all activities that aggravate a herniated disc, meaning that to make it symptomatic or to get the symptoms to the point that one would see a doctor. (PX 5, 27). His opinion is that this is what happened in this case. (PX5, 28).

Dr. Sundar's opinion was more succinct – simply that the April 17, 2015 work injury "was the direct causative factor of the large herniation at L3-4" and that the herniation was the cause of Mr. Cisse's symptoms and need for treatment. (PX7, 17).

By contrast, Dr. Singh has provided a report and testified that this injury was not work-related. Dr. Singh testified that Petitioner's symptoms were consistent with the disc herniation reflected on the April 21 MRI. (RX1, 9, 10). The sole basis for Dr. Singh's opinion that the work injury was not related was because he believed the injury to be on April 22nd. (RX1, 10). Because we know that the injury was on April 17th, Dr. Singh's testimony is not credible.

Petitioner testified as to two prior back injuries. Once in 2007, Petitioner mentioned that he hurt his lower back, but that he recovered within a few months. Petitioner was also questioned about a back injury from November 2011. This injury seemed to be solely left-sided, and also did not last very long. (RX 6). By contrast, Petitioner's current injury is right-sided.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that his current condition of ill-being is causally related to the accident of April 17, 2015.

Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
Issue (K): Is Petitioner entitled to any prospective medical care?

Petitioner submitted medical expenses totaling $10,546.36.(PX 4)

To date, the medical care and treatment provided to the Petitioner has given him some limited relief. There is no evidence or testimony on the record that the treatment was unreasonable or inappropriate. The Arbitrator finds that the treatment provided to Petitioner to date was reasonable and necessary.

The testimony and opinions of Dr. Berry and Dr. Sundar with regard to future medical care are more persuasive than those of Dr. Singh. The Arbitrator finds Petitioner is entitled to prospective medical treatment.

Respondent shall pay reasonable and necessary medical services of $10,546.36, as set forth in Petitioner's exhibit 4, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of $2,481.50 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any

claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Further, Respondent shall authorize and pay for prospective medical care as recommended by Dr. Berry and Dr. Sundar, as provided in Sections 8(a) and 8.2 of the Act.

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

"If an employer acts in reliance upon qualified medical opinion and disputes whether the employment was related to the alleged disability, such penalties are not ordinarily imposed. The test is whether the employer's conduct in relying on the medical opinion to contest liability is reasonable under the circumstances presented." *Miller v. Indus. Comm'n*, 255 Ill. App. 3d 974, 979–80, 627 N.E.2d 676, 680 (3rd Dist. 1993). In this case both Dr. Gordon and Dr. Singh opined that Petitioner's condition was not work related. The Arbitrator cannot conclude Respondent was unreasonable in relying on these opinions. Penalties are, therefore denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

William Brown

Petitioner,

vs.

NOS. 16WC027967
16WC027968

Best Practice Staffing,

Respondent.

19IWCC0268

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 6, 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 $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: MAY 30 2019
SJM/sj
o-5/1/2019
44

Stephen J. Mathis

Douglas McCarthy

SPECIAL CONCURRENCE/DISSENT

I concur with the majority in all aspects of its decision other than its order to compel Respondent to authorize medical treatment. This issue was previously addressed by the Court in *Hollywood Casino-Aurora, Inc. v. Illinois Workers' Compensation Commission*, 2012 IL App (2d) 110426WC, which is dispositive. The Court noted "Assuming for the sake of analysis that this provision of the Act [Section 8(a)] is sufficiently broad so as to include a requirement that an employer authorize medical treatment for an injured employee in advance of the services being rendered, the fact still remains that there is no provision in the Act authorizing the Commission to assess penalties against an employer that delays in giving such authorization." *Id.* at ¶ 19. Ordering Respondent to authorize medical treatment is meaningless where no enforcement

mechanism exists under the Act. In accordance with Section 8(a) of the Act and the Court's holding in *Hollywood Casino*, I would order Respondent to provide and pay for the awarded medical expenses and/or treatment.

Elizabeth Coppoletti

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

BROWN, WILLIAM
Employee/Petitioner

Case# **16WC027967**

16WC027968

BEST PRACTICE STAFFING
Employer/Respondent

19IWCC0268

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:

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST STE 810
CHICAGO, IL 60654

0507 RUSIN & MACIOROWSKI LTD
SAMANTHA SIMS
10 S RIVERSIDE PLAZA #1925
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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

19IWCC0268

William Brown
Employee/Petitioner

Case # 16 WC 027967

v.

Consolidated cases: 16WC027968

Best Practice Staffing
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 **Gregory Dollison**, Arbitrator of the Commission, in the city of **Chicago, Illinois**, on **6/21/18**. 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. [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. [ ] What were Petitioner's earnings?

H. [ ] What 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 dates of accident, **8/26/16 and August 29, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship *did* exist between Petitioner and Respondent.

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

Timely notice of these accidents *were* given to Respondent.

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

In the year preceding the injury, Petitioner earned $**21,068.32**; the average weekly wage was $**405.16**.

On the date of accidents, Petitioner was **50** years of age, *single* with **6** dependent children.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $43,370.98, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay the reasonable costs per the fee schedule for the surgery and post-operative care prescribed by Dr. Dixon

Respondent shall pay Petitioner temporary total disability benefits of $330.00/week for 93-3/7 weeks, commencing 9/6/16 through 6/21/18, 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.

Signature of Arbitrator

8/3/18
Date

ICArbDec19(b)

AUG 6 - 2018

Attachment to Arbitrator Decision
(16 WC 27967 and 16 WC 27968)

FINDINGS OF FACT

19IWCC0268

Petitioner testified that he was sent by Respondent to work at Amerigold Sugar in August of 2016. Petitioner testified that he was a laborer and his job duties consisted of loading and unloading on the dock. Petitioner testified that on August 26, 2016, he was performing these duties, unloading 50-pound bags of starch, when he felt a pop in his back and pain down his left leg to the calf. Petitioner testified he thereafter experienced severe pain in his lower back. Petitioner testified that called Respondent's staffing coordinator, Brittany, to inform her that he "hurt my back." Petitioner indicated Brittany wanted to know if he could finish the day. Petitioner stated that he worked the remainder of the day.

Petitioner testified he returned to work on August 29, 2016 at Amerigold, to the same job duties. Petitioner testified he again was loading a 50-pound bag of starch when his back pain, which had never gone away since August 26, 2016, worsened, with pain down both legs. Petitioner testified he again called Brittany and related his worsening back and leg pain and that he "couldn't hardly move" as he hurt it again loading the bags of starch that day. Petitioner testified that Brittany again asked if he could finish working his shift. Petitioner testified that he also gave notice of an accident to the onsite supervisor, "Roy," who responded "you[re] either going to work or you can go home." Petitioner confirmed that he did not complete an accident report; nor did anyone from Respondent request he complete a report. Petitioner did not return to work on August 30, 2016.

Records submitted show Petitioner initially sought treatment at Illinois Orthopedic Network (ION) where he saw Dr. Chunduri on September 6, 2016. At that time, Petitioner complained of lower back and left lower extremity pain. According to the notes, Dr. Chunduri recorded a history that Petitioner reported he was injured on August 27, 2016 while he was unloading a truck which was full of 50-pound bags of starch. Petitioner stated that towards the end of unloading a truck, he felt a pop with pain in his lower back and a burning sensation down his left lower extremity. Petitioner reported he returned to work the next day performing the same type of work which continued to aggravate and increase the pain in his low back. The doctor also noted that Petitioner denied any prior injury to his lower back. (PX1)

On examination, Dr. Chunduri noted Petitioner had a slightly antalgic gait. Petitioner was tender to palpation with spasms. Forward flexion was to 45 degrees with pain. No pain was reproduced with extension or rotation bilaterally. He had negative straight-leg raise test bilaterally and he had normal strength in both with decreased sensation and light touch in the left lower extremity when compared to the right. Dr. Chunduri diagnosed lower back pain and left lower extremity pain. Petitioner was prescribed medication and advised to begin physical therapy. Petitioner was also authorized off work. (PX 1)

On October 3, 2016, Petitioner underwent an MRI of the lumbar spine. According to the radiologist, it demonstrated: (1) straightening of the lumbar spine; (2) disc desiccation at L5-S1; (3) reduced intervertebral disc height at L5-S1; (4) Modic type II end plate degenerative changes at L5-S1; (5) at L4-L5, there was a three millimeter diffuse disc protrusion with effacement of the thecal sac and the spinal canal was noted to be compromised; there was also material and facet hypertrophy causing bilateral neuroforaminal narrowing that effaces the left and right L4 exiting nerve root; and (6) at L5-S1, there was a six millimeter focal left paracentral disc extrusion with slight inferior extension indenting the thecal sac and causing obliteration of the left lateral recess; disc material and facet hypertrophy causing bilateral nerve foraminal narrowing that effaces the left and right L5 exiting nerve roots. (PX 1)

Petitioner returned to Dr. Chunduri on October 10, 2016. Petitioner reported physical therapy was helping but not providing any substantial relief. Dr. Chundri noted Petitioner continued to ambulate with an antalgic gait. Petitioner had a positive straight leg raise on the left with plantar and dorsiflexion weakness compared to the right. Also noted was back spasms with myofascial tenderness and pain. Dr. Chunduri reviewed the MRI indicating it demonstrated three millimeter diffuse disc protrusion with effacement of the thecal sac at L4-5; compromised spinal canal; at L5-S1 there was a six millimeter focal left paracentral disc extrusion with slight inferior extension indenting the thecal sac and causing obliteration of the left lateral recesses; hypertrophy of the facet joints was noted; ligamentum flavum demonstrated normal configuration, disc material, facet hypertrophy causing bilateral neuroforaminal narrowing. Dr. Chunduri recommended diagnostic/therapeutic cortisone injections at L4-5 and L5-S1. Petitioner was prescribed Norco and authorized off work. (PX 1)

On October 20, 2016, D. Chunduri administered a left L4-5 transforaminal epidural steroid injection for a diagnosis of lumbar disk herniation with left radiculitis. Petitioner followed up with Dr. Chunduri on December 1, 2016. Petitioner reported the injection failed to provide significant relief. At that time, Petitioner rated his pain as 8/10 in the low back which radiated down his left leg, as well as pain radiating down the right buttock. Dr. Chunduri assessed lumbar disk herniation with left radiculitis. The doctor indicated Petitioner had a large 6 mm disk herniation and recommended an addition injection. Petitioner declined. Dr. Chunduri referred Petitioner to Dr. Dixon for a surgical consultation. (PX1)

Petitioner presented to Dr. Geoffrey Dixon at ION on January 23, 2017. At that time Petitioner complained of lower back pain radiating into the left buttocks, legs, and calf with recent extension into the right buttock. Dr. Dixon documented that Petitioner's pain began while at work on August 26, 2016. Petitioner reported that he was unloading bags of starch and felt a pop with an electric shock type of pain down the left buttock and leg. Petitioner stated since his accident, the pain had gotten progressively worse. He reported undergoing physical therapy and an injection with little relief. On examination, Dr. Dixon noted Petitioner had normal strength in the bilateral lower extremities and a "profoundly" positive straight leg raise on the left. Dr. Dixon reviewed Petitioner's MRI and opined it demonstrated a broad-based disc protrusion at L4-5 causing bilateral lateral recess and foraminal stenosis and a disc herniation at L5-S1 to the left causing nerve root compression within the lateral recess and foramen. Dr. Dixon diagnosed disk herniation at L4-5 and L5-S1. Dr. Dixon ordered an EMG of the bilateral lower extremities "in order to better delineate the pathology" and authorized Petitioner off work. (PX 1)

Petitioner underwent an EMG of his bilateral lower extremities on March 17, 2017. According to the EMG record, Petitioner was being evaluated due to severe right-sided lumbar pain. According to Dr. Kozlova the results were an abnormal study which demonstrated electrodiagnostic evidence of chronic severe right sided low lumbar radiculopathy involving L5 mostly with axonal lost distally and signs of muscle denervation. There was no evidence of left sided radiculopathy, spinal canal stenosis, lumbosacral plexopathy, lower extremity mononeuropathy peripheral neuropathy or inflammatory myelopathy effecting the bilateral lower extremities. (PX 1)

Petitioner followed up with Dr. Dixon on April 17, 2017. Dr. Dixon reviewed the EMG results indicating same suggested Petitioner had severe right-sided radiculopathy with axonal loss and muscle denervation. The doctor felt the results was consistent with Petitioner's right sided complaints of primarily fatigue and decreased muscle strength. Dr. Dixon also noted Petitioner's complaints of pain was primarily on the left side extending down to lower leg and foot. Dr. Dixon recommended a second L5-S1 epidural injection on the left side. Petitioner was also kept off work. (PX1)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Julie Wehner on April 21, 2017. Dr. Wehner recorded that Petitioner provided a history that he was working for People 2.0/BP Staffing Agency at Marigold Sugar in University Park unloading trailers with 50-pound bags of starch. Petitioner

provided that he first began to feel pain on August 26, 2016. The doctor recorded Petitioner stated he presented to work on Monday and continued to unload the truck. By Tuesday, August 30, he could no longer complete the task due to pain. Petitioner stated he asked to be sent to a doctor but that his employer denied this. According to Dr. Wehner, Petitioner said he initially went to the emergency in Blue Island and was then seen by Dr. Chunduri. Petitioner complained of back pain which he rated at 7/10. His back pain went into the buttocks of both legs, right worse than left. Petitioner indicated his lower back pain was "now" causing some pain in left shoulder. Petitioner also reported that his right leg was tired and he had a tingling and shocking sensation in the back of the legs. (RX 5, Dep. Ex. 2)

Dr. Wehner wrote that Petitioner denied any prior motor vehicle accidents or chiropractic care. She indicated Petitioner stated he was seen in the past for his back at St. James Health Center in Olympia Fields, when he was working at TDM. The doctor also wrote that Petitioner stated that he re-hurt his back while playing with his daughter and picking her up to put her on a bike. He was reportedly seen at Metro South Emergency Room for that incident. Dr. Wehner also wrote that Petitioner denied having sciatica, x-rays, MRI's or any chiropractic care at that time. (RX 5, Dep. Ex. 2)

Upon examination, Dr. Wehner noted Petitioner had normal gait. Petitioner complained of back pain with heel and toe walking. Petitioner complained of pain with light palpation; moderate pain in his low back with axial compression; and pain with axial rotation. The doctor noted that Petitioner was unwilling to attempt to touch his toes, as he claimed it was too painful. Petitioner demonstrated extension to 20 degrees. He had a positive straight leg raise on the right at 80 degrees and on the left at 90 degrees. There was normal strength and Petitioner complained of decreased sensation in the dorsum of his foot. (RX 5, Dep. Ex. 2)

Dr. Wehner's reported that she reviewed the MRI from October 3, 2016, the EMG from March 17, 2017, and the records from Illinois Orthopedic Network. Dr. Wehner diagnosed Petitioner with back pain and bilateral leg pain with radiographic findings of a left paracentral disc extrusion. Dr. Whehner indicated that Petitioner's subjective complaints included bilateral leg pain which did not correlate with a left-sided L5-S1 disc herniation. She noted the clinical exam showed some mildly positive straight leg raising bilaterally and that the EMG showed right-sided findings which did not correlate with the MRI findings. Dr. Wehner wrote that it was not clear that Petitioner's complaints had any relationship to the abnormal MRI findings. Again, she noted the complaints and the EMG did not correlate with the radiographic findings. She also noted that Petitioner's clinical exam was nonspecific. Dr. Wehner declined to provide a causal relationship opinion at that time indicating that because Petitioner reported prior back problems, she wanted to review any prior records to see if there was a more significant preexisting condition. Dr. Wehner opined that Petitioner's treatment had been reasonable and necessary, with the exception of the prescribed EMG and the medication given out at the clinic. She stated an EMG is not used for the diagnosis of back injuries. Lastly, the doctor indicated Petitioner was not at maximum medical improvement and opined that Petitioner could work restricted duty. (RX 5, Dep. Ex. 2)

On May 1, 2017, Petitioner presented for a general adult medical examination with Dr. Rita MelgarrejoGlaab of TCA Health. Documents submitted show that under the "HealthCare History" Petitioner reported that he had not seen another healthcare provider "since [his] last office visit." Also under "Pain Assessment" the records show Petitioner responded "No" to following question, "Are you currently having any pain which… Affects your activity level?" At that visit, a variety of tests were ordered for an assessment of "preventive health care, adult." (RX 9)

On May 4, 2017, Dr. Chunduri administered an L5-S1 transforaminal epidural steroid injection on the left side. (PX 1) He returned to Dr. MelgarrejoGlaab on May17, 2017. Again the records show Petitioner reported that he had not seen another healthcare provider "since [his] last office visit" and that he was not "…currently having any pain which… Affects your activity level" Also noted was that Petitioner reported that

he was experiencing "some nausea after spinal injection for herniated disk." Amongst other diagnosis, Dr. MelgarrejoGlaab assessed herniated lumbar disk with radiculopathy. (RX 9)

Petitioner follow-up with Dr. Chunduri on June 22, 2017. At that time, Petitioner reported that he had no improvement subsequent to the injection. Dr. Chunduri recommended a spine surgery consultation. (PX 1)

Petitioner returned to Dr. Dixon on July 17, 2017. In his follow-up notes, the doctor wrote, "Given that [Petitioner] has both radiographic and electrophysiologic evidence of both herniated disk and nerve root compression, I believe that since his pain was refractory to treatment with epidural injections and physical therapy, that a surgical intervention is both warranted and reasonable." (PX 1)

On July 19, 2017, Dr. Wehner issued an addendum report, after reviewing additional medical records following the IME. According to the doctor, she reviewed the April 17, 2017 record from Dr. Dixon, and the notes of South Suburban Physical Therapy which documented visits through March 27, 2017. Dr. Wehner opined that Petitioner had adequate course of 16 session of physical therapy and had plateaued in therapy with a pain scale of 5/10. She noted that Petitioner's major complaint was still right leg pain which does not correlate with a left-side L5-S1 disk protrusion. Dr. Wehner disagreed with Dr. Dixon's surgical recommendation stating, "...there would be no indication to perform any type of surgery for right-sided symptoms when the pathology on the MRI is on the left side." She also felt the finding at L4-L5 was small and would not correlate with Petitioner's pain complaints. Dr. Wehner also opined that Petitioner did not require any further therapy. She felt Petitioner had a pre-existing condition and "strongly" recommended reviewing prior medical records of Metro South Emergency Room and St. James Health Center. Lastly, the doctor opined that Petitioner could return to work in a "step-wise fashion" covering a four (4) week period before he would be at full duty capacity. (RX 5, Dep. Ex. 3)

Petitioner continued to treat with Dr. Dixon. He would see the doctor at two (2) to three (3) month intervals through March 23, 2018. Dr. Dixon continues to recommend surgery consisting of a microlumbar decompression and discectomy at L4-L5 and L5-S1. Also, the doctor continues to reiterate his prescription for total work restriction. (PX 1)

Petitioner testified he wants the prescribed surgery, and has no other way to pay for it. Petitioner testified that he has a follow-up appointment at ION on June 28, 2018. Petitioner testified that he has had no other accidents involving his back. Petitioner testified that he has not worked anywhere since August 30, 2016 and has been receiving Social Security Disability since November or December of 2017.

Petitioner testified that he continues to experience severe lower back pain and pain down both legs. Petitioner stated his pain levels vary but never "goes away." He provided that his discomfort is worse on sitting, getting up from a chair, walking and climbing stairs. Petitioner testified he continues to take the medications prescribed by Dr. Chunduri and Dr. Dixon, which are somewhat helpful with his pain. He indicated that his pain is more severe when he does not take the prescribed medications. He stated he cannot lift anything heavy, and the heaviest item he currently lifts is his shoes.

Petitioner testified regarding his prior lower back complaints. Petitioner testified that on June 9, 2016 he was showing his daughter how to ride a bike when he was struck by a handlebar in the midback on the right side. Petitioner reported he was seen at MetroSouth ER. Petitioner testified that his discomfort from the handlebar incident resolved and he continued to work full-time pain free through August 26, 2016. Petitioner also testified that his current pain is located in his lower back whereas the pain on June 6, 2016 was in the mid to upper back. Petitioner denied any other injuries or incidents involving his back.

Records submitted show Petitioner presented to Ingalls Memorial Hospital ER on June 9, 2016 where he saw Dr. Mahmooda Syed with complaints of right low back pain that radiated down the right leg. The onset of pain was noted to occur one (1) day prior. (The Arbitrator notes that the "ED Nursing Initial Assessment Note" indicate Petitioner presented with complaints of low back pain the radiated down his bilateral lower extremities. The onset was noted as two (2) days prior.) Petitioner was diagnosed with sciatica, prescribed pain medication and advised to follow-up with his primary care physician. (RX 3) Respondent introduced records from MetroSouth Medical Center. The records submitted show Petitioner sought treatment there in 2012. (RX 8)

Mr. Lewis Moore was called to testify on behalf of Respondent in this matter. Mr. Moore testified that on the date of accident, he was the warehouse supervisor at Marigold. Mr. Moore testified regarding Respondent's accident reporting policies. He stated employees are required to report any accidents to the supervisors and in the case of temporary employees, they are also required to report the accident to their staffing agency. Mr. Moore testified that Petitioner did not report an accident to him on either August 26, 2016 or August 29, 2016. Mr. Moore testified that if Petitioner had reported any injury there would be an email chain between himself and BP Staffing regarding the accident and steps taken. He testified that in instant case, there was no documentation regarding the accident. Mr. Moore also testified that in the event an employee reports an accident to their staffing agency, the staffing agency would then follow up with him regarding the accident. Mr. Moore testified that no one from BP Staffing has ever attempted to contact him regarding Petitioner's alleged injury.

Ms. Kristie Kierna was also called to testify on behalf of Respondent in this matter. Ms. Kierna testified that she was the corporate administrator for BP Staffing. Her job duties include HR, workers' compensation, and payroll responsibilities. She also testified regarding BP Staffing's policies regarding accident. Ms. Kierna stated the policy requires an employee to notify both her and the onsite supervisor of a claimed accident. Ms. Kierna testified that she was aware of Brittany and if an accident had been reported to Brittany, she would advise her same so that reports could be completed. Ms. Kierna provided that she never had a conversation with Brittany regarding Petitioner nor was able to locate documentation that Petitioner ever reported an accident.

Dr. Dixon testified via deposition in this matter. Dr. Dixon testified that Petitioner came under his care on January 23, 2017. At that time, Petitioner stated he was lifting 50-pound bags of starch when he felt a pop and an electric type pain radiate down his left buttock and into his left leg. Dr. Dixon testified that on examination, Petitioner was neurologically intact, but had a profoundly positive straight leg raise on the left. Dr. Dixon believed Petitioner displayed significant pain and symptomatology associated with slight amount of raising of his leg. (PX 10, pp. 8-9) Dr. Dixon testified that he had access to Petitioner's prior treatment records with Illinois Orthopedic Network and was aware that Petitioner had undergone a lumbar MRI and injections. (PX 10, p.7)

Dr. Dixon testified that he reviewed the MRI which he felt demonstrated a broad based protrusion at L4-L5 causing bilateral lateral recess and foraminal stenosis and a significant herniation at L5-S1, which was eccentric to the left causing name root compression within the lateral recess and foramen. Dr. Dixon testified the MRI findings were consistent with Petitioner's demonstrated symptoms and his injury. (PX 10, pp. 9-10) Dr. Dixon stated he ordered an EMG of the bilateral lower extremities. Dr. Dixon testified the EMG results was an abnormal study suggesting there was evidence of chronic severe right sided radiculopathy. Dr. Dixon testified that "…not having a positive EMG on the left, despite the findings of his MRI and physical examination, it was not inconsistent." The doctor indicated an EMG is not a dispositive test. Dr. Dixon testified "it has to do with any number of factors, including the examiner's technique as well as the duration of the symptoms, to determine whether or not you would expect to see electrophysiologic differences on the EMG study." The doctor added that there was nothing inconsistent with Petitioner's entire presentation. (PX 10, pp. 10-11)

Dr. Dixon testified regarding Petitioner's course of treatment which included physical therapy, injections which were not particularly helpful and off work prescriptions. Dr. Dixon testified he recommended Petitioner undergo surgery at L4-L5, L5-S1, microlumbar decompression and discectomy. Dr. Dixon stated the surgery was recommended to specifically alleviate Petitioner's symptoms as it would treat his herniated disc and radiculopathy. Dr. Dixon stated that the symptoms exhibited by Petitioner had been consistent since the start of the treatment. (PX 10, pp.13-15)

Dr. Dixon testified that he disagreed with Dr. Wehner's opinions regarding the EMG and his recommendation for surgery. Dr. Dixon stated, "She states that his major complaints are still right leg pain and this does not correlate with a left-sided L5-S1 disk protrusion, therefore, there would be no indication to perform any type of surgery for right-sided symptoms when the pathology on the MRI is on the left side; the findings at L4-5 is small and would not correlate with his pain complaints. I specifically disagree with that as per my first notation that he had a profoundly straight leg raise on the left side and that he was in fact complaining of left-sided complaints predominantly. I further disagree with the suggestion that the L4-5 disk is small and would not correlate with his pain complaints as that was the level that was found to be positive on the EMG." (PX 10, pp. 16-17) Dr. Dixon added that Petitioner complained of left greater than right-sided pain. He stated that Petitioner's complaint, the findings on examination as well as his interpretation of the MRI and EMG all correlated and were consistent. (PX 10, p.17)

Dr. Dixon testified Petitioner suffered a herniated disc at L4-L5 and L5-S1 with associated radiculopathies at both L4-5 and L5-S1. The doctor stated that all conservative treatment option were attempted and Petitioner's symptoms were refractory and as a result his surgical recommendation are both reasonable and necessary. The doctor further opined that based on the accident and history provided, a causal relationship exists between Petitioner's ill-being and the reported accident. (PX 10, pp.19-20)

On cross-examination, Dr. Dixon testified that with the exception of a positive straight leg raise, Petitioner's examinations were neurologically normal. Dr. Dixon testified that he believed Petitioner's pain was located in the S1 dermatome. The doctor indicated the EMG noted positive findings on the right side and the straight leg raise was on the left side. These findings indicate there are different pain generators. Dr. Dixon confirmed the MRI study demonstrated a broad base disc protrusion at L4-L5 causing bilateral lateral recess and foraminal stenosis. Dr. Dixon agreed stenosis was narrowing and it did not always result in pain. (PX 10, pp. 22-23) Dr. Dixon added that Petitioner's right-sided complaints are fatigue and decreased muscle strength which is consistent with the EMG findings. (PX 10, pp.24-25, 28)

Dr. Dixon testified that that he did not review any of Petitioner's prior medical records. (PX 10, p. 31) The doctor stated that his opinions regarding causation were based entirely on Petitioner's statements in his first evaluation that his pain started on the reported date of accident. (PX 10, p. 32)

On re-direct examination, Petitioner's attorney inquired as to whether Dr. Chundri's September 6, 2016 negative left straight leg raise finding and subsequent positive straight leg finding on December 1, 2016 was inconsistent with Dr. Dixon's examination. Dr. Dixon testified it was not inconsistent and would be expected as a common evolution of a herniated disc compressing on a nerve. Dr. Dixon also testified that he found Petitioner credible without symptom magnification. (PX 10, pp. 33-34)

Dr. Wehner testified via deposition in this matter. Dr. Wehner testified that she examined Petitioner on April 17, 2017. At that time, Petitioner reported that on Friday, August [26], 2016, he experienced an onset of back pain while unloading trailers with 50-pound bags of starch, palletizing and shrink-wrapping them by hand. He returned to work on Monday when he unloaded three trucks. By Tuesday, August 29, 2016, he could no longer perform the work and asked to be sent to a doctor. (RX 5, p. 7) Dr. Wehner testified Petitioner also reported that he hurt his back previously while working for TDM and re-hurt it while playing with his daughter.

He stated he was seen at MetroSouth Emergency Room and denied any prior sciatica, x-rays, MRIs, chiropractic care or physical therapy.(RX 5, p. 9). Dr. Wehner testified Petitioner reported his pain was usually 10/10 but was 6-7/10 with medication. He reported his right leg pain was worse than his left.

Dr. Wehner testified that Petitioner complained of back pain which radiated down both legs, right worse than left. His right leg was tired and he had tingling and shocking in the back of both legs. (RX 5, p. 8) On examination, Petitioner had normal gait. Petitioner complained of back pain with heel and toe walking; pain with light palpation; and moderate pain in his low back with axial compression and axial rotation. The doctor stated Petitioner was unwilling to attempt to touch his toes, as he claimed it would be too painful. Petitioner demonstrated extension to 20 degrees. There was paraspinal scoliosis with a positive straight leg raise on the right at 80 degrees and on the left at 90 degrees. Petitioner also complained of decreased sensation in the dorsum of his foot. (RX 5, p. 9)

Dr. Wehner testified that axial compression, axial rotation, and light palpation are Waddell findings and are used to validate a person's subjective complaint. Dr. Wehner stated that Petitioner's straight leg raising on the left and right was "not to specific." She stated that although a positive straight leg test can be a sign of a herniated disk, a positive straight leg raise at 80 degrees is not significant for a herniated disk. She stated that overall, Petitioner's examination showed fairly non-specific findings that did not fit into a specific distribution of any nerve root. (RX 5, p. 11)

Dr. Wehner testified she reviewed Petitioner's MRI from October 3, 2016. She opined the MRI showed a three millimeter diffuse protrusion at L4-L5 with effacement of the thecal sac and some facet hypertrophy and bilateral neural foraminal narrowing that effaced the left and right nerve roots. She opined this was a minor finding consistent with a 51-year old male. At L5-S1, there was some disc desiccation and decreased height as well as a 6 millimeter focal left paracentral disc extrusion with slight inferior extension indenting the thecal sac and causing obliteration of the left lateral recess. She opined this could cause pain but would require clinical correlation. (RX 5, p. 13)

Dr. Wehner testified regarding the EMG performed on March 17, 2017. The doctor stated same demonstrated chronic serve right sided low lumbar radiculopathy involving the L5 with axonal loss distally and signs of muscle denervation. There was no evidence of left sided radiculopathy. Dr. Wehner stated, "[t]he EMG showed right-sided symptoms which if there was any positive finding on the MRI,...it was on the left, it was L5-S1. It was a radiologic finding that would be possibly a pain generator. And the EMG showed that there was a finding on the right opposite of what the MRI did. It showed there was nothing going on on the left as far as any type of radiculopathy or a nerve irritation." In addition to citing the North American Spine Associates' position, Dr. Wehner also testified there was no medical reason to perform an EMG as it increases the cost of treatment and does not provide any benefit. The doctor stated, "[t]he idea would be that an EMG would help make a better diagnosis or direct a specific treatment program. The treatment for these types of problems are based on subjective complaints, clinical exams and MRI findings. An EMG does not direct treatment." (RX 5, p. 14,18)

Dr. Wehner testified that she diagnosed Petitioner with back pain and bilateral leg pain with a radiographic finding of left paracentral disc extrusion of L5-S1. She however felt that Petitioner's subjective complaints (bilateral leg pain) did not correlate with an L5-S1 disc herniation. She stated his clinical examination showed mildly positive straight leg raising which was not specific for L5-S1 pathology since it was positive bilaterally. She stated that since Petitioner's subjective complaints in the EMG did not correlate with his radiographic findings, it was not clear that Petitioner's complaints had any relationship to the abnormal MRI findings. She noted that it's well documented that disc herniations could be present in asymptomatic individuals. When asked, "[f]or a left-sided disc herniation, what kind of symptoms if a person had radicular symptoms in the left leg, what would you expect." The doctor replied, "[p]ositive straight leg raising and pain

radiating down the back and outside of their leg down to the lateral side of their foot." (RX 5, p. 19) Dr. Wehner went to state that it was impossible to date the abnormality on the MRI. She noted that because Petitioner reported some prior lower back pain, the MRI abnormality could have been present prior to August 2016. As a result, she wanted to see prior medical records to see if any pre-existing back pain correlated to Petitioner's MRI findings. She also wanted to see Petitioner's physical therapy records. The doctor further stated that other than the EMG, the treatment received through the Section 12 examination was reasonable and necessary. At that time, she did not believe Petitioner was at maximum medical improvement and he could have returned to light duty work. (RX 5, pp. 19-20)

Dr. Wehner testified she had the chance to review additional medical records following her IME, which included physical therapy records as well as further recommendations from Dr. Dixon. Dr. Wehner testified that she strongly recommended against any type of surgery. The doctor reasoned that Petitioner's clinical findings did not correlate with the MRI abnormality. The doctor stated that because Petitioner had at least 16 sessions of physical therapy, any continuing visits were no longer necessary. The doctor indicated that although she did not review any prior medical documentation, Petitioner had a preexisting condition. She believed Petitioner was at maximum medical improvement. She stated he could return to work in a light duty two week "step-wise fashion" before he would be at full-duty. (RX 5, pp. 21-22)

On cross examination, Dr. Wehner testified that her clinical examination did note some right leg pain and same could be consistent with the EMG findings. She agreed that Petitioner's presentation to Illinois Orthopedic Network was "somewhat initially" consistent with his MRI noting he was complaining primarily of left leg pain but then he also began complaining of right sided symptoms. Dr. Wehner added that the intensity of the symptoms can wax and wane in intensity. She also stated that if a person has a herniated disc in the paracentral location it usually does not switch back and forth. Lastly, the doctor stated that she did not believe Petitioner had failed conservative care "...because the symptoms he is complaining of are not verified with the clinical exam....because there is portions of it that truly do not appear very valid at all." (RX 5, pp.24-25)

<u>With respect to issue C.) Did an accident occur that arose out of and in the course of Petitioner's employment with Respondent, the Arbitrator finds the following:</u>

Petitioner testified that on August 26, 2016, he was unloading 50-pound bags of starch, when he felt a pop in his back and pain down his left leg to the calf. Petitioner testified he returned to work on August 29, 2016 performing the same job duties. Petitioner testified that the pain he initially experienced on August 26, 2016 never away and had gotten worse.

When Petitioner initially sought treatment at Illinois Orthopedic Network (ION), where he saw Dr. Chunduri on September 6, 2016, it was recorded that Petitioner provided a history that he was injured on August 27, 2016 while he was unloading a truck which was full of 50-pound bags of starch. Petitioner stated that towards the end of unloading a truck, he felt a pop with pain in his lower back and a burning sensation down his left lower extremity. Petitioner reported he returned to work the next day performing the same type of work which continued to aggravate and increase the pain in his low back.

Petitioner presented to Dr. Geoffrey Dixon at ION on January 23, 2017. Dr. Dixon documented that Petitioner's pain began while at work on August 26, 2016. Petitioner reported that he was unloading bags of starch and felt a pop with an electric shock type of pain down the left buttock and leg. Petitioner stated since his accident, the pain had gotten progressively worse.

Petitioner underwent a Section 12 examination with Dr. Julie Wehner on April 21, 2017. Dr. Wehner recorded Petitioner's history that he was working for People 2.0/BP Staffing Agency at Marigold Sugar unloading trailers with 50-pound bags of starch. Petitioner provided that he first began to feel pain on August

26, 2016. The doctor recorded Petitioner stated he presented to work on Monday and continued to unload the truck. By Tuesday, August 30, he could no longer complete the task due to pain.

Based on Petitioner's unrebutted testimony and the medical records which show a consistent history provided to all the medical professionals, the Arbitrator find Petitioner sustained accidents that occurred on August 26, 2016 and August 29, 2016 which arose out of and in the course of his employment for Respondent.

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

Petitioner testified that on August 26, 2016, he called Respondent's staffing coordinator, Brittany, to inform her that he "hurt my back." Petitioner indicated Brittany wanted to know if he could finish the day. Petitioner stated that he worked the remainder of the day. Petitioner testified that he returned to work on August 29, 2016 and experienced worsening pain. Petitioner testified he again called Brittany and related his worsening back and leg pain and that he "couldn't hardly move" as he hurt it again loading the bags of starch that day. Petitioner testified that Brittany again asked if he could finish working his shift. Petitioner testified that he also gave notice of an accident to the onsite supervisor, "Roy," who responded "you[re] either going to work or you can go home." Petitioner confirmed that he did not complete an accident report.

Respondent called two witnesses to support their position. Mr. Lewis Moore, the warehouse supervisor, testified that Petitioner did not report an accident to him on either August 26, 2016 or August 29, 2016. Mr. Moore testified that if Petitioner had reported any injury there would be an email chain between himself and BP Staffing regarding the accident and steps taken. He testified that in instant case, there was no documentation regarding the accident. Ms. Kristie Kierna, the corporate administrator for BP Staffing, testified regarding BP Staffing's policies regarding accident. Ms. Kierna stated the policy requires an employee to notify both her and the onsite supervisor of a claimed accident. Ms. Kierna testified that if an accident had been reported to Brittany, she would advise her same. Ms. Kierna provided that she never had a conversation with Brittany regarding Petitioner nor was able to locate documentation that Petitioner ever reported an accident. Brittany did not testify in this matter.

Notwithstanding the above, the Arbitrator notes that Applications for Adjustment of Claim were filed on September 12, 2016 for the August 26, 2016 and August 29, 2016 accidents (Arb. exhibits 3 & 4). Therefore, the Arbitrator finds that Petitioner provided timely notice of the accidents of August 26, 2016 and August 29, 2016 to Respondent.

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

Petitioner initially sought treatment at Illinois Orthopedic Network (ION) where he saw Dr. Chunduri on September 6, 2016. At that time, Petitioner complained of lower back and left lower extremity pain. Petitioner reported that he felt a pop with pain in his lower back and a burning sensation down his left lower extremity. Dr. Chunduri noted Petitioner was tender to palpation with spasms. Forward flexion was to 45 degrees with pain. He had negative straight-leg raise test bilaterally and he had normal strength in both with decreased sensation and light touch in the left lower extremity when compared to the right. Dr. Chunduri diagnosed lower back pain and left lower extremity pain. The doctor ultimately ordered a lumbar MRI. The MRI when performed on October 3, 2016, demonstrated: (1) straightening of the lumbar spine; (2) disc desiccation at L5-S1; (3) reduced intervertebral disc height at L5-S1; (4) Modic type II end plate degenerative changes at L5-S1; (5) at L4-L5, there was a three millimeter diffuse disc protrusion with effacement of the thecal sac and the spinal canal was noted to be compromised; there was also material and facet hypertrophy causing bilateral neuroforaminal narrowing that effaces the left and right L4 exiting nerve root; and (6) at L5-S1, there was a six millimeter focal

left paracentral disc extrusion with slight inferior extension indenting the thecal sac and causing obliteration of the left lateral recess; disc material and facet hypertrophy causing bilateral nerve foraminal narrowing that effaces the left and right L5 exiting nerve roots.

On October 10, 2016, Dr. Chundri noted Petitioner had a positive straight leg raise on the left with plantar and dorsiflexion weakness compared to the right. Also noted was back spasms with myofascial tenderness and pain. Dr. Chunduri recommended diagnostic/therapeutic cortisone injections at L4-5 and L5-S1. On October 20, 2016, D. Chunduri administered a left L4-5 transforaminal epidural steroid injection for a diagnosis of lumbar disk herniation with left radiculitis. By December 1, 2016, Petitioner reported the injection failed to provide significant relief. At that time, Petitioner continued to report low back which radiated down his left leg and for first time he reported pain radiating down the right buttock. Dr. Chunduri continued to assess lumbar disk herniation with left radiculitis. Dr. Chunduri referred Petitioner to Dr. Dixon for a surgical consultation.

When Petitioner first saw Dr. Dixon on January 23, 2017, Petitioner complained of lower back pain radiating into the left buttocks, legs, and calf with recent extension into the right buttock. Dr. Dixon documented that Petitioner's pain had gotten progressively worse. On examination, Dr. Dixon noted Petitioner had normal strength in the bilateral lower extremities and a "profoundly" positive straight leg raise on the left. Dr. Dixon reviewed Petitioner's MRI and opined it demonstrated a broad-based disc protrusion at L4-5 causing bilateral lateral recess and foraminal stenosis and a disc herniation at L5-S1 to the left causing nerve root compression within the lateral recess and foramen. Dr. Dixon diagnosed disk herniation at L4-5 and L5-S1. Dr. Dixon ordered an EMG of the bilateral lower extremities "in order to better delineate the pathology."

Petitioner followed up with Dr. Dixon after undergoing the prescribed EMG. Dr. Dixon reviewed the EMG results indicating same suggested Petitioner had severe right-sided radiculopathy with axonal loss and muscle denervation. The doctor felt the results was consistent with Petitioner's right sided complaints of primarily fatigue and decreased muscle strength. Dr. Dixon also noted Petitioner's complaints of pain was primarily on the left side extending down to lower leg and foot and recommended a second L5-S1 epidural injection on the left side. Following the injection, Petitioner reported no significant improvement. Dr. Chunduri recommended a spine surgery consultation.

On July 17, 2017, Dr. Dixon wrote, "Given that [Petitioner] has both radiographic and electrophysiologic evidence of both herniated disk and nerve root compression, I believe that since his pain was refractory to treatment with epidural injections and physical therapy, that a surgical intervention is both warranted and reasonable." Dr. Dixon recommended a microlumbar decompression and discectomy at L4-L5 and L5-S1.

Dr. Dixon testified the MRI demonstrated a broad based protrusion at L4-L5 causing bilateral lateral recess and foraminal stenosis and a significant herniation at L5-S1, which was eccentric to the left causing name root compression within the lateral recess and foramen. Dr. Dixon testified the MRI findings were consistent with Petitioner's demonstrated symptoms and his injury. Dr. Dixon acknowledged that the EMG results was abnormal suggesting evidence of chronic severe right sided radiculopathy. Dr. Dixon testified that not having a positive EMG on the left, despite the findings of Petitioner's MRI and physical examination, was not inconsistent. The doctor indicated an EMG is not a dispositive test, stating there was nothing inconsistent with Petitioner's entire presentation. Dr. Dixon testified Petitioner suffered a herniated disc at L4-L5 and L5-S1 with associated radiculopathies at both L4-5 and L5-S1. The doctor stated that all conservative treatment options were attempted and Petitioner's symptoms were refractory and as a result his surgical recommendation are both reasonable and necessary. The doctor further opined that based on the accident and history provided, a causal relationship exists between Petitioner's ill-being and the reported accident. Dr. Dixon noted Petitioner's initial presentation when he had a profoundly straight leg raise on the left side and that he was in fact complaining of

left-sided complaints predominantly. He disagreed with the suggestion that the L4-5 disk is small and would not correlate with his pain complaints as that was the level that was found to be positive on the EMG. Dr. Dixon added that Petitioner complained of left greater than right-sided pain. Dr. Dixon testified it was not inconsistent and would be expected as a common evolution of a herniated disc compressing on a nerve. Dr. Dixon found Petitioner credible without symptom magnification. He stated that Petitioner's complaints, the findings on examination as well as his interpretation of the MRI and EMG all correlated and were consistent.

Respondent's Section 12 examiner, Dr. Wehner, performed an examination on April 17, 2017. According to the doctor, Petitioner complained of back pain which radiated down both legs, right worse than left. His right leg was tired and he had tingling and shocking in the back of both legs. Dr. Wehner provided that during her examination, Petitioner's straight leg raising on the left and right was "not to specific." She stated that although a positive straight leg test can be a sign of a herniated disk, a positive straight leg raise at 80 degrees is not significant for a herniated disk. She stated that overall, Petitioner's examination showed fairly non-specific findings that did not fit into a specific distribution of any nerve root.

Dr. Wehner reviewed Petitioner's MRI from October 3, 2016. She opined the MRI demonstrated findings at L4-L5 was a minor finding consistent with a 51-year old male. At L5-S1, she noted there was some disc desiccation and decreased height as well as a 6 millimeter focal left paracentral disc extrusion with slight inferior extension indenting the thecal sac and causing obliteration of the left lateral recess. She opined this could cause pain but would require clinical correlation. Regarding the EMG performed on March 17, 2017 Dr. Wehner stated, "[t]he EMG showed right-sided symptoms which if there was any positive finding on the MRI,…it was on the left, it was L5-S1. It was a radiologic finding that would be possibly a pain generator. And the EMG showed that there was a finding on the right opposite of what the MRI did. It showed there was nothing going on on the left as far as any type of radiculopathy or a nerve irritation."

Dr. Wehner diagnosed Petitioner with back pain and bilateral leg pain with a radiographic finding of left paracentral disc extrusion of L5-S1. She felt that Petitioner's subjective complaints (bilateral leg pain) did not correlate with an L5-S1 disc herniation. She stated his clinical examination showed mildly positive straight leg raising which was not specific for L5-S1 pathology since it was positive bilaterally. She stated that since Petitioner's subjective complaints in the EMG did not correlate with his radiographic findings, it was not clear that Petitioner's complaints had any relationship to the abnormal MRI findings. She noted that it's well documented that disc herniations could be present in asymptomatic individuals. When asked, "[f]or a left-sided disc herniation, what kind of symptoms if a person had radicular symptoms in the left leg, what would you expect." The doctor replied, "[p]ositive straight leg raising and pain radiating down the back and outside of their leg down to the lateral side of their foot." Dr. Wehner stated it was impossible to date the abnormality on the MRI. She noted that because Petitioner reported some prior lower back pain, the MRI abnormality could have been present prior to August 2016. In her first report, Dr. Wehner declined to provide a causal relationship opinion indicating that because Petitioner reported prior back problems, she wanted to review any prior records to see if there was a more significant preexisting condition. She also wanted to see Petitioner's physical therapy records.

Dr. Wehner reviewed additional medical records following her IME, which included physical therapy records as well as further recommendations from Dr. Dixon. Dr. Wehner testified that she strongly recommended against any type of surgery. The doctor reasoned that Petitioner's clinical findings did not correlate with the MRI abnormality. The doctor indicated that although she did not review any prior medical documentation, Petitioner had a preexisting condition. Dr. Wehner acknowledged that her clinical examination did note some right leg pain and same could be consistent with the EMG findings. She agreed that Petitioner's presentation to Illinois Orthopedic Network was "somewhat initially" consistent with his MRI noting he was complaining primarily of left leg pain but later began complaining of right sided symptoms. The doctor did not

believe Petitioner had failed conservative care "...because the symptoms he is complaining of are not verified with the clinical exam....because there is portions of it that truly do not appear very valid at all."

The Arbitrator is persuaded by the opinions expressed by Petitioner's treating physician, Dr. Dixon. The doctor opined that based on the accident and history provided, a causal relationship exists between Petitioner's ill-being and the reported accident. Dr. Dixon noted Petitioner's initial presentation when he had a profoundly straight leg raise on the left side and that he was in fact complaining of left-sided complaints predominantly. He disagreed with the suggestion that the L4-5 disk is small and would not correlate with his pain complaints as that was the level that was found to be positive on the EMG. Dr. Dixon added that Petitioner complained of left greater than right-sided pain. He stated that Petitioner's complaint, the findings on examination as well as his interpretation of the MRI and EMG all correlated and were consistent. Dr. Dixon opined that the MRI findings were consistent with Petitioner's demonstrated symptoms and his injury. Dr. Dixon acknowledged that the EMG results was abnormal suggesting evidence of chronic severe right sided radiculopathy. Dr. Dixon testified that not having a positive EMG on the left, despite the findings of Petitioner's MRI and physical examination, was not inconsistent. The doctor indicated there was nothing inconsistent with Petitioner's entire presentation.

Although Dr. Wehner felt Petitioner's reported symptoms did not appear to be valid because they were not verified with her clinical exam, she acknowledged that her clinical examination did note some right leg pain and same could be consistent with the EMG findings. She agreed that Petitioner's presentation to Illinois Orthopedic Network was "somewhat initially" consistent with his MRI noting he was complaining primarily of left leg pain. When asked, "[f]or a left-sided disc herniation, what kind of symptoms if a person had radicular symptoms in the left leg, what would you expect." The doctor replied, "[p]ositive straight leg raising and pain radiating down the back and outside of their leg down to the lateral side of their foot." She also felt Petitioner's treatment had been reasonable and necessary. The doctor also appeared to be non-committal regarding her causal relationship opinion. In her initial report, Dr. Wehner declined to provide a causal relationship opinion indicating that because of Petitioner's reported prior back problems she wanted to review any prior records to see if there was a more significant preexisting condition. In her subsequent report, the doctor noted that she did not review prior medical records. She did not provide a concrete causation opinion stating Petitioner had a preexisting condition. Her opinion is ambiguous and not convincing.

Based on all the above, the Arbitrator finds that a causal relationship exists between Petitioner's low back condition and the accidents sustained on August 26, 2016 and August 29, 2016.

<u>With respect to issue J.) Were the medical expenses reasonable? Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:</u>

Incorporating the Arbitrator's finding in Paragraph C.) Accident and Paragraph F.) Causal Connection, the Arbitrator awards the following medical expenses:

PX 1	Illinois Orthopedic Network	$13,775.88
PX 2	South Suburban Physical Therapy	$5,327.87
PX 3	Metro Health Solutions	$9,739.73
PX 4	Metro Anesthesia Consultants	$3,479.78
PX 5	IWP	$35.27
PX 6	Premium Healthcare Solutions	$2,486.00
PX 7	Nova Pharmacy	$71.53
PX 8	Midwest Specialty Pharmacy	$4,104.92
PX 9	Chicago Lipo Laser, LLC	$4,350.00

Respondent shall pay the above referenced medical expenses as provided in Sections 8(a) and 8.2 of the Act.

With respect to issue K.) Is Petitioner entitled to prospective medical care, the Arbitrator finds as follows:

Dr. Dixon diagnosed Petitioner with a herniated disc at L4-L5 and L5-S1 with associated radiculopathies at both L4-5 and L5-S1. The doctor opined that all conservative treatment options were attempted and Petitioner's symptoms were refractory. As a result, the doctor recommended Petitioner undergo surgery at L4-L5, L5-S1, microlumbar decompression and discectomy. Having found Dr. Dixon's opinions persuasive, the Arbitrator finds that Respondent shall authorize and pay the reasonable costs per the fee schedule of said surgery and post-operative care.

With respect to issue L.) What temporary benefits (TTD) are in dispute, the Arbitrator finds the following:

Petitioner request temporary total disability commencing August 30, 2016. Records submitted show Petitioner initially sought treatment at Illinois Orthopedic Network (ION) where he saw Dr. Chunduri on September 6, 2016. At that time, the doctor authorized Petitioner off work. Both Dr. Chunduri and Dr. Dixon continued to authorize Petitioner's off work status. Incorporating the Arbitrator's findings in Paragraph F., the Arbitrator finds Petitioner was temporarily and totally disabled from September 6, 2016, the day he first saw Dr. Chunduri, through the date of arbitration or June 21, 2018, a period of 93-3/7 weeks.

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 PEORIA	)	☒ Reverse ☐ Other (explain) Ex Parte Hearing	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NICOLE STRAKER,

Petitioner,

vs. NO: 16 WC 14172

SUBWAY,

19IWCC0269

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/ee relationship, accident, notice, causation, benefit rate, wage calculations, medical expenses, nature and extent, and penalties and fees, and being advised of the facts and law, vacates the Decision of the Arbitrator as stated below and remands this matter to the Arbitrator for a new trial.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1) Petitioner filed an Application for Adjustment of Claim on May 5, 2016.

2) On August 5, 2016, Petitioner's attorney sent a Notice of Motion and Order to Respondent setting this case on the Peoria docket for October 12, 2016. It was received by Respondent on August 11, 2016, as indicated by the copy of the certified mail return receipt that is in evidence. *T.9, Px3.*

3) Nobody appeared for Respondent on October 12, 2016, so Petitioner's attorney sent another letter to Respondent on October 18th, attaching a Request for Hearing form to be heard at the January 11, 2017 Peoria docket. This was sent by certified mail return receipt requested and was received by Respondent on October 22, 2016. *Id.*

4) Nobody appeared for Respondent on January 11, 2017, so Petitioner's attorney sent a third letter to Respondent, on January 20, 2017, and included a Notice of Motion and Order that contained Arbitrator Gallagher's order, dated January 18, 2017, stating:

    X – Set for trial (date certain) on "4/10/2017 Peoria Call
    Default if no one appears for Respondent"

    This letter was received by Respondent on January 24, 2017. *T.10, Px.3.*

5) On April 12, 2017, the Arbitrator noted on the record that nobody appeared on Respondent's behalf at the call on April 10th, and stated, "we are going to proceed to a default judgment at this time." *T.11.* An *ex parte* trial was then held.

6) Arbitrator Gallagher issued a decision on May 23, 2017.

7) Respondent filed a timely Petition for Review on June 22, 2017.

Although Petitioner gave timely notice to Respondent of the Arbitrator's order that the case was set for a trial date certain on April 10, 2017, the hearing did not actually proceed on that date. Rather, the trial was held on April 12, 2017. We find that, pursuant to Commission Rule 9030.20(c)(2), since Respondent was not given proper notice of the actual date that the *ex parte* trial would take place this was a violation of due process.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision, filed May 23, 2017, is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for a new trial.

IT IS FURTHER ORDERED BY THE COMMISSION that this decision is interlocutory and no review may be taken.

DATED: MAY 30 2019

D. Douglas McCarthy

Stephen J. Mathis

L. Elizabeth Coppoletti

SE/
O:
52

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STRAKER, NICOLE
Employee/Petitioner

Case# **16WC014172**

19IWCC0269

SUBWAY
Employer/Respondent

On 5/23/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0724 JANSSEN LAW CENTER
MATTHEW A BREWER
333 MAIN ST
PEORIA, IL 61602

0000 SUBWAY
1800 N KNOXVILLE AVE
PEORIA, IL 61603

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Nicole Straker
Employee/Petitioner

v.

Subway
Employer/Respondent

19IWCC0269

Case # 16 WC 14172

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Peoria, on April 12, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On September 19, 2015, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury Petitioner earned $26,000.00; the average weekly wage was $500.00.

On the date of accident, Petitioner was 23 years of age, single with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $0.00for 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 6, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner permanent partial disability benefits of $300.00 per week for 37.5 weeks because the injuries sustained caused the seven and one-half percent (7 1/2%) loss of use of the person as a whole as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner attorneys' fees of $1,822.70, as provided in Section 16 of the Act and penalties of $9,113.50, as provided in Section 19(k) of the Act. Petitioner's petition for Section 19(l) penalties is denied.

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

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

William R. Gallagher, Arbitrator

May 18, 2017
Date

MAY 23 2017

Petitioner was subsequently seen by Dr. Brett Miller, her family physician, on December 9, 2015. Petitioner informed Dr. Miller of the accident of September 19, 2015, and he ordered that the blood tests be performed again. That set of blood tests were also negative (Petitioner's Exhibit 5).

Petitioner was subsequently seen by Dr. Miller on October 27, 2016. Blood tests were ordered by Dr. Miller which were again negative (Petitioner's Exhibit 5). This was the last time Petitioner was seen by Dr. Miller for issues related to the accident of September 19, 2015.

At trial, Petitioner testified that coming into contact with the syringe has had a significant effect on her life. In spite of the fact that all of the blood tests have been negative, Petitioner remains fearful that she may have contracted a disease. Petitioner stated she exercises extreme caution whenever she has a cut or open wound because she is concerned about transferring anything she may have contracted to either her fiancé or stepson. Petitioner testified that her concern about possibly contracting the disease has caused an increase in her anxiety and has had a lasting effect on her emotional state. Further, Petitioner was studying to become an RN at the time of trial so she does have knowledge regarding anatomy, transmission of diseases, etc.

Conclusions of Law

In regard to disputed issues (A), (B), (C), (D), (E), (F), (G), (H) and (I) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes that on September 19, 2015, Petitioner and Respondent were operating under the Illinois Workers' Compensation Act and that there was an employer/employee relationship at that time.

The Arbitrator further concludes that on September 19, 2015, Petitioner was 23 years old, single without dependence, had an average weekly wage of $500, that Petitioner sustained an accidental injury arising out of and in the course of her employment for Respondent, that Respondent was provided with notice of said accident and that Petitioner's current condition of ill-being is causally related to the accident.

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and that Respondent is liable for payment of the medical bills incurred there with.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 6, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of seven and one-half percent (7 1/2%) loss of use of the person as a whole.

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment for Respondent on September 19, 2015. According to the Application, Petitioner was "Poked by a needle throwing away trash" and sustained an injury to the "Left arm, MAW). The Application was filed with the Commission on May 4, 2016 (Petitioner's Exhibit 1).

There has been no Entry of Appearance filed on behalf of the Respondent. On August 5, 2016, Petitioner's counsel sent, via certified mail/return receipt requested, a "Request for Hearing" to Respondent setting this case for trial on the Peoria docket on October 12, 2016. On that date, no one appeared on behalf of Respondent and the case was continued to the Peoria docket of January 11, 2017. On October 18, 2016, Petitioner's counsel sent, via certified mail/return receipt requested, another "Request for Hearing" to Respondent setting the case for trial on the Peoria docket on January 11, 2017. Once again, on that date, no one appeared on behalf of Respondent (Petitioner's Exhibit 3).

When the case was set on the Peoria docket on January 11, 2017, the Arbitrator entered an Order setting the case for a trial date certain on the Peoria docket on April 10, 2017. The Order specifically stated that a default would be heard at that time if no one appeared for Respondent. On January 20, 2017, Petitioner's counsel sent another "Request for Hearing" to Respondent along with the Arbitrator's Order of January 11, 2017, setting this case for a trial date certain on April 10, 2017 (Petitioner's Exhibit 3). No one appeared on behalf of Respondent on April 10, 2017, so the case was tried as a default hearing.

At trial, Petitioner testified that she worked for Respondent as a crew member for approximately five years. Petitioner stated that at the time of the accident, she was 23 years old, single, had no dependents and had an average weekly wage of $500.00.

In regard to the accident of September 19, 2015, Petitioner testified she was in the process of taking out the trash. She had just removed the trash from the women's restroom and placed it in a large plastic garbage bag. When Petitioner was in the process of putting the garbage bag in the dumpster, a hypodermic needle protruded from the bag and poked Petitioner's left arm.

Petitioner reported the accident to the store manager, Jen Servis. A handwritten report was prepared which noted Petitioner was scratched with a dirty syringe while taking out the bathroom trash. This report was signed both by Petitioner and Jen Servis (Petitioner's Exhibit 2).

Following the accident, Petitioner went to the ER of St. Francis Medical Center. At that time, Petitioner advised how she sustained the injury and it was noted Petitioner had a superficial scratch to the left anterior forearm. Various blood tests were performed for hepatitis, HIV and other blood borne pathogens. The tests were all negative and Petitioner was discharged (Petitioner's Exhibit 4).

Petitioner returned to the ER of St. Francis Medical Center on October 8, 2015. The blood tests were repeated and they were again negative (Petitioner's Exhibit 4).

In support of this conclusion the Arbitrator notes the following:

An AMA impairment rating was not tendered into evidence at trial. The Arbitrator gives this factor no weight.

At the time of the accident, Petitioner was a crew member for Respondent; however, at the time of trial, Petitioner was studying to become and are and. Arbitrator gives this factor moderate weight.

Petitioner was 23 years old at the time of the accident will have to live with the anxiety and fear that she has as a result of this accident for the remainder of her life. The Arbitrator gives this factor significant weight.

There was no evidence that the injury had any effect on Petitioner's future earning capacity. The Arbitrator gives this factor no weight.

The medical records contained a history of the accident which was consistent with Petitioner's testimony regarding same. Numerous blood tests have been performed and while they have all been negative, Petitioner's anxiety and fear of a possible infection is reasonable. The Arbitrator gives this factor significant weight.

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

The Arbitrator concludes this Section 19(k) penalties of $9113.50 and Section 16 attorneys' fees of $1822.70, should be imposed upon Respondent, but that Section 19(l) penalties should not be imposed upon Respondent.

In support of this conclusion the Arbitrator notes the following:

The total amount of the medical bills incurred by Petitioner was $6977.00 in the amount of permanent partial disability awarded by the Arbitrator to Petitioner was $11,250.00, seven and one-half percent (7 1/2%) loss of use of the person as a whole, 37.5 weeks at $300.00 per week. These total $18,227. Respondent was aware of the fact that Petitioner has sustained a work related accident and the circumstances of same on the day it occurred. Respondent was subsequently notified of the filing of an Application for Adjustment of Claim and provided with notices of Petitioner's counsel intentions to proceed to trial. In the order signed by the Arbitrator on January 11, 2017, setting this case for trial date certain on April 10, 2017, it clearly and unequivocally stated that if no one appeared on half of Respondent, the case would proceed to a default hearing.

Respondent paid nor the of four stated notices and shows not to have anyone appear on its a half our present any defense. The Arbitrator finds the actions of Respondent to be unreasonable in vexatious and awards Section 19(k) penalties of $9113.50 which is 50% of the total medical and permanent partial disability awarded.

As aforestated, Petitioner incurred medical expenses of $6977.00; however, there was no evidence tendered that a demand for payment of the medical bills was tendered to Respondent that would have subsequently mandated payment by Respondent of Section 19(l) penalties.
The Arbitrator also imposes Section 16 attorneys' fees on Respondent in the amount of $1822.70, 20% of the Section 19(k) penalties.

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	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JORGE OROZCO,

Petitioner,

vs. NO: 11 WC 015990

BRICKMAN LANDSCAPING,

Respondent.

19IWCC0270

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 5, 2018 is hereby affirmed and adopted.

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

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

The 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: MAY 3 0 2019
o050719
DS/bsd
046

Deborah Simpson

Thomas J. Tyrrell

Maria Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OROZCO, JORGE
Employee/Petitioner

Case# **11WC015990**

BRICKMAN LANDSCAPING
Employer/Respondent

19IWCC0270

On 6/5/2018, 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 2.07% 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:

0293 KATZ FRIEDMAN EAGLE ET AL
TIMOTHY WINSLOW
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
AUKSE R GRIGALIUNAS
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jorge Orozco
Employee/Petitioner

Case # **11** WC **15990**

v.

Consolidated cases: _____

Brickman Landscaping
Employer/Respondent

19IWCC0270

An *Application for Adjustment 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 **05-07-18**. 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. [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. [ ] What were Petitioner's earnings?
H. [ ] What 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 **Two-doctor chain of referrals.**

FINDINGS

On **4/19/2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 $**17,160.00**; the average weekly wage was $**330.00**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**220.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**220.00**.

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

ORDER

The petitioner failed to prove that he sustained an accident arising out of and in the course of his employment on April 19, 2011. All relevant medical records indicate an incident date of April 20, 2011, and the petitioner's accident histories vary to such a degree that no accident can be found. Furthermore, the petitioner failed to prove that his conditions as relate to his right knee and low back are causally related to the injury. As such, all other issues are moot and no benefits are awarded. See attached Findings of Fact and Conclusions of Law.

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

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

Signature of Arbitrator

06-04-18
Date

JUN 5 - 2018

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jorge Orozco,	)	
	)	
Petitioner,	)	
	)	
vs.	)	No. 11 WC 15990
	)	
Brickman Landscaping,	)	
	)	
Respondent.	)	19IWCC0270

DECISION OF THE ARBITRATOR

FINDINGS OF FACT

The petitioner testified that he did not recall when he was hired, however he stated that on April 19, 2011 he was working for Brickman Landscaping. He stated that he earned minimum wage and worked about 4-5 days per week about 10 hours per day. He stated that his job was to help people do whatever he was asked to do.

On April 19, 2011 the petitioner testified that he was moving cement blocks in a parking lot and he felt something pull in the back of his right knee. He also testified that he started to have pain into his low back. He stated that he continued to work, but could not put weight on his right leg and so he told his boss and stayed in the truck for the rest of the shift. The petitioner stated that the blocks weighed about 70 pounds and he was moving them for about 2-3 hours. He stated that he went home and then went to the hospital the next day. He stated that he never had any problems with his right knee before this.

According to the records from Fahey Medical, however, the petitioner was seen there on July 21, 2008 complaining of bilateral knee pain, indicating pain in the back of the knees (the same location as his complaints in April of 2011) following a fall when walking up the stairs. (PX 1) In fact, an x-ray was performed on July 29, 2008 indicating suprapatellar joint effusion. On August 11, 2008 the petitioner returned complaining of right knee pain. (PX 1)

According to the Application for Adjustment of Claim, the petitioner stated that he was injured on April 19, 2011 while "Carrying buckets in and out of truck." (RX 1) This Application was signed by the petitioner on April 25, 2011, just 5 (or 6) days following the alleged incident.

Following the alleged incident, the petitioner presented to Northwest Community Hospital in the emergency room on April 21, 2011. (PX 4) At that time, the accident history that was noted was that the petitioner reported, "since with 3 pm yest with twisting at work moving bricks yesterday". This would specifically place the accident date on April

20, 2011. Petitioner's last day of work with Respondent was the 19th. An x-ray was performed at that time which showed acute right knee effusion – the same diagnosis as in 2008. (PX 4)

The petitioner came to see Dr. Levin at Barrington Orthopedics on April 28, 2011. (RX 4) At that time, Dr. Levin indicated that the petitioner stated that on April 20, 2011 he was "dumping garbage cans and had to move a parking cement block. At that time, he felt pain over the posterior aspect of his right knee with a pulling. He felt that with any twisting he had pain." (RX 4) According to the evaluation form dated May 2, 2011, it stated that the petitioner had a "R knee injury at work 4/20/11. Progressing worse through the work day." (RX 4) The petitioner followed up with Dr. Levin following obtaining an MRI on May 1, 2011. (RX 4) Dr. Levin stated that the MRI showed chronic changes with no acute changes. He stated that the petitioner may have a ruptured Baker's cyst, which he stated was a "pre-existing, chronic condition. It is based strictly on his report of an alleged work injury that there is any association with that potentially occurring, because ruptured Baker's cysts do occur in the general population without any traumatic episodes." (RX 4)

On May 9, 2011, Dr. Levin indicated that the petitioner presented with his knee brace on and was walking normally into the exam room. However, when asked to walk during the exam, "Initially he walked shifting, leading with the right leg, but then his gait changed in a non-physiologic manner and eventually he did develop a normal, reciprocal gait" (RX 4) Dr. Levin went on to say that he has inconsistencies noted in his exam and his subjective complaints of pain did not correlate with the objective pathology relating to any type of work injury. Dr. Levin placed the petitioner at full duty and at MMI on May 9, 2011. (RX 4)

On May 24, 2011, the petitioner was seen by Dr. Morgan at Chicago Pain and Orthopedic Institute. At that time, the petitioner reported that on April 20, 2011, he was at work, "moving a number of concrete blocks that weighed 60-70 pounds. He relates that after he finished doing that, he was then walking up the stairs when he had the onset of pain in his right knee." (PX 2) At that time, it was stated that the petitioner was provided medications by Dr. Christ and should continue with modified work restrictions.

The petitioner eventually came to see Dr. Markarian on May 31, 2011. Dr. Markarian testified that the petitioner was a male landscaper who injured himself on April 20, 2011 while moving concrete blocks. He stated that he twisted his knee and experienced an acute onset of pain. He stated it was in his right knee and the petitioner denied prior history of right knee pain. (PX 19, p. 12)

The petitioner underwent an IME at the request of the respondent with Dr. Verma on June 29, 2011. Dr. Verma stated in his testimony that on April 20, 2011, the petitioner stated that "he was stacking some parking blocks . . . after he was completed with that, he was walking and felt some tightness in the posterior aspect of the knee. He did not describe any injury mechanism, such as a fall, trauma, twisting event, et cetera." (RX 3, p. 7) Regarding the accident history, Dr. Verma stated that:

> I would point out that the initial injury records were consistent with my history obtained, in that the patient didn't report any specific history of injury or trauma; that the initial MRI scan did not show any significant intra-articular pathology other than a posterior Baker's cyst; and that Dr. Levin evaluated the patient, felt that he may have had some leakage of the Baker's cyst but otherwise no internal derangement and released him at full-duty status; also noting that he had evidence of symptom magnification or inconsistent presentation on examination. (RX 3, p. 9)

Dr. Verma diagnosed the pre-existing osteoarthritis and did not find evidence of any acute injuries. He indicated the petitioner's symptoms were unrelated to the work injury. He agreed with Dr. Levin's opinions that the petitioner could work full duty and did not need any further treatment. Dr. Verma testified that there were several reasons as to why the petitioner's condition was not related to the alleged work incident. He stated that:

> A, I did not see a mechanism of onset that would be consistent with meniscal pathology or other internal derangement; B, the MRI scan did not disclose any acute or traumatic injury; C, his examination was essentially normal with distracted testing; and D, his . . . x-rays and MRI scan clearly showed a preexisting degenerative condition." (RX 3, p. 12-13)

He stated that any activity could cause symptoms with arthritis. Finally, he opined that a 40-20 millimeter osteochondral lesion is very large and it would be a degenerative finding. (RX 3, p. 14)

The petitioner underwent surgery at the hands of Dr. Markarian on July 21, 2011 in the form of a right knee arthroscopy and partial medial menisectomy with chondroplasty. The operative report body did note, however, that the petitioner's meniscus was intact in contraindication to what was written as to the procedures performed! (PX 19) The day after the surgery, Dr. Markarian was already recommending another surgery in the form of a medial femoral condyle resurfacing. (PX 19)The petitioner did undergo surgery in the form of a medial femoral condyle resurfacing on December 1, 2011. The petitioner then began restarted physical therapy at Grandview Health Partners. (PX 2)

The petitioner underwent an FCE on March 27, 2012 indicating that he can perform at the medium to heavy physical demand level which was within his work duties for Brickman Landscaping. (PX 15) On May 15, Dr. Markarian indicating that the petitioner could return to work pursuant to his FCE restrictions. (PX 19)

The petitioner returned to Dr. Markarian on June 12, 2012 complaining of pain in his SI joint, and the petitioner was provided with an SI joint injection. (PX 19) The petitioner was referred for pain management in the SI joint. The petitioner was seen by Dr. Lewis at the Chicago Pain & Orthopedic Institute on June 19, 2012, and was referred for an MRI of his lumbar spine and was released to return to work with restrictions. (PX

7) An MRI was performed on June 26, 2012 which showed central disc herniations at L4-L5 and L5-S1 central bulge at T12 to L1.

According to Dr. Lewis' notes dated July 3, 2012, the petitioner reported an injury of April 20, 2011 indicating that he was moving concrete blocks, and stated that "he stepped forward while stepping on a concrete block and it caused pain immediately in part of his right knee." (PX 7) Petitioner reported that he tried to walk again and felt the pulling sensation pain in the posterior aspect of the knee. Allegedly, the petitioner started to develop low back pain in therapy on the right side. The petitioner underwent a course of injections on July 17, 2012 and July 31, 2012. (PX 7)

The petitioner was then seen by Dr. Markarian on August 7, 2012 stating that he was walking with a limp and complains of pain in the SI joint. (PX 19) He was placed off of work at that time. The petitioner underwent an L5-S1 medial branch block and S1-S3 lateral branch block on August 9, 2012. (PX 7) On October 30, 2012 the petitioner was referred for another FCE. This was performed at Associated Medical Centers of Illinois on December 5, 2012 which showed that the petitioner could work at the medium physical demand level. (PX 6) The petitioner was placed at MMI by Dr. Markarian on December 10, 2012. (PX 19)

The petitioner was seen by Dr. Lorenz on May 2, 2013 at Hinsdale Orthopedics and Dr. Lorenz indicated that the petitioner's back pain was not due to a work injury, but he referred the petitioner back to Dr. Jain for additional facet joint injections and released the petitioner to return to full duty work at that time. (RX 5)

The petitioner was scheduled for a Section 12 exam at the request of the respondent on August 14, 2014 with Dr. Butler. (RX 2) The petitioner reported to Dr. Butler that he began to have lower back pain at the time of the April, 2011 injury, and got worse in June of 2012 after completing therapy for the knee. (RX 2, p. 9, Dep. Ex. 2) Dr. Butler stated that this was inconsistent with the medical records that he reviewed because low back pain was not documented anywhere in the medical records, especially at the time of the incident in April of 2011. (RX 2, p. 10) Dr. Butler stated that there was no causal relationship between the low back condition and the work injury because there was no documentation of any low back issues until 14 months after the first report of injury. (RX 2, p. 14) He also stated that it was not reasonable to opine that the low back issued had anything to do with an altered gait post-surgically, because he would have had crutches and other devices to normalize his gait. (RX 2, p. 14)

The petitioner testified that since the injury and his treatment, he has gone back to work for a drywall company. He stated, however, that he can no longer dance, play soccer, go upstairs, or run. He stated that at the end of the day after working all day, his knee would be swollen and he would have cramping and pain. This goes away every evening and then he is able to go to work the next day. The petitioner stated that he has had no other accidents to his low back or right knee.

CONCLUSIONS OF LAW

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

The petitioner claims that he injured his right knee while working for the respondent on April 19, 2011. The Arbitrator finds that the petitioner did not prove that he sustained an accident arising out of and in the course of his employment for the respondent. In so finding, the Arbitrator relies on the following facts:

Primarily, there are multiple and varying accident histories contained throughout the medical records, the petitioner's testimony and the Application for Adjustment of Claim. It is noted that the petitioner is not a very good historian, and he was unable to recall how long he worked for the respondent before the incident, could not remember the names of his treating doctors, IME doctors or dates of treatment, and could not, with any specificity, even describe his job duties for the respondent. The petitioner also stated to his physicians, and during testimony, that he never had any prior problems with the right knee. This is inconsistent with the medical records from Fahey Medical indicating that he had right knee pain and problems after a fall in 2008. (PX 1)

While the action of moving concrete blocks or bricks appears and reappears somewhat consistently throughout the records, what is inconsistent is how and when the petitioner actually injured his knee. The accident histories contained in the record are as follows:

1. The petitioner testified that his right knee started hurting when he was moving concrete blocks over the course of several hours. He did not testify as to a single incident of trauma of any kind.

2. The Application for Adjustment of Claim dated April 25, 2011 states that the petitioner was "carrying buckets in and out of truck." (RX 1) The petitioner testified that he told the truth on this Application.

3. The Northwest Community Hospital emergency room records on April 21, 2011 stated that the accident history reported was that the petitioner reported, "twisting at work moving bricks 3 pm. yesterday". (PX 4)

4. The fourth accident history report to Dr. Levin was on April 28, 2011. (RX 4) The accident history was that on April 20, the petitioner was "dumping garbage cans and had to move a parking cement block. At that time, he felt pain over the posterior aspect of his right knee with a pulling. He felt that with any twisting he had pain." (RX 4)

5. The fifth accident history was reported to Dr. Morgan on May 24, 2011, when the petitioner reported that on April 20, 2011, he was at work, "moving a number of concrete blocks that weighed 60-70 pounds. He relates that after he finished doing that, he was then walking up the stairs when he had the onset of pain in his right knee." (PX 2)

6. The petitioner reported to Dr. Markarian on May 31, 2011 that he twisted his knee when moving concrete blocks. (PX 19)

7. The seventh accident history was provided to Dr. Verma on June 29, 2011. The petitioner told him that "he was stacking some parking blocks . . . after he was completed with that, he was walking and felt some tightness in the posterior aspect of the knee. He did not describe any injury mechanism, such as a fall, trauma, twisting event, et cetera." (RX 3, p. 7)

8. According to Dr. Lewis' notes dated July 3, 2012, the petitioner reported an injury of April 20, 2011 indicating that he was moving concrete blocks, and stated that "he stepped forward while stepping on a concrete block and it caused pain immediately in part of his right knee." (PX 7)

Petitioner's eight histories are somewhat consistent, indicating that he was moving concrete blocks or bricks or buckets on April 20, 2011, the mechanisms of injury reported are all divergent and there was never any really any meaningful explanation for the discrepancies. There are many mechanisms of injury reported such as twisting during the moving of the blocks, pain with twisting after the blocks had already been moved, stepping forward, simple walking, and walking up the stairs. Most of these histories indicate some type of benign movement following the moving of the blocks, bricks or buckets. The petitioner did not testify to a single incident of trauma. Indeed, he stated that when he was moving cement blocks in a parking lot, something pulled in the back of his right knee. He stated that this occurred while he was moving the blocks for about 2-3 hours.

It is the petitioner's burden to prove every element of their claim. In a case where no two histories are exactly alike, the Arbitrator may make reasonable inferences regarding what, indeed, might or could have occurred. In this case, however, while the petitioner's activities throughout the day remain somewhat consistent throughout the records, what he was doing when the actual onset of pain occurred is unclear. As such, it is impossible to state, based on the preponderance of the evidence, that the petitioner sustained an accident arising out of and in the course of his employment, as most of the actual mechanisms of injury involve something that does not rise to the level of being at a risk greater than the general public. If the petitioner's knee began hurting AFTER the moving or lifting or whatever he was doing with the concrete blocks or bricks, and he was simply walking or stepping up, or standing, this would not rise to the level of arising out of his employment. Unfortunately, the records provide nearly eight different explanations as to what the petitioner was doing at the moment his right knee began to hurt.

Therefore, the Arbitrator finds that the petitioner did not sustain an accident arising out of or in the course of his employment.

WITH RESPECT TO ISSUE D, WHAT WAS THE DATE OF THE ACCIDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Assuming that the petitioner was able to prove an accident history, a mechanism of injury, or that he sustained an accident arising out of or in the course of his employment, the petitioner failed to prove that he sustained an injury on April 19, 2011. While this is the date that is contained on the Application for Adjustment of Claim and the Request for Hearing form (Arb. Ex. 1), there is no single medical record on or near the accident date that supports this date of injury. Every medical record indicates that the petitioner had an incident on April 20, 2011. The Northwest Community Hospital records dated April 21, 2011 indicated that the petitioner was injured "3 pm. yesterday" pinpointing the date to April 20, 2011. (PX 4) The petitioner reported to Dr. Levin, Dr. Verma, Dr. Markarian and Dr. Morgan that he was injured on April 20, 2011. Not knowing when the accident was allegedly sustained makes the petitioner's testimony not credible.

Therefore, since there are no records supporting an accident date of April 19, 2011, and the petitioner's testimony was not credible, the Arbitrator finds that the petitioner did not sustain an accident while working for the respondent on that date.

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

Even if the petitioner sustained an accident arising out of and in the course of his employment on April 19, 2011, the petitioner must also prove that his current condition of ill-being is causally related to the injury. The Arbitrator finds that the petitioner failed to prove that his current condition of ill-being with regards to his right knee and low back are causally related to the injury. The Arbitrator relies on the following facts in support of his decision:

A. Right knee

First, the initial medical records from Dr. Levin do not support causation. The petitioner underwent an initial MRI on May 1, 2011 which was relatively benign apart from a possibly ruptured Baker's cyst. (RX 4) The petitioner demonstrated non-organic pain behaviors and Dr. Levin indicated that the petitioner's condition was not related to work. (RX 4)

Second, the Arbitrator finds the opinions of Dr. Verma to be more credible than those of Dr. Markarian for several reasons. First, Dr. Verma testified credibly as to the petitioner's right knee pathology and how it was degenerative in nature. He stated that the onset of pain could have occurred with any activity, and that he specifically discussed in great deal the petitioner's accident history and mechanism of accident with him. (RX 3, p. 7, 9) Indeed, it seems as though the petitioner was confused as to what activity actually caused his right knee pain, having reported several different mechanisms of injury to various physicians. Dr. Verma indicated that none of the pathology in the petitioner's right knee was acute or traumatic in nature, and that all findings were degenerative in nature,

and would have progressed over a long period of time. (RX 3, p. 12-13) This coincides with the petitioner's medical records indicating that he initially had an onset of knee pain in 2008. (PX 1) Finally, Dr. Verma was able to review all of the petitioner's medical records in determining causation, and used those records and histories provided to other physicians as a basis for his opinions. (RX 3, p. 8)

Dr. Markarian's opinions are less credible than Dr. Verma's for several reasons. First, Dr. Markarian stated that he did not review any of the petitioner's medical records. (PX 19, p. 27-9) He stated that he was not aware of any of the other accident histories contained in those records. (PX 19, p. 32-33) Dr. Markarian also seems to have a keen interest to knee cartilage resurfacing procedures. At his deposition he presented posters about a study that he did regarding "second looks with the inlay resurfacing". (PX 19, p. 6-7). He also performed a study specifically relating to workers' compensation patients and success rates regarding inlay resurfacing, which is a procedure that Dr. Markarian specializes in. (PX 19, p. 7) Indeed, while the petitioner's initial surgery on July 21, 2011 was an arthroscopy, partial medial menisectomy and chondroplasty, the very next day, on July 22, 2011, Dr. Markarian recommended the inlay resurfacing procedure that he was studying and presenting papers on. (PX 19) Dr. Markarian stated that, "we have a very good track records of flipping these cases that failed arthroscopy to 91 per cent returning to work." (PX 19, p. 17) Dr. Markarian recommended this second procedure the day after the arthroscopy. (PX 19) It is curious that he would recommend a procedure the day after a surgery, not knowing what the outcome might be, not only that, but a procedure that he was specifically studying and writing papers on.

Based on the above, the Arbitrator finds that the petitioner did not prove that his right knee condition was causally related to the injury in question.

B. Low Back

The Arbitrator finds that the petitioner's low back condition is not causally related to the injury in question. In support of same, the Arbitrator relies on the following facts:

First, while the petitioner testified that he injured his low back on April 19, 2011, there is not one single medical record that supports a history of low back pain for over a year following April 19, 2011. June 12, 2012 was the first time the petitioner complained of low back pain to any of his physicians. (PX 19) This was shortly after the petitioner completed an FCE and was released to return to work and placed at MMI for his right knee.

Second, the primary causation opinion that the petitioner relies upon is that of Dr. Markarian. He stated that the petitioner developed an SI joint problem due to problems with his gait post-surgically. (PX 19, p. 19) The petitioner, however, did not make any complaints about his back or SI joint area until after he was released from treatment by Dr. Markarian. There were no gait issue complaints during physical therapy treatments or in any medical record or treatment record during the petitioner's post-surgical recovery. Dr. Markarian indicated that he does not primarily treat the lumbar spine or SI joints. (PX

19, p. 37) Additionally, most of the petitioner's low back treatment was not actually to his SI joint. He underwent epidural steroid injections and facet injections and radiofrequency ablations at the levels of L4-S1 in his lumbar spine. Apart from two SI joint injections on July 20, 2012 and August 9, 2012, all other treatment was directed towards his lumbar spine and discs. (PX 7)

Further, Dr. Butler, a board certified orthopedic surgeon specializing in the lumbar spine, indicated that the surgery would not have caused gait problems because he would have used assistive devices such as crutches or a brace in order to alleviate any type of gait issues. (RX 2, p. 14) Dr. Butler credibly testified that due to the significant gap in treatment (14 months) the low back issues were not causally related to the injury, either directly or indirectly. (RX 2, p. 14)

Finally, Dr. Lorenz, an orthopedic surgeon specializing in the lumbar spine, stated that the petitioner's low back discogenic pain did not appear to be due to the work injury. (RX 5)

Based on the lack of evidence linking the petitioner's low back pain to the injury, and the suspicious onset of pain occurring after the petitioner had reached MMI and had been released from treatment to his right knee, the Arbitrator finds that the petitioner's condition relating to the low back is not causally related to the alleged work incident of April 19, 2011. In light of the Arbitrator's findings regarding accident, accident date and causation, all other issues are moot.

ARBITRATOR

06-04-18

DATED AND ENTERED

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Fredrickson,
Petitioner,

vs. NO: 16 WC 35609

19IWCC0271

Roesch Ford,
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 issue of nature and extent of permanent partial disability, and being advised of the facts and law, hereby modifies the Decision of the Arbitrator as noted below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. As explained below, the Arbitrator's award representing 20% loss of use of the person as a whole under Section 8(d)2 is modified to 25% loss of use of the person as a whole.

Petitioner, 54, has been an auto mechanic his entire adult life and in Respondent's employ for the past 25 years. On December 18, 2015, he injured his right shoulder while lifting a heavy tire. On March 7, 2016, he underwent right shoulder arthroscopic surgery to repair a torn rotator cuff. After this surgery, he complained of ongoing pain, numbness and weakness in his dominant right arm, extending into his right hand. Ultimately, however, it was determined that further surgery was not indicated. On February 19, 2018, he was found to have reached maximum medical improvement and was issued permanent work restrictions. These restrictions limited his lifting to 10 to 20 pounds, with no overhead or repetitive activity with the right arm.

During all relevant time periods and continuing up to the present, Petitioner has been employed by Respondent, for whom Petitioner now works light duty. With respect to his present condition, he testified that he experiences ongoing right-hand pain and numbness, an inability to fully close his right fist, pain radiating down his right arm, and inability to raise his right arm above his head. He must perform much of his work duties using his non-dominant left hand and has difficulty using and manipulating certain tools because of his limitations.

His condition has impaired his earning capacity, as he works at a slower pace now. He explained that his wages are determined based on the number of jobs that he completes during the work day. In his occupation as an auto mechanic, various jobs are expected to be performed -- and are paid -- based on a pre-determined formula. For instance, a mechanic who completes an oil change is paid for three-tenths hours, regardless of whether it takes him a longer or shorter time than that to finish the job. In her Decision, the Arbitrator noted that, during 2015, the year prior to his accident, Petitioner earned almost $66,000. During 2017, he earned about $45,000. Petitioner's wages for 2018, extrapolated for the balance of the year, appeared to be about the same as 2017.

The Arbitrator found Petitioner to be credible. The Arbitrator explained her review of the five factors enumerated in Section 8.1b in concluding that Petitioner established 20% loss of use of his person.[1] As to those factors, it is noted that, in the instant case, no AMA impairment rating has been submitted. Regarding the remaining factors of §8.1b, the Arbitrator explained that she gave "great weight" to the factors of "occupation" and "future earning capacity." As to occupation, she wrote of the adverse impacts to Petitioner's ability to perform the physical aspects of his auto mechanic duties. As to his future earning capacity, she noted that, because Petitioner is paid by the job and not by the hour, his permanent restrictions have adversely impacted his earning capacity. Petitioner's wages are now about two-thirds of what they were prior to his accident.

Petitioner contends that the Arbitrator's award is inadequate and argues for compensation representing 50% loss of use of the person. Petitioner cites two cases for comparison: *Ralph Clemmons v. Central Can Company*, 4 IIC 316 (50% loss of use of the person award); and *Daniel Donaldson v. Central Grocers*, 16 IWCC 780 (37.5% loss of use of the person). As Respondent points out in its review brief, the claimants in these cases were injured before the Act was amended to include the criteria for determining permanent partial disability or these claimants otherwise sustained their accidents before September 1, 2011. To-wit: The claimant in *Clemmons* was injured in 2001. The

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1 For injuries that occur after September 1, 2011, the determination of extent of permanent partial disability is governed by §8.1b of the Act. This section outlines five factors to be used by the Commission in determining the level of permanent partial disability: (i) the reported level of impairment (also known as "AMA impairment rating," as contained in the physician-prepared disability impairment report described in this section); (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.

Donaldson claimant was injured on January 30, 2011 (furthermore, Mr. Donaldson's shoulder condition post-surgery was far more serious than that of the petitioner at bar, as Mr. Donaldson developed a sepsis infection that required further surgeries).

The Commission finds the Arbitrator's analysis of the 8.1b factors to be sound. However, the Commission weighs the evidence to find that the factors of Petitioner's occupation and earning capacity warrants a modest increase in his Section 8(d)2 award. In light of the totality of the evidence and the Section 8.1b factors, the Commission finds that permanent partial disability would be more appropriately assessed at 25% loss of use of the person as a whole. The Arbitrator's Decision is modified accordingly. All other findings are affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $755.22 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 permanent loss of use of 25% of Petitioner's person as a whole.

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 THEREFORE ORDERED BY THE COMMISSION that the decision of the Arbitrator filed October 4, 2018, is hereby modified as discussed above.

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: MAY 30 2019

o-04/09/19
sm/ac
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Stephen J. Mathis
Stephen Mathis

D. Douglas McCarthy
D. Douglas McCarthy

L. Elizabeth Coppoletti
L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FREDRICKSON, JOHN
Employee/Petitioner

Case# 16WC035609

ROESCH FORD
Employer/Respondent

19IWCC0271

On 10/4/2018, 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 2.33% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

5001 GAIDO & FINTZEN
MALLORY ZIMET
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

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

19IWCC0271

- ☐ Injured 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

John Fredrickson
Employee/Petitioner

v.

Roesch Ford
Employer/Respondent

Case # **16** WC **35609**

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 **Steffen**, Arbitrator of the Commission, in the city of **Wheaton**, on **July 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 **12/18/2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**65,832.00**; the average weekly wage was $**1,266.00**.

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

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

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

Respondent shall be given a credit of $**18,965.32** for TTD, $**20,360.73** for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

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

ORDER

Respondent shall pay Petitioner 100 weeks of permanent partial disability at a rate of $755.22 as the injuries caused a loss of use of 20% of the person as a whole pursuant to Section 8(d)2.

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

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

KSSteffen

Signature of Arbitrator

10/2/18

Date

OCT 4 - 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION

JOHN FREDRICKSON,	)	
	)	
Petitioner,	)	
	)	
v.	)	**No. 16 WC 35609**
	)	
ROESCH FORD,	)	
	)	
Respondent.	)	

ATTACHMENT TO ARBITRATOR'S DECISION

I. Findings of Fact.

Petitioner has been an automobile mechanic for his entire adult life and in Respondent's employ for the past 25 years. On December 18, 2015, he injured his right shoulder while lifting a heavy truck tire. He continued working but noticed that the pain increased over the course of the next month. He finally sought treatment from the Elmhurst Immediate Care which, in turn, referred him to Dr. Daryl O'Connor, an orthopedic surgeon.

On January 20, 2016, an MRI of Petitioner's right shoulder revealed a torn rotator cuff. (PX 3, p. 26) Dr. O'Connor performed surgery to Petitioner's right shoulder on March 7, 2016 consisting of an arthroscopic rotator cuff repair and subacromial decompression. (PX 3, p. 28) Post-operative physical therapy was administered and Petitioner returned to light duty work in August, 2016.

On August 24, 2016, Petitioner was examined at Respondent's request pursuant to Section 12 of the Act by Dr. Aaron Bare. Dr. Bare noted Petitioner's complaints of ongoing shoulder pain, loss of motion and swelling of the right hand. He felt that Petitioner should undergo an MRI to further delineate those issues. (RX 1)

On September 16, 2016. Dr. O'Connor injected Petitioner's right shoulder with a steroid and he agreed that a repeat MRI would be appropriate. (PX 3, p. 7-8) The MRI was done on December 19, 2016. It revealed post-operative changes and low grade tendinopathy and arthrosis. (PX 4, p. 12) On January 17, 2017, Dr. O'Connor felt that Petitioner's ongoing symptoms stemmed from adhesive capsulitis and posterior capsular contracture. He prescribed a home exercise program but indicated that additional surgery might be needed in the future. (PX 4, p. 7)

On May 23, 2017, Dr. O'Connor administered another steroid injection to Petitioner's right shoulder and indicated that the ongoing symptoms might be permanent. (PX 4, p. 5)

Petitioner was re-examined by Dr. Aaron Bare at Respondent's request on July 31, 2017. Dr. Bare diagnosed Petitioner with post-operative frozen shoulder. He felt that Petitioner should undergo an EMG to explore whether there was a radicular basis for his symptoms of pain down the arm and burning in the right hand. (RX 2) Petitioner underwent the EMG on August 30, 2017. It revealed moderate carpal tunnel syndrome in Petitioner's right hand. (PX 4, p. 10)

Petitioner saw Dr. O'Connor for the final time on September 26, 2017. Dr. O'Connor found no clinical evidence of carpal tunnel syndrome but did diagnose sympathetic dysfunction and mild ulnar neuritis. He felt that Petitioner had attained MMI, that the work restrictions should remain in effect and that he should "seek other options." (PX 4, p. 3)

On December 20, 2017, Petitioner sought a second opinion from Dr. Anthony Romeo of Rush University Medical Center. Dr. Romeo recommended an MR-arthrogram to evaluate the integrity of the rotator cuff. (PX 5, p. 4-5) The arthrogram was performed on January 11, 2018. (PX 5, p. 9)

Petitioner returned to Dr. Romeo on February 19, 2018. Dr. Romeo felt that there was no indication for further surgery and that Petitioner was at MMI. Dr. Romeo imposed a permanent work restriction of 10 to 20 lbs with no overhead or repetitive activity with the right arm. (PX 5, p. 1-2, 6)

Petitioner has continued to work light duty for Respondent. His ongoing symptoms of right hand pain numbness, an inability to fully close his right fist, pain radiating down his right arm, an inability to raise his right arm above his head and the need to perform much of his work duties left handed has impaired his earning capacity.

Petitioner's wages are determined based on the number of jobs that he is able to complete during the work day. Various jobs are expected to be performed—and are paid—based on a pre-determined formula. For instance, a mechanic who performs an oil change is paid 0.3 hours, regardless of whether it actually takes him more or less time to complete the job.

During the year 2015, prior to his accident, Petitioner earned almost $66,000.00. (Arb. Ex. 1) During the year 2017, Petitioner earned about $45,000.00. (PX 1) Petitioner's wages in 2018, extrapolated for the balance of the year, appear to be about the same as they were in 2017. (PX 2)

Analysis/Findings

In support of the Arbitrator's decision relating to whether Petitioner's current condition of ill-being is causally connected to the accident ("F"), the Arbitrator concludes as follows:

Petitioner testified that he never had any right shoulder problems prior to his accident of December 18, 2015. There is no evidence to the contrary. Although Petitioner's medical treatment began about a month after the accident, the histories that he provided to his doctors identify only the accident of December 18, 2015 as the source of the problem. All three doctors who have treated or examined Petitioner (Dr. O'Connor, Dr. Bare and

Dr. Romeo) have identified the work accident as the cause of Petitioner's ongoing problems. There is no evidence to the contrary.

Based on the foregoing, the Arbitrator concludes that Petitioner's current condition of ill-being relative to his right shoulder, arm and hand is causally connected to the accident of December 18, 2015.

In support of the Arbitrator's decision relating to the nature and extent of the injury ("L"), the Arbitrator concludes as follows:

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

With regard to subsection (ii) of Section 8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as an automobile mechanic at the time of the accident and that he is not able to return to full duty work in that trade. The Arbitrator notes that Petitioner remains employed by Respondent, that he is attempting to perform as many duties of an automobile mechanic as his permanent restrictions will allow, and that these restrictions have directly—and adversely—impacted Petitioner's earning capacity. In this regards, the Arbitrator notes that Petitioner is unable to fully close his hand to make a fist. His ability to manipulate objects with his injure hand/arm will likely be compromised. The limitations on lifting and specifically, overhead lifting is also detrimental. Therefore, the Arbitrator gives great weight to this factor.

With regard to subsection (iii) of Section 8.1b(b), the Arbitrator notes that Petitioner was 54 years of age at the time of his accident. Because Petitioner will have approximately ten more years in the work force before reaching normal retirement age, the Arbitrator gives some weight to this factor.

With regard to subsection (iv) of Section 8.1b(b), Petitioner's future earning capacity, the Arbitrator notes that although Petitioner's hourly rate of pay has increased from $31.65 to $33.00 per booked hour since his accident, his wages are only about two-thirds of what they were prior to his accident. Petitioner's permanent restrictions, including his inability to raise his right arm above his head and his having to perform much work with his non-dominant left hand, have directly and adversely impacted his earning capacity. Petitioner's testimony regarding the method of payment is relevant since Petitioner gets paid by the job, not by the hour. An injured worker who is able to return to employment but performs the same work with limitations will have diminished earning capacity. This is borne out by the loss of income Petitioner has suffered since the accident. Therefore, the Arbitrator gives great weight to this factor.

With regard to subsection (v) of Section 8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner has undergone right shoulder surgery which has left him with ongoing pain, numbness and weakness in his dominant right arm, extending into his right hand. For a person in a manual trade such as an automobile mechanic, these symptoms and their corresponding restrictions have had a seriously detrimental effect on Petitioner's ability to earn a living in the same fashion as he had prior to the accident. Petitioner's subjective complaints have not been questioned by any of the doctors who have seen or examined him. Petitioner is not prone to exaggeration and has made a faithful effort to continue his work life. The Arbitrator heard Petitioner's testimony, observed his demeanor on the witness stand and finds him to be credible.

Based on the foregoing factors of Section 8.1b, the Arbitrator find that Petitioner is disabled to the extent of 20% loss of use of the person as a whole or 100 weeks at the rate of $ 755.22 per week. This award reflects Petitioner's injuries being beyond a simple rotator cuff repair surgery and also that the surgery results were less then optimum. There are signs of greater functional incapacity in the arm and additional impairment to the hand. This is less than optimum for Petitioner's job functions.