STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Delois Broome,

Petitioner,

vs. NO. 15WC002789

16IWCC0712

Home Direct USA/MXD,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $20,000.00. 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: NOV 1 - 2016
SJM/sj
o-9/29/2016
44

Stephen J. Mathis

David L. Gore

Mario Basurto

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

BROOME, DELOIS
Employee/Petitioner

Case# **15WC002789**

HOME DIRECT USA/MXD
Employer/Respondent

16IWCC0712

On 12/15/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.58% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1315 DWORKIN & MACIARIELLO
JORDAN BROWEN
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

2097 GRANT & FANNING
DANIEL SWANSON
300 S RIVERSIDE PLZ SUITE 2050
CHICAGO, IL 60606

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

16IWCC0712

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

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

Delois Broome
Employee/Petitioner

v.

Home DirectUSA/MXD
Employer/Respondent

Case # 15 WC 02789

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 **Christine Ory**, Arbitrator of the Commission, in the city of **Wheaton on September 29, 2015 & Chicago on October 8, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [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. [X] Is Respondent due any credit?
O. [X] Other **Does the theory of Collateral Estoppel bar petitioner's claim?**

FINDINGS

On the date of accident **January 15, 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 **$33,456.28**; the average weekly wage was **$643.39**.

On the date of accident, Petitioner was **51** years of age, **single** with **0** dependent children.

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

Respondent is entitled to a credit of **$ 2,481.62** under Section 8(j) of the Act.

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services of **$ 10,699.00**, in accordance with in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay for all reasonable and necessary costs relative to the surgical release to petitioner's right wrist De Quervain's tenosynovitis, and the attendant care pursuant to §8 and §8.2.

Temporary Total Disability

Respondent shall pay Petitioner temporary partial disability benefits of **428.93** per week for **8-2/7**weeks, commencing **February 22, 2015** through **April 20, 2015**, as provided in Section 8(b) of the Act.

Credits

Respondent is entitled to a credit of **$ 2,481.62** under 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.

Christine Moy

Signature of Arbitrator

12/15/2015
Date

IC ArbDec19(b)

DEC 15 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Delois Broome,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 15 WC 02789**
	)	
Home Direct USA/MXD,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter was heard pursuant to § 19b and § 8a of the Act on September 29, 2015 in Wheaton and proofs were closed on October 8, 2015 In Chicago. The parties agree that on January 15, 2015 petitioner and respondent were operating under the Illinois Workers' compensation or Occupational Diseases Act, and their relationship was on of employee and employer. They agree that in the year pre-dating the accident petitioner earned $33,456.28 and her average weekly wage was $643.39.

At issue in this hearing is as follows:

1. Whether the petitioner sustained accident injuries that arose out of and in the course of her employment;
2. Whether petitioner's current condition of ill-being is causally connect to the claimed injury.
3. Whether respondent is liable for the unpaid medical bills totaling $10,699.00.
4. Whether petitioner is due TTD as claimed from February 21, 2015 through April 20, 2015 and from May 29, 2015 through the date of hearing on September 29, 2015.
5. Whether petitioner is entitled to payment for prospective medical treatment.
6. Whether respondent is given TTD credit for severance pay.
7. Whether petitioner's case should be dismissed based upon respondent's theory of collateral estoppel based upon a previously entered settlement agreement.

STATEMENT OF FACTS

Petitioner testified that on January 15, 2015 she was employed by respondent as a customer service representative whose duties included data entry and computer work. She worked eight hours a day doing a majority of computer work. She had been employed by respondent for almost 14 years. Petitioner testified she was laid off in March, 2014.

Petitioner testified that on January 15, 2015, she was performing her job when she noticed throbbing pain, aching and stiffness of the right wrist.

Petitioner testified that in 2014 she was treated for right wrist. She went to the ER and was given a splint and ibuprofen. She then saw her primary care physician who prescribed a cream and referred her to a hand specialist. The hand specialist provided the first cortisone shot in January or February, 2014. She did not receive any treatment from that time, until January, 2015.

She presented to Diversey Medical Center on January 24, 2015, where she was seen by Dr. Senno. She complained of pain at the base of the right thumb periodically and stiffness. She had complained of the same injury previously and was given a cortisone injection. She now reports the condition as new. Dr. Senno diagnosed the condition as carpal tunnel syndrome, work related injury occurring January 15, 2015. He ordered an EMG, indomethacin, MRI in case chiropractic treatment doesn't work and massage or physical therapy to wrist. Dr. Senno released her to return to regular work (PX.1).

She returned to Diversey on January 27, 2015 with complaints of soreness, stiffness, and feeling of electricity shooting through hands. She reported to typing for the majority of the day and used the mouse with her right hand. Petitioner returned to Dr. Senno on February 7, 2015. Her complaints remained the same. She was prescribed wrist splinting and MRI. Petitioner returned to Dr. Senno on February 21, 2015 for the results of her EMG and MRI. Dr. Senno ordered her off work as of February 22, 2015 (PX.1).

Dr. Senno recommended a surgical consult for the diagnosed carpal tunnel syndrome. She returned to Dr. Senno on March 7, 2015, after seeing hand specialist, Dr. Bilko. According to Dr. Senno's March 7, 2015, Dr. Bilko diagnosed the condition as De Quervain's syndrome and gave petitioner a cortisone injection. Petitioner returned to Dr. Senno on March 21, 2015. She was to continue physical therapy. On April 20, 2015 petitioner was released to return to regular work (PX.1)

EMG showed right greater than left mild neuropraxia carpal tunnel syndrome (PX.2).

Petitioner was examined by orthopedist, Dr. Thomas Bilko on March 4, 2015. The history recorded by Dr. Bilko was: "She states that she was gradually having right wrist pain for a year while working as an account representative due to having to withstand repetitive movement of her wrist with a computer mouse. She informed her supervisor but was provided no medical attention. She saw her PCP who prescribed medications and referred her to an orthopedic specialist. In February, 2014, the orthopedic specialist provided her a steroid injection. Both the injection and medications provided some relief, so she continued working her regular duties of repetitive typing and repetitive use of a computer mouse. On 1/15/15, her wrist pain worsened and weakened to where she could no longer withstand the above duties."

Petitioner was examined by Dr. Scott Sagerman on April 16, 2015 at the request of respondent's insurance carrier. Dr. Sagerman testified in behalf of petitioner via deposition (PX4). Dr. Sagerman performed a physical examination and reviewed medical records provided (PX.4, p. 9). Dr. Sagerman took a history, but did not review a job description or injury report (PX.4, pp. 9-10).

Dr. Sagerman's examination of petitioner's right wrist revealed tenderness at the radial aspect over the first extensor compartment with subcutaneous nodule over the retinaculum with

slight subcutaneous atrophy. There was no sensitivity or Tinel sign. The Finkelstein's test was positive. There was pain with resisted thumb abduction (PX.4, p.10).

The Finkelstein test is a provocative test for a condition called De Quervain's tenosynovitis (PX.4, p.11). Petitioner's history to Dr. Sagerman was consistent with her testimony (PX.4, p.12). Dr. Sagerman reviewed medical records from January 15, 2014 and February 12, 2014, which was relative to the earlier treatment from the December, 2013 claim (PX.4, p.13). The next records Dr. Sagerman reviewed were the records from January 24, 2015 (PX.4, p.13).

Dr. Sagerman diagnosed petitioner's condition as right De Quervain's tenosynovitis (PX.4, p.14). Dr. Sagerman did not believe that typing could have aggravated her wrist condition, but the use of a computer mouse may have aggravated her wrist condition (PX.4, pp.15-16). This is caused by grasping and wrist posturing necessary to utilize the computer mouse (PX.4, p.16). Dr. Sagerman confirmed that petitioner's right wrist De Quervain's tenosynovitis was related to the work accident of January, 2015(PX.4, p.16). Dr. Sagerman also agreed that the surgery to release the first extensor retinaculum was appropriate (PX.4, p.16).

Dr. Sagerman testified he would restrict the patient before surgery to limited gripping and grasping activities. Post-operatively, Dr. Sagerman would place restrictions on petitioner for a limited period of time, depending upon her recovery; after that, restrictions would be limited (PX.4, p.17). Post-operative treatment would include supervised occupational therapy for exercise and scar treatment and functional activities (PX.4, pp.17-18). Dr. Sagerman agreed that diabetes was a risk factor, not a cause of De Quervain's tenosynovitis (PX.4, p.25).

In the report attached to Dr. Sagerman's deposition, Dr. Sagerman stated that because there was no indication of on-going treatment in 2014 that the recurrent symptoms in January, 2015 were related to the work injury of January 15, 2015 (PX.4, Pet. Ex. 2).

Petitioner testified she was on short-term disability from January until April, 2015. After that, petitioner was released by her doctor to return to regular work. She returned to work in April, 2015 and worked until May 29, 2015 when she was laid off as part of a huge lay off with respondent.

On cross examination petitioner confirmed she was laid off on March 31, 2014 and rehired on August 19, 2014 doing the same job. When petitioner returned to work in August, 2014, respondent accommodated her by allowing a 10 minute break for each hour she worked. Respondent also provided padding for petitioner's keyboard. Respondent also purchased a mouse for petitioner.

Petitioner acknowledged she signed a settlement contract which settled her workers' compensation claim from December, 2013, but did into understand she was waiving certain rights (RX.4). Petitioner testified she understood that her settlement as for tendonitis and not De Quervain's tendonitis.

In October, 2014, she was moved from respondent's Hillside location to the Downers Grove facility, but her job duties remained the same. Petitioner testified that when the pain returned in January, 2015, it was worse than it was before. She had not done much work between Mach 31, 2014 through August 19, 2014, when she returned to work for respondent

after the layoff. The pain had started in late December; early part of January, to the point petitioner knew she had to see a doctor at it was like it was before. Petitioner testified she had no pain from August [2014] until January [2015]. Petitioner testified that when she returned to work in August, 2014, she did less talking on the phone; the majority of her work was typing.

Carla Novak-Hines was called upon to testify in behalf of respondent. She was employed by respondent as managing director, general counsel. She was responsible for any legal matter that came across her desk, which included real estate, customer and subcontractor agent contracts, as well as all human resources activities.

In November, 2013 a warning went out to all employees advising there was a reduction in work force that would be taking place in the first and second quarters of 2014. Novak-Hines confirmed petitioner was laid off on March 31, 2014 in the first wave of layoffs. Petitioner was paid 12 weeks of severance pay.

Petitioner was rehired on August 19, 2014. Petitioner's job function did not change when she was rehired in August, 2014. Novak-Hines confirmed respondent had obtained ergonomically correct mouse pads and keyboards with gel pads for petitioner (RX. 1 & 2). Novak-Hines confirmed the essential functions of the job of Customer Care Manager (RX.5) and Network Quality Coordinator (RX.6) were the same, which required the use of the same equipment; a personal computer and mouse. Hines-Novak also confirmed that petitioner's work stations in all locations were the same, except that the one at the Downers Grove location was newer.

CONCLUSIONS OF LAW

In support of the Arbitrator's decision with regard to whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator makes the following conclusions of law:

The Arbitrator finds petitioner sustained an accident which arose out of and in the course of her employment with respondent on the manifestation date of January 15, 2015. The Arbitrator basis this conclusion on the testimony of petitioner, who testified she did no have ongoing problems or treatment for her original claim of December, 2013 after she completed her treatment in February, 2014; the testimony of respondent's examining physician, Dr. Sagerman, who testified in behalf of petitioner, that petitioner had a new occurrence in January, 2015 as petitioner had no ongoing treatment or problems related to her December, 2013 injury; and also the medical records from the treating physicians, Dr. Senno and Dr. Bilko, support a finding of a new accident occurring on January 15, 2015.

The Arbitrator makes this finding despite respondent's defense that there was no new accident, but rather ongoing problems from the December, 2013 claim that had been settled on August 18, 2014, As indicated, the evidence does not support respondent's defense; it does support petitioner had a new and distinct accident on January 15, 2015.

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

All of the evidence, which includes petitioner's testimony, the medical records of the treating physicians at Diversey Medical Center and the treating orthopedic surgeon, Dr. Bilko; and, most importantly, respondent's examining physician, Dr. Scott Sagerman, supports a finding that the diagnosed condition of right wrist De Quervain's tenosynovitis, for which petitioner now needs surgical release, was caused by the work accident of January 15, 2015.

This is true, despite the fact that petitioner had received treatment for purportedly the same diagnosis in January and February, 2014. Petitioner had not received any treatment for the condition from the December, 2013 accident after her release in February, 2014. The evidence supports a finding that petitioner's condition reoccurred at the beginning of January, 2015.

Therefore, the Arbitrator finds petitioner proved by a preponderance of the evidence that the right wrist De Quervain's tenosynovitis, which now requires surgery, was caused by the work accident of January 15, 2015.

In support of the Arbitrator's decision with regard to the medical bills incurred, the Arbitrator makes the following conclusions of law:

Respondent's dispute regarding medical bills was to liability only. There was no evidence presented that the treatment received by petitioner was not reasonable or necessary. Therefore, the Arbitrator, having found petitioner's right wrist De Quervain's tenosynovitis, which necessitate the treatment obtained, awards the following bills pursuant to the fee schedule:

Diversey Medical Center $4,695.00
Suburban Pain Care Center $2,009.00
AMCI – Aurora (Dr. Thomas Bilko) $745.00
Advanced Diagnostics $3,250.00

In support of the Arbitrator's decision with regard to whether petitioner is entitled to prospective medical care, the Arbitrator makes the following conclusions of law:

The treating physicians, as well as the examining physician, Dr. Sagerman, agree petitioner requires a surgical release of her right wrist De Quervain's tenosynovitis as treatment for her work injury. Therefore, the Arbitrator awards payment for the recommended surgery, and the attendant care, pursuant to §8 and §8.2 of the Act.

In support of the Arbitrator's decision as to whether petitioner is entitled to temporary total disability, the Arbitrator makes the following conclusions of law:

Petitioner was authorized off work by her treating physicians, Dr. Senno and Dr. Bilko from February 22, 2015 through April 20, 2015. She was released to return to her regular employment by her physician on April 20, 2015, and worked her regular position until she was laid off in a general lay off as of May 29, 2015.

Although respondent had made accommodations to petitioner when she had returned from layoffs in August, 2014, she was working with these accommodations when the new work accident occurred. Therefore, petitioner was working the same position when injured on January 15, 2015, that she was working when laid off on May 29, 2015. Accordingly, no temporary total disability is due petitioner after April 20, 2015 until she undergoes surgery.

In support of the Arbitrator's decision as to whether respondent is entitled to credit, the Arbitrator makes the following conclusions of law:

Respondent is not entitled to credit for the severance pay in 2014 as petitioner does not claim any disability for the new accident of January 15, 2015 during the period she was paid severance. Furthermore, as petitioner is entitled to severance pay, whether disabled or not, respondent is not allowed to take credit for this payment.

Respondent is allowed to take credit under §8 j of the Act in the amount of $2,841.62 for the disability benefits paid during the period of petitioner's disability from February 21, 2015 through April 20, 2015.

In support of the Arbitrator's decision as to whether petitioner's case should be dismissed on the theory of Collateral Estoppel, the Arbitrator makes the following conclusions of law:

Respondent claims that because petitioner settled her claim for an injury of December 17, 2013 involving her thumb and right wrist in August, 2014, that her subsequent claim of January 15, 2015 should be dismissed on the theory of Collateral Estoppel. The contract, for case number 14 WC 2713, introduced into evidence by respondent as Respondent's Exhibit 4, was approved on August 18, 2014 (RX.4). It did not, nor could it, foreclose petitioner's rights for any future claims. In fact, the terms of the settlement did not include any sequela of the condition up to the date of the settlement.

The treating physicians provided that petitioner's injury was the result of the new accident of January 15, 2015. Also, Dr. Sagerman, who examined petitioner at the request of respondent pursuant to §12 of the Act, believed petitioner's condition was the result of a new work accident of January 15, 2015.

For these reasons, the Arbitrator denies Respondent's Motion to Dismiss petitioner's claim.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Omar Soto,
Petitioner,

vs.

NO: 14 WC 25250

Main Pizza Chalavi and The Illinois State Treasurer as Custodian of The Illinois Injured Workers' Benefit Fund,
Respondent,

16IWCC0713

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 employer/employee relationship and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 7, 2016, is hereby affirmed and adopted.

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

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

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

DATED: NOV 2 - 2016
o102716
DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SOTO, OMAR
Employee/Petitioner

Case# **14WC025250**

MAIN PIZZA CHALAVI AND THE ILLINOIS STATE TREASURER AS CUSTODIAN OF THE ILLINOIS INJURES WORKERS' BENEFIT FUND
Employer/Respondent

16IWCC0713

On 3/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% 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:

1980 STEVEN J TENZER LTD
20 S CLARK ST
SUITE 700
CHICAGO, IL 60603

5125 LAW OFFICES OF JOSEPH YOUNES
166 W WASHINGTON ST
SUITE 600
CHICAGO, IL 60602

5165 ASSISTANT ATTORNEY GENERAL
JEANNIE D SIMS
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

16IWCC0713

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

Omar Soto
Employee/Petitioner

v.

Case # **14** WC **25250**

Consolidated cases: _____

Main Pizza, Chalavi and the Illinois state treasurer, as custodian of the Illinois Injures Workers' Benefit Fund
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **December 22, 2014 and proofs were closed on January 27, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

B. On **June 29, 2014**, Respondent *was* operating under and subject to the provisions of the Illinois Workers' Compensation or Occupational Diseases Act.

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

ORDER

Petitioner has not proven, by a preponderance of the evidence that an employee-employer relationship existed between Petitioner and Respondent-Employer on the date of accident therefore, no benefits are awarded, pursuant to the Act.

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

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

FINDINGS OF FACT

This action was pursued under the Illinois Workers' Compensation Act by Omar Soto, ("Petitioner") and relief sought from Main Pizza, Chalavi, ("Respondent"). This action also seeks relief from the Illinois Injured Workers' Benefit Fund because the employer allegedly did not maintain workers' compensation insurance. A hearing was held before Arbitrator Lynette Thompson-Smith on December 22, 2015 in Chicago, Illinois and proofs were closed in this matter on January 27, 2016. All parties were represented by counsel, who fully participated in the arbitration proceedings. The Illinois Attorney General's Office appeared on behalf of the Illinois State Treasurer, as *ex-officio* custodian of the Injured Workers' Benefit Fund, and participated in the arbitration proceedings. All issues are in dispute.

Petitioner's testimony

Mr. Omar Soto testified that he was 22 years old, single and had no dependent children on the alleged date of accident. That on June 29, 2014, he was employed by Main Pizza, Chalavi, ("Respondent"), located at 2931 West Touhy Avenue, in Chicago. He was a delivery driver for the business and also helped with food prep work and building pizza boxes. Petitioner's primary duty was delivering pizzas. He had set hours and worked from 11 a.m. until 7 p.m. five days a week and would also work additional hours on Saturdays, for approximately forty (40) hours each week. Petitioner earned wages in the amount of $600.00 per week and was initially paid by personal checks, but was later added to the payroll. After he was added to the payroll in 2014, Respondent began withholding taxes from his paychecks. Petitioner submitted into evidence, paychecks he received from Respondent. Tr. pp. 14-17, 82; PX12.

Petitioner always drove and maintained his own car for deliveries, paid for the gas and his insurance. Petitioner stated that he was allowed to maintain employment outside of that with Respondent and did not wear a uniform. Petitioner independently selected the routes he used to deliver pizzas. Petitioner testified he had worked at Respondent approximately two and a half to three years prior to the alleged date of accident and that he did not have to keep a time sheet or clock-in, when he arrived at work each day. Tr. pp. 85-87.

Petitioner testified that on June 29, 2014, he arrived at Respondent, between 11:45 a.m. and 12:30 p.m. and there was an order ready for delivery to a business located at 3939 Emerson. Petitioner went to Church Street, then drove to McCormick and took McCormick to the business for the scheduled delivery. Petitioner testified after making the delivery he headed back to Respondent and was involved in a car accident at the intersection of McCormick and Dempster. He was heading south on McCormick and the other vehicle was heading north on the same street attempting to make a left turn. Petitioner testified both vehicles had a green light; however, the other driver tried turn in front of him. Tr. pp. 18-21.

The police arrived at the scene and made a traffic report. The front of Petitioner's car and the passenger door of the other vehicle were damaged. Petitioner testified that following the accident, he saw that his right leg looked out of place and that his right femur was broken. He tried to crawl out of his vehicle and other people helped him out of the car and covered him with their jackets, until an ambulance arrived. The ambulance took Petitioner to St. Francis Hospital and the doctors admitted him for treatment. He was in the hospital for nine (9) days and underwent surgery to repair his broken right femur. PX6; Tr. pp. 27-39.

Petitioner testified that on the morning of the alleged date of accident, he only spoke to the "guys in the back" of the restaurant, prior to making the delivery. Petitioner testified that Ephraim Tatelbaum, the owner, was not present that morning and that Yehuda Berkowitz was just another employee and not his supervisor. Petitioner did not believe Mr. Berkowitz could supervise him because Petitioner had worked at Respondent's place of business longer than Mr. Berkowitz and that while he worked there; he was only supervised by a man named Yerochum. Petitioner could not remember Yerochum's last name.

Petitioner testified that Yerochum was not at the restaurant when he arrived at work on the alleged date of accident. He was Respondent's only delivery driver, so when he arrived to work each day, if deliveries were waiting, he would just take the deliveries without speaking to anyone. Mr. Berkowitz was present at the restaurant on the alleged date of accident but Petitioner did not speak to him or anyone else about his deliveries because all the information he needed was on a sheet of paper on a clipboard. Tr. pp. 68-73.

Petitioner testified that he knew most of the delivery addresses and already knew the location and time of the delivery, on the alleged date of accident. Petitioner testified the delivery had to be made between 11:45 a.m. and 12:30 p.m. Petitioner always arrived at work between 10 to 15 minutes prior to the first deliveries being ready. Petitioner denied that he was fired in February 2014 and instead testified that he quit the job. According to Petitioner, Respondent hired him back because the business needed him. Petitioner testified that when he left in February, he was still on good terms with everyone at Respondent and would stop in and talk to the workers. Yerochum asked him to return because their other delivery driver was not "doing it." Petitioner testified he returned to work at Respondent's restaurant two to three weeks after he quit.

Petitioner denied that anyone ever reprimanded him for being late to work prior to the alleged date of accident. Petitioner testified that Yerochum told him that as long as hewas on time for the deliveries, it did not matter if he was 10 or 15 minutes late for his shift. Petitioner admitted that he was at least 30 minutes late for work on the alleged date of accident and testified no one ever told him that if he were late again he would be fired. Petitioner denied that Mr. Berkowitz told him that he was fired on the alleged date of accident and that another employer was going to make the deliveries. Tr. pp. 76-78.

Petitioner testified that he called Yerochum's cell phone from the hospital and told him he was in a car accident, was hospitalized and broke his leg. Petitioner further testified that Yerochum visited him in the hospital, but could not remember the date or time during which this visit occurred. Petitioner testified that Yerochum visited him a few times after he was discharged from the hospital, but again did not provide details regarding the time of those alleged visits. Upon cross-examination, Petitioner gave a different account of his contact with Yerochum following the car accident. When cross-examined, Petitioner testified that he spoke to Yerochum once a week for approximately three months. Yerochum was not present at the hearing. Tr. pp. 44-52, 67, 89.

Petitioner testified that he spoke on the phone with Mr. Tatelbaum approximately one week after he was discharged from the hospital and that Mr. Tatelbaum told him that he would give Petitioner some money and a car so he could continue to work if Petitioner "...got like the lawyer away..." Upon further examination, Petitioner testified that he could not remember the details regarding the amount of money Mr. Tatelbaum allegedly offered him to drop his workers' compensation case; however, he did remember Mr. Tatelbaum offering an insufficient amount of money, given the amount of time he had worked with Respondent.

Petitioner testified he never spoke to Mr. Tatelbaum after this conversation took place however upon cross-examination, he testified that he continued to call Respondent for several weeks after he was discharged from the hospital, to see if they would provide any benefits, because he had not hired a lawyer. Petitioner testified he had not hired a lawyer in November 2014, when his doctor released him to return to work with restrictions. However, Petitioner submitted into evidence, a letter written by his attorney that shows that Petitioner was represented in September 2014. Tr. pp. 58-60, 90; PX10.

Petitioner testified that prior to the alleged date of accident, he never had any problems with his right leg, hip and thigh and that he has sought no further treatment related to this alleged work accident since Dr. Prieto released him from care on June 9, 2015. Currently, his right leg is always swollen and is sometimes painful when the weather changes however, he does not take any medication for his complaints. Petitioner testified his medical bills were not paid and that he began working for a hospice warehouse in January 2015. Petitioner further testified that his duties included cleaning dirty equipment and that he has only worked in this position for approximately four to six months.

Petitioner's treatment

St. Francis' emergency room records note that Petitioner was involved in a car accident with air bag deployment. An examination noted right knee discoloration, right leg swelling and pain. It also revealed gross deformity of the right leg with bruising over the medial knee and proximal tibia. A chest x-ray, as well as CT scans of Petitioner's head, cervical spine, and chest were normal relating to the motor vehicle accident. An x-ray of the pelvis, right hip femur and knee revealed two transverse fractures within the mid-distal right femur, with a 10 cm segment of femur separating the two fracture sites. An x-ray of the right femur revealed the middle fracture fragment was displaced

posterior/superior, with respect to the proximal femur; and the distal femur was displaced posterior/superior/medial, with respect to the femoral fracture fragment. Petitioner was admitted to the hospital on the alleged date of accident and was not discharged until July 7, 2014. PX 1B.
Petitioner underwent an orthopedic consultation on June 30, 2014, wherein the doctor diagnosed a right midshaft, segmental femur fracture and scheduled surgery with a retrograde IM nail rodding. Petitioner underwent a nephrology consultation due to the development of hypokalemia. This condition required the doctors to postpone the planned surgery. During this consultation, Petitioner told the doctor that "...he does use marijuana daily, and used cocaine but stopped 1 month ago." The doctor further noted that Petitioner's urine tested positive for cannabinoids. However, on cross-examination, Petitioner denied ever using cocaine and denied using marijuana on a daily basis. Petitioner testified he never smoked when working and had last smoked marijuana perhaps two to three days prior to the accident. The doctor diagnosed severe hypokalemia and metabolic alkalosis. The doctor further noted that Petitioner's condition was chronic and that marijuana has been associated with hypokalemia in case reports and small studies. Tr. pp. 41-65; PX 1B; RX1 & 2.

Dr. Prieto performed a reduction intramedullary rodding of the right segmental femur fracture; retrograde intramedullary rodding of the right femur fracture. The post-operative diagnosis was a comminuted, segmental fracture of the right femoral shaft. Petitioner began physical therapy in the hospital following the surgery and was discharged on July 7, 2014. Petitioner testified he was using crutches when he was released from the hospital and was barely able to get out of bed initially. Petitioner continued to treat with Dr. Prieto on an outpatient basis.

On July 24, 2014, Dr. Prieto noted that Petitioner was using crutches but reported improved pain levels. Dr. Prieto also noted that Petitioner had an attorney. Dr. Prieto prescribed additional physical therapy which he attended from July 29, 2014 through January 2, 2015. On September 2, 2014, Dr. Prieto noted that Petitioner was healing well and was able to wean off the crutches. He noted that the physical therapist had raised the issue of whether Petitioner needed a manipulation treatment, but Dr. Prieto said he could not perform a manipulation until Petitioner was fully healed. PX3.

Petitioner testified Dr. Prieto released him to work on a light duty basis on or around November 20, 2014; and that he was still using at least one crutch at the time. He also was not able to drive and would need his crutches to enter and exit the car and to walk to the houses or businesses to deliver pizzas. Petitioner testified that he continued to use crutches until approximately New Year's Day of 2015.
However, the medical records show that on November 20, 2014, Dr. Prieto noted that while Petitioner limped, he was walking without any external support. The doctor determined Petitioner could return to work but was unable to climb ladders and squat. Those were the only restrictions noted by Dr. Prieto and there is no evidence that Petitioner could not have returned to work with those restrictions. Dr. Prieto also told Petitioner to schedule a manipulation of his right knee, under anesthesia.

Petitioner testified that he never attempted to return to work at any time, following the alleged date of accident. Petitioner testified he never called Mr. Tatelbaum because he "kn[ew] the personality that Ephraim has, so [he] kn[ew] that he was not going to let [him] back in the restaurant. PX2.

Petitioner cancelled the planned manipulation surgery in December because he did not want to pay the required deposit. Dr. Prieto finally performed a manipulation under anesthesia of the right knee on March 11, 2015. Following the manipulation procedure, Dr. Prieto prescribed home exercises and additional physical therapy. Petitioner attended a second round of physical therapy from March 12, 2015 through May 22, 2015. In the discharge note, the therapist noted that Petitioner had functional range of motion and strength, but continued to lack terminal knee extension. The therapist also noted that Petitioner walked with a flexed knee posture but was able to tolerate functional activities, without pain. Petitioner was able to lift and carry up to twenty-five (25) pounds and could squat and lift twenty (20) pounds. Petitioner told the therapist that he was able to perform his normal activities and noted that he was performing at his prior level of function. PX 2 & 4.

Petitioner underwent a functional capacity evaluation ("FCE") on May 26, 2015. The therapist performing the evaluation determined that the petitioner demonstrated functional capabilities at a medium demand level and could return, without restrictions, to his job as a pizza delivery driver. Petitioner saw Dr. Prieto for the final time on June 9, 2015, who told Petitioner to continue his home exercise program and noted that the fracture had solidly healed. Petitioner was to return as needed. Petitioner has not sought any additional treatment, following this release.

Respondent's first witness

Two witnesses testified on behalf of Respondent. Yehuda Berkowitz testified that he is currently in the process of completing his Master's degree at UIC and that he was formerly a teacher and worked in television production for a few years. He also worked in another food establishment as an assistant manager for two years and as a caterer for a kosher company. Mr. Berkowitz testified he also sold office equipment in the past and is currently employed by Respondent. Tr. pp. 103-109.

Mr. Berkowitz began working for Respondent in April 2014 and his job duties included assisting Yerochum Steinberg, the other manager, and managing the restaurant on week-ends. Mr. Berkowitz testified that he would delegate tasks to employees, was in charge of taking and arranging delivery orders and handling customer service. Petitioner was the delivery person for Respondent when Mr. Berkowitz began working there. Mr. Berkowitz testified he would take orders on an order sheet and let the kitchen staff know when he had an order for delivery. Mr. Berkowitz would check to make sure the food was in the oven or going into the oven prior to the time the delivery needed to go out.

Mr. Berkowitz testified that on June 26, 2014, both he and Petitioner were working. Thursday is always a very busy night in the restaurant and everyone, including the delivery person, needed to be "on the ball". On June 26, the deliveries were getting delayed and Petitioner was taking longer to

return from deliveries. By 5:00 p.m., the deliveries were running 45 to 50 minutes behind schedule. Mr. Berkowitz testified that he told Mr. Tatelbaum about his problems with Petitioner on that day and he also discussed the issue with Mr. Tatelbaum on June 28, 2014. Mr. Tatelbaum told him that he informed Petitioner that based on what happened that Thursday, as well as his past history of being late to work; Petitioner would be terminated if he were late one more time. Mr. Berkowitz testified that Petitioner was often late to work and often took an unreasonable amount of time to return from deliveries. Mr. Berkowitz testified that he knew that Petitioner had been reprimanded in the past for his tardiness and had had his pay docked as well. Tr. pp. 110-127.

Mr. Berkowitz arrived at the restaurant at 9:45 a.m. on the alleged date of accident. Petitioner was supposed to start work at 11 a.m. that day. There were two orders that had been placed the night before and Petitioner had been told about the deliveries the night before. Petitioner did not arrive at work until 11:30 a.m. Mr. Berkowitz testified that when Petitioner finally arrived, Mr. Berkowitz went into the kitchen and told Petitioner that per his earlier conversation with Mr. Tatelbaum, Petitioner was terminated because he was late again. Mr. Berkowitz testified that he told Petitioner to go home and that an employee named Rigo would handle the deliveries. Mr. Berkowitz testified he terminated Petitioner under Mr. Tatelbaum's authority.

After terminating Petitioner, Mr. Berkowitz testified that he returned to the front of the restaurant to serve customers and when he returned to the kitchen, he saw that the food waiting to be delivered was missing and Rigo was still at the restaurant. Mr. Berkowitz testified that Petitioner took the food and left to perform the deliveries, despite Mr. Berkowitz telling him he was terminated and to go home.

Mr. Berkowitz testified he never spoke with Petitioner again and that he told Mr. Tatelbaum what happened within 45 minutes of discovering Petitioner had taken the deliveries. Mr. Berkowitz testified that when Petitioner arrived at work that morning, he appeared to be very disheveled and smelled like marijuana. Mr. Berkowitz testified that he never tried to call Petitioner once he discovered Petitioner had taken the deliveries against his instructions. Mr. Berkowitz assumed Petitioner had taken the deliveries in an attempt to try to sway him allow Petitioner to keep his job. Tr. pp. 118-131.

Respondent's second witness

Mr. Ephraim Tatelbaum also testified on behalf of Respondent. Mr. Tatelbaum is the owner of the restaurant and has operated it for fifteen (15) years. Mr. Tatelbaum testified that Petitioner did not quit his job in February 2014; instead, Mr. Tatelbaum fired him, due to his tardiness and poor performance. Mr. Tatelbaum testified that after a few weeks Petitioner asked for his job back and Mr. Tatelbaum rehired him, making it clear that there was to be no more tardiness or delinquency.

Mr. Tatelbaum confirmed that Mr. Berkowitz discussed with him Petitioner's tardiness and poor performance on the Thursday prior to the alleged date of accident. Mr. Tatelbaum testified that he

told Mr. Berkowitz that Petitioner would automatically be fired if he were to arrive at work late again and have further problems. Mr. Tatelbaum stated that one of the requirements of a pizza delivery driver was to deliver pizzas on time. Mr. Tatelbaum also testified that Petitioner was required to chop vegetables at time, make pizza boxes, and assist others as needed. Mr. Tatelbaum testified that he gave Mr. Berkowitz the authority as the manager, to terminate Petitioner's employment.

Mr. Tatelbaum testified that the business was never run in a way where Petitioner could just show up when he wanted, not check in with anyone, and just take pizzas for delivery without any supervision. Due to Petitioner's past poor performance, he especially emphasized to Petitioner that he was to check in with the manager on duty upon Petitioner's arrival at work. Mr. Tatelbaum testified he never offered Petitioner anything after he was terminated, including the use of a car following the accident. Mr. Tatelbaum testified that he never spoke with Petitioner following his car accident and that no one asked him to pay Petitioner money for his time off work. Tr. pp. 132-153.

Upon cross-examination, Mr. Tatelbaum testified that Mr. Berkowitz told him, within the hour that he fired Petitioner that the petitioner still took the pizzas and made a delivery. Mr. Tatelbaum admitted that he did not have workers' compensation insurance on the alleged date of accident. Mr. Tatelbaum testified that Yerochum was one of the managers at Respondent and that Yerochum never told him about any discussions Yerochum had with Petitioner following the car accident.

CONCLUSIONS OF LAW

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

It is clear from the testimony of all the witnesses that Respondent was a restaurant in operation on the alleged date of accident. Respondent's employees were engaged in serving food to the public and used cutting and slicing tools and instruments as well as equipment such as ovens to prepare the food. Petitioner testified he at times would help with chopping vegetables and it is clear from the testimony that the pizzas served by Respondent were cooked in an oven. Based on the foregoing, the Arbitrator finds that Respondent was operating under and subject to the Illinois Workers' Compensation Act pursuant to Section 3.14 of the Act.

C. Was there an employee-employer relationship?

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a causal

connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

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

It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).
The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances support the decision. *See generally, Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), *see* also *Seiber v Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill.App. 3d 665, 674 (2009).

Petitioner testified that he was employed as a pizza delivery driver at Respondent on June 29, 2014. Petitioner testified his primary duty was to deliver pizzas but he also helped with tasks in the restaurant as needed. Petitioner testified that he arrived to work on June 29, 2014 around 11:30 a.m., did not check in with the manager on duty, and simply took the deliveries that were ready without first discussing the deliveries with anyone. Petitioner testified he received a salary from Respondent and had worked at the restaurant for two to three years prior to the alleged date of accident. Petitioner testified that he was never fired by anyone at Respondent.

There is no question that Petitioner has the burden of proving every element of his claim. This includes proving the existence of an employment relationship with Respondent on the alleged date of accident. The existence of an employment relationship is a prerequisite for any award of benefits pursuant to the Act.

The critical issue in this matter is whether Petitioner was employed by Respondent at the time of the car accident. There is conflicting testimony on this issue. All witnesses provided testimony regarding the status of Petitioner's employment at the time of the car accident. Petitioner testified that nothing out of the ordinary happened when he arrived at work on June 29, 2014, and he delivered pizzas for a waiting order in his usual manner. Petitioner testified that Mr. Berkowitz was not a manager at Respondent and did not supervise him in any way. Petitioner further testified he was allowed to arrive late for work each day as long as the deliveries were made on time and that he never had a conversation with Mr. Berkowitz prior to making the pizza delivery; and was certainly never told he was fired due to his tardiness and poor performance.

Misters Berkowitz Tatelbaum both testified that Mr. Berkowitz was the manager of Respondent on the weekends and was the assistant manager during the week, when the other manager was present. Both testified that Petitioner had been reprimanded in the past regarding his chronic tardiness and poor performance at work. Both testified that on the Thursday prior to the date of accident, Petitioner's performance at work was so poor that he was warned that he would be immediately terminated if there were any further problems with his attendance and performance.

Mr. Berkowitz testified that when Petitioner again arrived 30 minutes late for his shift on June 29, he immediately terminated Petitioner and told him someone else would make the pizza delivery. Mr. Berkowitz testified he terminated Petitioner with Mr. Tatelbaum's approval and notified Mr. Tatelbaum of Petitioner's termination within 45 minutes of it happening. Mr. Berkowitz testified that he also notified Mr. Tatelbaum that despite his termination, Petitioner still took the waiting deliveries. Mr. Tatelbaum corroborated this testimony.

After reviewing all the evidence in the record, it is clear that the final determination of Petitioner's employment status depends on the credibility of each witness. The Arbitrator notes that Petitioner provided no evidence to corroborate his testimony while two separate witnesses testified on behalf of Respondent. However, Petitioner's lack of corroborating evidence is not the only factor considered by the Arbitrator. Instead, Petitioner's conflicting and at times unbelievable testimony throughout the hearing ultimately led the Arbitrator to determine Petitioner was not a credible witness. Thus, his uncorroborated testimony regarding his employment status at the time of the accident was simply not sufficient to meet Petitioner's burden of proving, by a preponderance of the evidence, that he was employed by the Respondent on the date of the accident.

The Arbitrator notes that Petitioner's testimony lacked credibility on several key issues during the hearing. For example, Petitioner testified that he never told anyone that he smoked marijuana on a daily basis. However, the doctor during the nephrology consultation made special note of Petitioner's admission to smoking marijuana on a daily basis. If fact, it appears Petitioner's admission regarding his marijuana use was integral to the treatment of his condition as the doctor noted that marijuana use had been linked to the development of a certain medical condition. Petitioner's testimony regarding his marijuana use was further undercut by his toxicology screening which was positive for marijuana. Furthermore, Mr. Berkowitz testified that Petitioner smelled of marijuana when he arrived to work on June 29, 2014. Petitioner also denied ever telling anyone he used cocaine and in fact denied ever using cocaine. However, the medical record is very clear and the doctor notes that Petitioner stated he used cocaine but stopped one month prior to the car accident.

Petitioner also failed to testify credibly regarding his contact with Yerochum and Mr. Tatelbaum following the car accident. On one hand, Petitioner testified he called Yerochum from the hospital and that Yerochum visited him a few times following his release from the hospital. However, on cross-examination, Petitioner testified that he actually continued to call and speak to Yerochum every week for approximately three months following his discharge from the hospital.

The Arbitrator also notes that Petitioner did not testify credibly regarding any contact he may have had with Mr. Tatelbaum following the car accident. Petitioner initially testified that he spoke to Mr. Tatelbaum approximately one week after his discharge from the hospital and Mr. Tatelbaum told him he would provide money and the use of a car to Petitioner if he would drop his workers' compensation claim and get rid of his lawyer. Mr. Tatelbaum categorically denied this conversation ever occurred. Petitioner initially testified that he never contacted again Mr. Tatelbaum or Respondent regarding benefits or a return to work because he knew Mr. Tatelbaum would not allow him to return. Petitioner then contradicted this testimony when he testified that he continued to call Respondent for several weeks to see if they would provide any benefits to him because he had not yet hired a lawyer and further testified that he even called after Dr. Prieto released him to work with restrictions in November 2014 because he did not have lawyer and wanted to return to work. Petitioner's exhibits contradict this testimony.

On July 24, 2014, Dr. Prieto noted in his medical record that Petitioner already had an attorney. Furthermore, Petitioner's Exhibit 10 is a copy of a letter his lawyer wrote relating to this matter on September 18, 2014. Petitioner testified he had to use crutches until the New Year; however, this testimony is directly contradicted by Dr. Prieto's treatment records.

Finally, the Arbitrator simply does not believe Petitioner's testimony that he was allowed to come and go as he pleased while working at Respondent, without checking in with anyone at the business. The Arbitrator finds it hard to believe that Petitioner was never previously reprimanded for consistently arriving to work late. The Arbitrator also finds it hard to believe that Petitioner did not know that Mr.

Berkowitz was a manager at Respondent. The Arbitrator finds the testimony of both Misters Berkowitz and Tatelbaum far more credible regarding Petitioner's history with the company, the manner in which the business operated; and most importantly Petitioner's immediate termination when he arrived late yet again to work on June 29, 2014. Petitioner's testimony is inconsistent at best, to meet his burden of proof, without any corroborating evidence in light of the evidence provided by Respondent.

Based on the foregoing, the Arbitrator finds that the petitioner has not proven, by a preponderance of evidence, that an employer-employee relationship existed, on the alleged date of accident therefore, no benefits are awarded to Petitioner. In that the petitioner has not proven an employer-employee relationship existed, all other issues are moot and will not be addressed.

16IWCC0713

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
14WC25250
SIGNATURE PAGE

Signature of Arbitrator

March 7, 2016
Date of Decision

MAR 7 - 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WINNEBAGO

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mary LaDore,
Petitioner,

vs.

NO: 11 WC 49072

16IWCC0714

McHenry School District 15,
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, temporary total disability, causal connection, medical, prospective medical, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 14, 2016, is hereby affirmed and adopted.

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

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

NO BOND REQUIRED FOR SCHOOL DISTRICTS.

The party commencing 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: NOV 2 - 2016
O10272016
DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

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

LaDORE, MARY
Employee/Petitioner

Case# **11WC049072**

McHENRY S D #15
Employer/Respondent

16IWCC0714

On 3/14/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

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

STATE OF ILLINOIS)
)SS.
COUNTY OF MCHENRY)

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

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

Mary LaDore
Employee/Petitioner

v.

McHenry S.D.#15
Employer/Respondent

Case # **11** WC **49072**

16IWCC0714

An *Application for Adjustment 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 **Woodstock**, on **January 8, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **February 1, 1010**, Respondent ***was*** operating under and subject 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 $**25,542.92**; the average weekly wage was $**491.21**.

On the date of accident, Petitioner was **52** 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 $**30,875.73** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**30,875.73**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**327.47**/week for **182.13** weeks, commencing **February 2, 2010** through **February 23, 2011**, and from **August 2, 2013** through **January 8, 2016**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**30,875.73** for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of $**8,744.41**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay **the reasonable and necessary medical expenses associated with the cubital tunnel surgery prescribed for the Petitioner by Dr. Freedberg**, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Arbitrator Anthony C. Erbacci

March 9, 2016
Date

MAR 14 2016

FACTS:

On February 1, 2010 the Petitioner was employed by the Respondent as a bus driver, having been so employed since April of 2004. The Petitioner testified that on February 1, 2010, she was driving her bus on the last route of her day when a child who was exiting the bus began to fall forward down the steps. The Petitioner testified that, while she was still belted in her seat, she reached to her right and grabbed the child with her right hand but the child continued to fall into the arms of her mother. The Petitioner testified that as she grabbed the falling child, she felt a popping sensation in her right arm and a throbbing pain in her entire right arm. The Petitioner testified that she completed her route and reported the incident to her supervisor, Vicky Nichols, the next morning.

The Petitioner testified that she completed an accident report and was directed to Centegra Occupational Health where she complained of pain in her right arm as well as tingling in her right ring and little fingers. The Petitioner testified that she is right hand dominant.

The Petitioner was first seen at Centegra Occupational Health Center on February 2, 2010. She reported symptoms in her right shoulder with radiating pain into her right arm. She was advised to utilize a sling, ice the shoulder, and perform light duty work. She treated at Centegra Occupational Health on several occasions under a working diagnosis of right shoulder strain. X-rays to the right shoulder were normal and an MRI performed at Open Advanced MRI on February 18, 2010 was reported to demonstrate a small appearing glenoid labrum with mild degenerative type signal change and no discrete labral tear, mild degenerative changes, and intact rotator cuff and biceps tendon. The Petitioner was directed to begin physical therapy.

On March 4, 2010, the Petitioner was seen by Dr. David Alengo, her primary care physician. He referred her to Dr. Robert Nixon at McHenry County Orthopedics. The Petitioner saw Dr. Nixon on March 17, 2010 and was noted to have complaints of pain in her right shoulder with radiation into the right arm as well as some tingling into her fourth and fifth fingers. Dr. Nixon diagnosed a right shoulder sprain and provided a subacromial cortisone injection. He also recommended physical therapy.

The Petitioner participated in physical therapy at McHenry County Orthopedics beginning on March 23, 2010. During her initial evaluation, the Petitioner was noted to have complaints which included tingling in her fourth and fifth digits. The Petitioner was eventually referred for arthroscopic surgery to the right shoulder, and on August 17, 2010, Dr. Nixon performed right shoulder surgery which consisted of arthroscopic debridement and manipulation under anesthesia. The post-operative diagnosis was right shoulder sprain with adhesive capsulitis and biceps tendonitis.

After surgery, the Petitioner participated in physical therapy at McHenry County Orthopedics between October, 2010 and January, 2011. On January 25, 2011, the Petitioner participated in a Functional Capacity Evaluation. The report of that evaluation indicates that the Petitioner failed 11 out of 22 objective validity criteria and demonstrated inconsistent reliability. The evaluator stated that the Petitioner was more capable than the light to light/medium level of work exhibited during the evaluation. The Petitioner was then referred for work conditioning, which was conducted through mid-February, 2011 at Accelerated Rehab. On February 18, 2011, Dr. Nixon released the Petitioner to return to work as a bus driver and he placed her at maximum medical improvement with no work restrictions as of May 18, 2011.

There is no evidence that the Petitioner treated or sought any treatment for her right shoulder or right upper extremity for nine months, between May 18, 2011 and February 21, 2012. At Arbitration, the Petitioner testified that Dr. Nixon advised her that the right elbow/hand complaints were not causally related to her shoulder.

On February 21, 2012, the Petitioner presented to Dr. Howard Freedberg at Suburban Orthopaedics. The Petitioner related the history of her accident and medical treatment and reported that she was still working full duty, but that she still experienced shoulder pain radiating down into her arm and hand, and that she had felt this pain ever since the date of her work injury. The Petitioner reported experiencing a tingling sensation in her ring finger and pinky finger, and stated that the pain and tingling would affect the whole hand if she did not put her arm down. Dr. Freedberg assessed the Petitioner with right shoulder bicipital tenosynovitis with impingement and ACJ DJD right hand numbness and he recommended an MRI arthrogram of Petitioner's right upper extremity, as well as an EMG nerve test. He kept Petitioner at work full duty.

On March 26, 2012, the Petitioner underwent an EMG/NCV of the bilateral upper extremities, which disclosed multi-level chronic cervical radiculopathy, most prominent at bilateral C6-7 and also active at C5-6 on the right only. She also exhibited mild bilateral carpal tunnel syndrome without denervating changes, and moderate right ulnar sensory neuropathy. On April 16, 2012, Petitioner underwent an MR arthrogram of her right shoulder which was noted to demonstrate mild undersurface partial tearing of the infraspinatus and supraspinatus tendons, mild diffuse tendinopathy, and significant labral substance loss, suggesting a nondisplaced SLAP-type tear and possibly a type IV SLAP tear.

On April 18, 2012, the Petitioner followed up with Dr. Freedberg complaining of right shoulder pain and continued tingling in her fingers--particularly in the little and ring fingers of her right hand. Dr. Freedberg listed the "Cause / mechanism" of Petitioner's condition as "traumatic work reached out to grab a child that was going to fall down the stairs of her bus." Dr. Freedberg ordered a cervical spine MRI which was performed on May 1, 2012, and was reported to demonstrate a minimal central disk protrusion at C5-6, and a minimal left paramedian disk protrusion at C6-7.

On May 23, 2012, Petitioner returned to Dr. Freedberg and reported that she continued to have pain and tingling in her fingers. Dr. Freedberg diagnosed the Petitioner as having right shoulder bicipital tenosynovitis with possible Type 4 SLAP lesion with impingement and ACJ DJD right hand numbness, bilateral carpal tunnel syndrome, right cubital tunnel syndrome, and right cervical radiculopathy. Dr. Freedberg discussed treatment options, including a right shoulder arthroscopic biceps tenotomy vs tenodesis with possible open distal clavicle resection, and the Petitioner elected to proceed with surgery.

On August 2, 2013, the Petitioner underwent a right shoulder arthroscopy, labral debridement, chondroplasty of the humeral head, biceps tenodesis, subacromial decompression, distal clavicle resection, and rotator cuff repair. The Petitioner followed up with Dr. Freedberg post-surgically, and on October 2, 2013, she reported numbness and tingling in the right hand and fingers and new onset of right elbow symptoms. Dr. Freedberg recommended right elbow surgery to address cubital tunnel syndrome.

On April 16, 2014, the Petitioner was examined by Dr. Nikhil Verma at the request of the Respondent. The Petitioner complained to Dr. Verma of numbness in her right hand which began with numbness in the ulnar digits and moved throughout the entire hand. The Petitioner reported that she had not worked since the second shoulder surgery and that she could not work due to the numbness in her right hand. Dr. Verma diagnosed the Petitioner with right lateral epicondylitis and right hand numbness of unclear etiology, and he opined that the Petitioner's right elbow condition was unrelated to her work injury in February, 2010. He saw no temporal relationship between the right elbow complaints and the work accident. Dr. Verma opined that the Petitioner was at maximum medical improvement and was capable of a full duty return to work as a school bus driver.

The Petitioner followed up with Dr. Freedberg on June 25, 2014 and reported that she had no shoulder pain, but she complained of shooting pain from her arm into her right hand, with her hand going completely numb in certain positions. Dr. Freedberg continued the Petitioner off of work pending surgical right ulnar nerve transposition.

On July 28, 2014, the Petitioner was again examined by Dr. Verma at the request of the Respondent. Dr. Verma testified that the history given at this time was consistent with the initial history of injury, two subsequent surgeries, and continued complaints of numbness and tingling in Petitioner's hand. Dr. Verma examined the Petitioner's right shoulder and elbow; he observed a deficit in external and internal shoulder rotation, complaints of pain with external shoulder rotation, and numbness in all digits of her hand. Dr. Verma diagnosed the Petitioner with shoulder status post revision arthroscopy with mild persistent anterior pain. Dr. Verma did not render an opinion with regard to whether the Petitioner's right shoulder condition was causally related to her work accident. Dr. Verma opined that Petitioner had reached maximum medical improvement with regard to her right shoulder and right elbow, that she could return to work as a school bus driver without restrictions, and that there was no indication for further shoulder treatment.

The Petitioner returned to Dr. Freedberg on July 31, 2014 and reported that she had a dull aching pain in her right arm all the time, and that the 10/10 shooting pain comes out of the blue, unpredictably. She remained off work, awaiting surgical authorization. The Petitioner continued to treat with Dr. Freedberg at Suburban Orthopedics between July, 2014 and the date of hearing. At subsequent appointments with Dr. Freedberg on September 4, 2014, October 13, 2014, December 4, 2014, December 23, 2014, January 15, 2015, February 26, 2015, April 9, 2015, May 21, 2015, September 24, 2015, and November 5, 2015, he renewed her Tramadol prescription and continued to opine that she was medically unable to work until right elbow surgery. The Petitioner last saw Dr. Freedberg on December 17, 2015. At that visit, she reported that her symptoms remained unchanged; with tingling in the 4th and 5th fingers on her right hand, as well as sharp pain in her right shoulder on extension of her right arm that radiates down into her forearm. She also reported that the pain would get worse the more she used her right hand, and that it would wake her up at night.

Dr. Freedberg's August 8, 2014 deposition testimony was admitted into the record as Petitioner's Exhibit 8. Dr. Freedberg testified that the Petitioner's shoulder was doing better after her surgery of August 2, 2013, but that the numbness and tingling that had been present from her first visit remained an issue. Dr. Freedberg opined that the shoulder and biceps conditions which he treated surgically on August 2, 2013 were directly causally connected to the Petitioner's work accident of February 1, 2010. Dr. Freedberg opined that but for the Petitioner's continuing cubital tunnel syndrome, she would have been able to return to work as a bus driver.

Dr. Freedberg testified that the Petitioner's mechanism of injury--reaching out with her arm and feeling a pop in her shoulder--was not an uncommon way to produce cubital tunnel syndrome. He testified that if the Petitioner complained of cubital tunnel symptoms to her original treaters, the mechanism of injury she described would be consistent with her diagnosis. Based on the Petitioner's history of symptoms and based on the fact that she complained about them to her initial treating physicians, Dr. Freedberg opined that the Petitioner's cubital tunnel syndrome is causally connected to her work accident.

The October 29, 2014 deposition testimony of Dr. Verma was admitted into the record as Respondent's Exhibit 1. Dr. Verma opined that the Petitioner's right elbow condition was not causally related to her February, 2010 right shoulder work injury. Dr. Verma testified that the EMG performed in 2012 was 2 years after the accident and there was no way to relate those findings back to the 2010 accident. He opined further that there was no indication for further treatment involving the Petitioner's right elbow and that she required no restrictions from working. Dr. Verma stated that for there to have been a causal relationship between cubital tunnel syndrome and the 2010 work injury you would have expected to see a mechanism of injury involving the elbow, pain complaints over the medial aspect of the elbow in the location of the ulnar nerve, and distal numbness complaints in the dermatomal distribution of the ulnar nerve, or in the pinky and ring finger.

The Petitioner testified that she currently continues to experience tingling in her right hand as well as a loss of strength in her right arm and hand. The Petitioner testified that she has not worked since May of 2014 and that she wants to undergo the cubital tunnel surgery recommended for her by Dr. Freedberg.

CONCLUSIONS:

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

The Arbitrator finds that the Petitioner did sustain an accidental injury which arose out of and in the course of her employment by the Respondent. The Petitioner credibly testified to the circumstances of her February 1, 2010 injury and she reported the circumstances of her accident consistently throughout the course of her medical treatment. The Petitioner's testimony was unrebutted and was supported by the medical records admitted into the record. As the Petitioner's testimony was both credible and unrebutted, the Arbitrator finds that the Petitioner did sustain an accidental injury which arose out of and in the course of her employment by the Respondent on February 1, 2010.

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 conditions of ill-being are causally related to the injury of February 1, 2010.

With regard to the Petitioner's right shoulder and biceps, the medical records demonstrate that the Petitioner had no symptoms in her right upper extremity prior to the accident of February 1, 2010. During her initial visit with Dr. Nixon, the Petitioner did not relate shoulder pain existing prior to the accident; her medical history was relevant only for prior thyroid surgery for thyroid cancer. Similarly, the Petitioner denied any prior injury to her right shoulder or neck during her initial visit with Dr. Freedberg. After the February 1, 2010 work accident, the Petitioner began to have consistent symptoms of pain in her right shoulder, particularly in the anterior region. Her right shoulder injuries were established objectively via MRI arthrogram, and via arthroscopic observation in two separate surgeries. Dr. Freedberg opined that the Petitioner's shoulder and biceps conditions which he treated surgically on August 2, 2013 were causally connected to Petitioner's work accident of February 1, 2010. The Arbitrator finds Dr. Freedberg's opinion's regarding the Petitioner's right shoulder and biceps to be credible, reliable, and persuasive, and finds that the Petitioner's right shoulder and biceps injuries are causally connected to her workplace accident of February 1, 2010.

With regard to the Petitioner right cubital tunnel condition, the Arbitrator notes that Dr. Nixon's records of March 23, 2010 demonstrate that the Petitioner complained of right anterior shoulder pain that was shooting down her arm and tingling down into her fourth and fifth digits. The Petitioner's physical therapy records from March 23, 2010 and March 25, 2010 likewise contain evidence of such complaints. On February 21, 2012, the Petitioner reported to Dr. Freedberg that she experienced shoulder pain radiating down into her arm and hand, with a tingling sensation in her ring finger and pinky finger that would affect the whole hand if she did not put her arm down. She stated that she had told Dr. Nixon about these symptoms, and that he never addressed them in his treatment. On April 18, 2012, the Petitioner reiterated that the tingling in her fingers was primarily in her pinky and ring finger. On September 4, 2014, the Petitioner followed up with Dr. Freedberg, complaining of continued pain in her right elbow. She reiterated these complaints repeatedly, and as recently as her last visit of December 17, 2015.

At his evidence deposition, Dr. Verma, testified that if the ulnar nerve had been involved in the Petitioner's injury, he would expect to see complaints of right elbow pain and complaints of distal numbness in the Petitioner's dermatomal distribution: the pinky and ring finger. Dr. Freedberg gave similar testimony during his deposition, testifying that he would expect cubital tunnel syndrome to manifest as some level of symptoms in the little and ring finger, numbness, tingling, decreased sensation, abnormal feelings in that area which could be radiating pain down the arm or elbow pain associated with it.

Based on the Petitioner's history of symptoms and based on the fact that she complained about these very symptoms to her initial treating physicians, Dr. Freedberg opined that the Petitioner's cubital tunnel syndrome is causally connected to her work accident. Dr. Freedberg's opinion finds support in the medical records which indicate that the Petitioner complained of pain radiating down her right arm, as well as numbness and tingling down into her 4th and 5th digits, as early as March 2010. The Petitioner made these complaints to Dr. Nixon on March 23, 2010, again at her initial physical therapy evaluation on March 23, 2010, and a third time at her next physical therapy appointment of March 25, 2010. These complaints appear consistently throughout Dr. Freedberg's records as well, starting with her initial visit of February 21, 2012. While the Arbitrator is somewhat troubled by the nine month gap in treatment prior to her seeing Dr. Freedberg, that gap did not appear to be a consideration in the opinions of Dr. Berna or Dr. Freedberg.

Given that complaints of pain radiating down her right arm and tingling in her ring and pinky finger appear consistently throughout the medical records, and given that the Petitioner's EMG study of March 26, 2012 objectively showed moderate right ulnar sensory mononeuropathy, the Arbitrator finds the opinions of Dr. Freedberg to be credible, reliable, and persuasive. The Arbitrator finds that, in the instant matter, the opinions of Dr. Freedberg are more reliable and persuasive than those of Dr. Verma with regard to the Petitioner's cubital tunnel syndrome. In accordance with Dr. Freedberg's opinion, the Arbitrator finds that the Petitioner's current condition of cubital tunnel syndrome is causally related to her February 1, 2010 workplace injury.

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 parties agree that the Respondent has paid all outstanding medical bills related to the Petitioner's shoulder and biceps injuries, but has not paid any bills related to her cubital tunnel condition. The Arbitrator notes that Dr. Freedberg credibly opined that the Petitioner's treatment to date was reasonable and necessary. As the Arbitrator has found that the Petitioner's current condition of cubital tunnel syndrome is causally related to her February 1, 2010 work injury, the Respondent is ordered to pay all related outstanding related medical bills, totaling $8,744.71.

In Support of the Arbitrator's Decision relating to (K.), Is Petitioner entitled to any prospective medical care, the Arbitrator finds and concludes as follows:

The Arbitrator has found that the Petitioner's current condition of cubital tunnel syndrome is causally related to her February 1, 2010 work injury and the Arbitrator notes that the Petitioner consistently reported symptoms which both Dr. Freedberg and Dr. Verma agree appear in patients with cubital tunnel syndrome. Dr. Freedberg has prescribed additional treatment for the Petitioner to address her cubital tunnel condition. The Arbitrator finds that the Petitioner is entitled to the prospective cubital tunnel surgery prescribed for her by Dr. Freedberg.

In Support of the Arbitrator's Decision relating to (L.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The parties stipulated that the Petitioner was temporarily and totally disabled as a result of this accident from February 2, 2010 through February 23, 2011, as well as from August 2, 2013 through May 1, 2014, and that Petitioner was paid Temporary Total Disability benefits for this period. The Petitioner asserts that she has also been temporarily and totally disabled from March 2, 2014 to the present.

Dr. Freedberg never returned Petitioner to work following her August 2, 2013 surgery. Dr. Freedberg opined that but for the Petitioner's continuing cubital tunnel syndrome, the Petitioner would have been able to return to work as a bus driver. Thus, the disagreement over Temporary Total

Disability benefits seems to turn solely on whether the Petitioner's cubital tunnel syndrome is causally related to her work accident. As the Arbitrator has found that the Petitioner's cubital tunnel syndrome is causally related to her February 1, 2010 work accident, the Arbitrator finds that the Petitioner is entitled to payment of Temporary Total Disability benefits for 182.13 weeks (2/2/2010 - 2/23/2011 and 8/2/2013 - 1/8/2016), minus a credit for Temporary Total Disability benefits previously paid by the Respondent.

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

John Kokolias,
Petitioner,

vs.

NO: 13 WC 15109

16IWCC0715

Sheriff of Cook County,
Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 17, 2016, is hereby affirmed and adopted.

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

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

THERE IS NO BOND REQUIRED FOR COUNTY CASES.

The party commencing 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: NOV 2 - 2016
O10272016
DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

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

KOKOLIAS, JOHN
Employee/Petitioner

Case# **13WC015109**

16IWCC0715

SHERIFF OF COOK COUNTY
Employer/Respondent

On 3/17/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.51% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
DAVID M BARISH
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0132 COOK COUNTY STATE'S ATTORNEY
KEVIN G WALLACH ASA
500 RICHARD J DALEY CENTER
CHICAGO, IL 60602

16IWCC0715

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

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

John Kokolias
Employee/Petitioner

v.

Sheriff of Cook County
Employer/Respondent

Case # **13** WC **15109**

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 **February 18, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned $**65,291.20**; the average weekly wage was $**1,255.60**.

On the date of accident, Petitioner was **34** 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 $**86,218.21** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $**86,218.21**.

Respondent is entitled to a credit of $**deferred – see below** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $837.07/week from April 30, 2013 through March 30, 2015 and from April 30, 2015 through July 24, 2015, a total of 112 2/7 weeks, as provided in Section 8(b) of the Act, with Respondent receiving credit for the $86,218.21 in benefits it paid prior to the hearing.

Respondent shall authorize and pay for the MR arthrogram prescribed by Dr. Hennessey.

Respondent shall pay $8,220.00 in penalties under Section 19(l) for its failure to pay temporary total disability compensation from May 21, 2015 (the day after Petitioner failed his penalties petition) through July 24, 2015.

For the reasons stated in the attached decision, the Arbitrator finds that the physical therapy rendered to Petitioner was reasonable and necessary. Certain disputed physical therapy bills, which were paid by a group carrier, were not available at the hearing. The parties agreed that Petitioner can offer these bills and that Respondent can offer credit-related evidence at a future hearing.

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

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

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

Molly C Mason

Signature of Arbitrator

MAR 17 2016

3/8/16
Date

John Kokolias v. Sheriff of Cook County
13 WC 15109

Summary of Disputed Issues

The parties agree that Petitioner, a deputy sheriff, was involved in a motor vehicle accident while working for Respondent on April 29, 2013. There is also no dispute that this accident led to the need for right shoulder surgeries in 2013 and 2014. The disputed issues include causation, temporary total disability, reasonableness and necessity of physical therapy, prospective care and penalties/fees.

Summary of Parties' Agreement Concerning Incurred Medical Expenses

The parties agreed that Petitioner's group carrier paid some medical bills. However, these bills were not available at the hearing. The parties asked the Arbitrator to address the reasonableness and necessity of the underlying care and agreed Petitioner would not seek penalties or fees on the bills. They also agreed that Petitioner could present bills and Respondent could produce Section 8(j) credit-related evidence at a subsequent hearing.

Arbitrator's Findings of Fact

Petitioner testified he has worked for Respondent since July 2002. He is a deputy sheriff and a sworn officer. His primary duties involve serving summons, orders of protection and other documents in a designated area of the northwest side of Chicago but he is occasionally called upon to perform other duties.

Petitioner testified he underwent training at an academy before being sworn in. He has since undergone additional in-house training. As of the accident, he was qualified to use a firearm.

Petitioner testified his right shoulder felt fine when he began his shift on April 29, 2013. He denied having any right shoulder problems before that day. He is right-handed. Shortly after his shift began, a co-worker called from a different location requesting back-up. Petitioner testified his supervisor directed him to travel to that location to provide assistance. Petitioner began driving his work vehicle eastbound on Grand. At the intersection with Grand, a northbound vehicle struck his vehicle. Petitioner testified the impact was forceful enough to jolt his body and cause his vehicle to spin around. After the impact, he was dazed and felt pain in his head and right arm.

Petitioner testified that paramedics transported him to the Emergency Room at St. Mary of Nazareth Hospital. The paramedic run sheet reflects that Petitioner reported being struck by another vehicle at Grand and Western while heading to a call with his lights and siren activated. The run sheet also reflects that Petitioner complained of right shoulder and back pain. PX 2.

The Emergency Room records set forth a consistent history of the accident. The records also reflect that Petitioner complained of right shoulder and elbow pain and abrasions on the right elbow and near the right eyebrow. The examining physician, Dr. Bannigan, noted a superficial right lateral eyebrow abrasion, mild right lateral cervical muscular tenderness and mild diffuse glenohumeral tenderness with slight crepitance on external/internal range of motion. The physician ordered right shoulder X-rays, which showed no fracture or deformity. The physician diagnosed abrasions and a shoulder sprain/strain. After a technician dressed the abrasions, the physician discharged Petitioner with instructions to rest, apply ice, take Ibuprofen as needed and seek follow-up care. PX 2.

On May 6, 2013, Petitioner saw Dr. Hennessy, an orthopedic surgeon. Petitioner testified that a friend referred him to Dr. Hennessy.

The doctor's initial note sets forth a consistent history of the motor vehicle accident. The doctor noted that Petitioner primarily complained of right elbow and right shoulder pain. He also noted a healing cut near the right eyebrow and a healing abrasion on the right elbow.

On right elbow examination, Dr. Hennessy noted a full range of motion, no biceps defect and a fully intact triceps. On right shoulder examination, he noted near full motion in every direction, negative crossover testing, no acromioclavicular joint tenderness, a little posterior pain with apprehension, occasional clicking, good strength and minimally positive impingement signs.

Dr. Hennessy indicated that Petitioner's right elbow contusion seemed to be resolving and that no formal care was needed. With respect to the right shoulder, he indicated Petitioner "has a strain and possible injury to the rotator cuff or internal structures." He recommended that Petitioner stay off work and begin physical therapy. He directed Petitioner to return in three weeks. PX 3.

Petitioner underwent an initial physical therapy evaluation on May 10, 2013. The evaluating therapist recorded a history of the motor vehicle accident and noted complaints of pain deep in the right shoulder joint and popping with elevation of the right arm. PX 3.

Petitioner continued attending therapy thereafter. On May 28, 2013, the therapist noted improved motion and strength but persistent pain. The therapist recommended four more weeks of therapy. PX 3.

On June 12, 2013, Dr. Hennessy reviewed the MR arthrogram films and agreed with the radiologist's reading of a labral tear. He recommended surgery, noting that "lengthy rehab" would be required and that it was likely Petitioner would not be able to resume working as a deputy sheriff for six months. He directed Petitioner to put the remaining four approved therapy sessions on hold and stay off work pending the surgery. PX 3.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Brian Cole on July 29, 2013. In his report of that date, Dr. Cole recorded a consistent history of the intersection collision of April 29, 2013 and subsequent treatment. He noted complaints referable to the right shoulder and indicated Petitioner reported no relief following three weeks of physical therapy.

On right shoulder examination, Dr. Cole noted significant pain with passive forward elevation, with a positive Neer's sign, along with a positive O'Brien's sign and "legitimate pain with rotator cuff strength testing."

Dr. Cole indicated he reviewed the right shoulder MRI images. He interpreted the MRI as showing a "legitimate superior labral tear with displacement," "nothing worse than rotator cuff tendinitis" and some fluid in the acromioclavicular joint.

Dr. Cole diagnosed a "work-related superior labral tear with legitimate pain, right shoulder." He recommended a right shoulder arthroscopy with evaluation of the superior labrum and "likely biceps tenodesis versus superior labral repair." He indicated he "would maintain a very low threshold, from a surgical standpoint, to perform biceps tenodesis over superior labral repair." He related the need for the surgery to the work accident. He projected that Petitioner would reach maximum medical improvement within four to six months of the surgery. He found Petitioner capable of performing restricted duty, with no lifting/pushing/pulling over 15 pounds, no handling of firearms and no risk for altercation, while awaiting surgery. He characterized the treatment to date as reasonable and necessary. RX 1.

Petitioner next saw Dr. Hennessy on August 28, 2013. In his note of that date, the doctor indicated he met with a nurse case manager after examining Petitioner. He also noted that workers' compensation had "finally" approved the recommended surgery. He directed Petitioner to stay off work and prescribed Norco and Naprosyn to be used postoperatively. PX 3.

On September 23, 2013, Dr. Hennessy operated on Petitioner's right shoulder at Elmhurst Memorial Hospital. In his operative report, he documented a significant labral tear "going posterior from about 12 o'clock all the way to 6 o'clock" as well as some "minimal undersurface mutation of the supraspinatus." He described the biceps tendon as intact. He repaired the tear and performed a glenohumeral debridement and subacromial decompression. PX 3.

At the first post-operative visit, on October 2, 2013, Dr. Hennessy described Petitioner's labral tear as "pretty extensive." He instructed Petitioner to stay off work, return in three weeks and continue performing passive motion exercises at home. PX 3.

On October 22, 2013, Petitioner began a course of care at Midwest Physical Therapy. The evaluating therapist noted that Petitioner reported performing home exercises and complained of waking frequently at night due to right shoulder pain.

Subsequent physical therapy notes describe Petitioner as making some gains in terms of function but continuing to complain of anterior right shoulder pain and weakness with activity. On January 15, 2014, the therapist noted that Petitioner described his shoulder as having worsened since feeling a pop with resisted external rotation on January 8th. Petitioner saw Dr. Hennessy the same day, with the doctor describing the visit as an unfortunate "step backward." The doctor noted that, due to lack of approval, Petitioner had only attended two or three therapy sessions since his last office visit. He described Petitioner's range of motion as having decreased during this period, despite his compliance with a home exercise program. He addressed work status as follows: "'up to now [Petitioner] was making good progress and anticipation was for light duty. That is clearly not going to happen at this visit." He directed Petitioner to stay off work and attend therapy three times a week for one month. He indicated he asked the nurse case manager to "talk to the County about more timely approval [of therapy] particularly this early in the post-op period."

When Petitioner next saw Dr. Hennessy, on January 24, 2014, the doctor noted "yet another setback" due to Petitioner having felt a pop in his right shoulder while using Therabands during therapy for strengthening twelve days earlier. He indicated that Petitioner now exhibited reduced motion and was only able to get to about 130 degrees. He expressed concern that Petitioner "may have torn his repair." He also noted that therapy had been stopped and re-started due to a delay in approval. He described this as sub-optimal. He ordered an MR arthrogram. He directed Petitioner to stay off work and engage in a little therapy. PX 3.

At some point in January 2014, Dr. Cole re-examined Petitioner, at Respondent's request. The report concerning this re-examination is not in evidence. In his subsequent report of September 15, 2014 (RX 2), Dr. Cole indicated that, in January 2014, he had recommended a cortisone injection and had opined that an MR arthrogram "would likely not change decision-making."

Petitioner underwent the prescribed right shoulder MR arthrogram on March 17, 2014. The interpreting radiologist indicated he could not clearly identify the anterior/superior labrum and it was not certain whether this was related to post-operative changes or tearing. He described the rotator cuff as intact and noted findings "suggesting mild biceps tendinopathy."

A "physical therapy discharge report" dated April 17, 2014 reflects that Petitioner was still experiencing anterior shoulder pain and weakness but was being discharged "due to insurance denial." PX 3.

At Respondent's request, Petitioner underwent another Section 12 examination by Dr. Cole on September 15, 2014. In his report of that date, Dr. Cole noted that Petitioner did not experience relief following a previously recommended cortisone injection. He also noted that Petitioner had undergone an MR arthrogram and remained off work, with Dr. Hennessy recommending additional surgery.

On right shoulder re-examination, Dr. Cole noted positive Neer and Hawkins impingement signs and rotator cuff strength of 4+/5 with pain. He described the left shoulder as "unremarkable in comparison."

Dr. Cole interpreted the March 2014 MR arthrogram as showing small, subtle post-operative changes from the previous surgery.

Dr. Cole indicated that Petitioner had only one option other than living with his pain, i.e., a repeat arthroscopy of the right shoulder with biceps tenodesis and evaluation of any other plausible pain generator. He stressed that Petitioner "has enough symptoms in and around the biceps that an empirical long head biceps tenodesis should simply just be done." He found Petitioner capable of restricted duty, with no overhead use of the right arm and no lifting/pushing/pulling over 15 pounds, in the meantime. He found causation as to the need for the repeat arthroscopy. RX 2.

On October 27, 2014, Drs. Hennessy and O'Connor operated on Petitioner's right shoulder at Elmhurst Memorial Hospital. In their operative report, the doctors documented a partial-thickness tear at the base of the biceps tendon and fraying of the inferior labrum. They performed a "mini open biceps tenodesis" and arthroscopic labral debridement. PX 3.

Respondent offered into evidence a ClaimsEval utilization review report dated February 2, 2015 declining to certify another four-week period of therapy. The report is authored by Dr. Brooks, a California-licensed orthopedic surgeon. Dr. Brooks indicated that Petitioner had undergone 24 therapy sessions to date and that ODG guidelines called for exactly that number of sessions following a labral repair. Dr. Brooks explained the decision as follows:

> "While there are ongoing symptoms and improvement from prior physical therapy, the medical necessity of additional physical therapy is not evident considering that the claimant already completed the maximum recommended treatment PT visits. The documentation does not support any extenuating circumstances to support exceeding recommended guidelines for chronic pain. Furthermore, there is no documentation that this claimant has tried and failed an established home exercise program to address the residual complaints prior to return to skilled care. Without further clear and detailed documentation, the medical necessity of additional skilled care has not been established."

RX 5.

At Respondent's request, Dr. Cole examined Petitioner yet again on February 9, 2015. In his report of that date, he indicated that Petitioner reported improvement and near resolution of his right shoulder pain since undergoing the second surgery.

On right shoulder re-examination, Dr. Cole noted a well-healed 4-centimeter incision over the anterior right deltoid, no atrophy in the upper right arm versus the left, internal rotation on the right to L1, full forward elevation and rotator cuff strength of +5/5 against resistance.

Dr. Cole described Petitioner as "nearing maximum medical improvement." He characterized the treatment to date as reasonable, necessary and related to the work accident. He indicated that Petitioner would be capable of resuming full duty, including weapon handling, within six to eight weeks. He recommended that Petitioner continue therapy (specifically a strengthening program) and avoid using his right arm overhead and lift no more than 20 to 25 pounds during that period. RX 3.

Petitioner returned to Dr. Hennessy on February 20, 2015, with the doctor noting that therapy still had not been approved and that Petitioner had requested, but not yet received, Dr. Cole's report of February 9, 2015. The doctor indicated he had twice appealed the denial of therapy and no one had responded to a voice mail he left the preceding Friday. He commented that the delay in treatment was "again jeopardizing [Petitioner's] result." He described Petitioner as "starting to go backwards again." In the last paragraph of the report, he noted that his staff had learned from "Twendolyn [sic] from the insurance company" that Dr. Cole's report had not yet been received and that they needed this report before they would authorize or deny further therapy. Dr. Hennessy directed Petitioner to remain off work and continue his home exercises. PX 3.

On March 20, 2015, Dr. Hennessy noted that Petitioner was still performing home exercises, taking Advil twice daily and attempting to secure a copy of Dr. Cole's most recent report so as to be able to resume therapy. Dr. Hennessy again prescribed therapy, commenting: "hopefully we will get some approved this time." He directed Petitioner to return in four weeks. He did not comment as to work status. PX 3.

A physical therapy re-evaluation dated March 31, 2015 reflects that Petitioner reported to therapy that day "after being off since 2/13/15" due to lack of approval. The therapist noted some deficits in range of motion but indicated Petitioner was still able to use the same weights he had previously used. He recommended another four weeks of therapy. PX 3.

Petitioner returned to Dr. Hennessy on April 20, 2015. The doctor noted overall improvement and indicated Petitioner was still taking Ibuprofen but was now able to perform 10-pound curls in therapy. He prescribed another month of therapy, to be followed by work conditioning, and continued "the same work restrictions." Those restrictions are not outlined. PX 3.

Respondent discontinued the payment of temporary total disability benefits on approximately April 21, 2015.

On April 27, 2015, Petitioner's physical therapist noted overall progress and an average symptom level of 2/10, with ongoing complaints of intermittent crepitus with abduction and internal rotation. The therapist recommended that Petitioner continue therapy three times weekly for four more weeks and then transition to work conditioning. Subsequent records show Petitioner attended only one more session, on April 29th, before therapy was again denied. PX 3.

Petitioner raised no objection to a letter dated May 5, 2015 sent to him by Respondent's director of human resources services. [In fact, that letter is included in PX 4.] The letter advises Petitioner that he is "currently in an unauthorized pay status" with Respondent due to having refused a light duty assignment on the advice of his attorney. The letter offered Petitioner the option of calling to provide an update on his status or reporting to human resources by May 12, 2015 with a medical report from his doctor "to complete the return to work process." RX 10.

Respondent offered into evidence a ClaimsEval utilization review report dated May 8, 2015 authored by Dr. Makda, an Illinois-licensed orthopedic surgeon. In his report, Dr. Makda referenced several recent physical therapy notes, with the last dated April 27, 2015. He indicated the records showed that Petitioner did not participate in therapy between February 13, 2015 and March 30, 2015 but completed an additional twelve sessions between March 31, 2015 and April 29, 2015.

Dr. Makda recommended non-certification of both an additional four weeks of therapy and a subsequent course of work conditioning. He based his non-certification recommendation on the therapy records, which documented an improved range of shoulder motion and strength, and various ODG guidelines. He also indicated that, based on the number of formal therapy sessions Petitioner had attended, Petitioner should be independent in a home exercise program to manage any symptom exacerbations. RX 6.

On May 8, 2015, Dr. Hennessy issued a note describing Petitioner's therapy as incomplete and indicating Petitioner was to "remain off work to complete the additional four weeks as recommended by Dr. Cole as well as myself." PX 4.

On May 11, 2015, Petitioner's counsel transmitted a letter to a Respondent risk management employee, Twanderlyn Salaam, attaching Dr. Hennessy's "off work" note of May 8, 2015 and stating that Petitioner "will not work until he finishes physical therapy." PX 4.

On May 20, 2015, Petitioner filed a 19(b) petition and a petition for penalties and fees citing Dr. Cole's opinions and Respondent's failure to authorize therapy and pay benefits. PX 6.

At Respondent's request, Dr. Cole examined Petitioner again on May 21, 2015. In his report of that date, the doctor noted that Petitioner reported having undergone only four of

the recommended six to eight weeks of therapy due to a delay in getting the therapy started. He also noted that Petitioner was still experiencing mild weakness and pain when positioning his arm overhead.

On right shoulder re-examination, Dr. Cole noted "persistent weakness that is mild in adducted and abducted external rotation against resistance." He also noted subjective pain with passive overhead positioning. He described Petitioner's right shoulder as "appreciably weaker" than his left.

Dr. Cole indicated that, while he would have normally expected Petitioner to be at maximum medical improvement, he felt there were some deficits that could be corrected with four additional weeks of job-specific aggressive rotator cuff and scapulothoracic strengthening. He continued to link the need for treatment to the work accident. He indicated Petitioner should not resume full duty until completing the recommended four weeks of therapy. RX 4.

Petitioner returned to Dr. Hennessy on May 22, 2015 and reported that Dr. Cole agreed with the need for more therapy. Dr. Hennessy noted no change in Petitioner's examination findings. He directed Petitioner to stay off work and resume therapy. He indicated Petitioner should "continue with the home exercise program as best he can in the meantime." He noted that Petitioner's benefits had been terminated as of April 21, 2015. He instructed Petitioner to return to him six weeks after the therapy. PX 3.

A physical therapy discharge note dated May 28, 2015 reflects that Petitioner had attended only one therapy session, on April 29th, since his last visit with Dr. Hennessy "due to denial from workmen's compensation." The therapist indicated Petitioner "would have benefited from transition to work conditioning per MD orders." PX 3.

Petitioner testified he eventually resumed physical therapy after Dr. Cole's May 21, 2015 re-examination. He used his group insurance to pay for this therapy. Petitioner testified this round of therapy helped him significantly. The therapist had him performing more advanced exercises.

On June 3, 2015, therapist Valentini performed an "initial therapy evaluation," noting he had not seen Petitioner since April 29th due to lack of authorization. He described Petitioner as "compliant with his home exercise program." On re-examination, he noted pain with Hawkins testing and some irritability with O'Brien's testing. He also noted "some slight limitations in range of motion, strength, functional mobility, endurance, scaphulohumeral rhythm and reaching." He recommended four weeks of therapy. PX 3.

On July 1, 2015, therapist Valentini noted that Petitioner had progressed "fairly well" during the preceding month. He noted Petitioner was still complaining of posterior right shoulder pain with quick reaching. He described Petitioner's goals as "all nearly met at this time." PX 3.

Petitioner returned to Dr. Hennessy on July 10, 2015. In his note of that date, the doctor indicated that Petitioner "finally had the therapy approved" and reported performing "almost work conditioning levels of training." He also indicated that Petitioner was "finally feeling stronger" and also felt his shoulder was "more stable now that he is getting strengthening." The doctor described the shoulder motion as good. He recommended that Petitioner continue therapy three times weekly through July 20, 2015 and then attend work conditioning two times weekly for four weeks. He released Petitioner to light duty as of July 27, 2015 with no lifting over 10 pounds overhead and with the expectation Petitioner would attend work conditioning twice weekly. PX 5. He directed Petitioner to return in one month. PX 3.

Petitioner offered into evidence a statement from a Respondent nurse, Winifred Shelby, RN, CCM, dated July 24, 2015 opining that Petitioner could resume full duty "per IME" as of July 26, 2015. PX 5.

Petitioner testified he returned to work on approximately July 25, 2015. Dr. Hennessy had released him to light duty a few days earlier. He returned to the same shift in the same unit but performed only office work.

Petitioner returned to Dr. Hennessy on August 14, 2015. The doctor noted that Petitioner attended therapy through July 20th but was unable to secure workers' compensation authority for the prescribed work conditioning. He also noted that Petitioner reported regression and increased soreness in the shoulder.

Dr. Hennessy continued the previous 10-pound overhead lifting restriction and added a restriction of no firing of a firearm. He indicated Petitioner would continue performing light duty in an office setting. He prescribed two weeks of work conditioning and directed Petitioner to return in five weeks. PX 3.

Respondent offered into evidence a Claims Eval utilization report dated August 19, 2015 authored by Dr. Yousef, an Illinois-licensed orthopedic surgeon. In this report, Dr. Yousef recommended non-certification of two additional weeks of work conditioning. He referenced various ODG guidelines and physical therapy notes from July 2015 indicating Petitioner was feeling stronger and performing "almost work conditioning levels of training." He noted Petitioner had attended 42 post-operative therapy sessions between January 7, 2015 and July 17, 2015. RX7.

On August 31, 2015, Dr. Hennessy wrote to utilization review referencing Dr. Yousef's recent non-certification of physical therapy and work conditioning. He described the denial of the recommended care as "completely outside the realm of usual customary treatment." He indicated he disagreed with Dr. Yousef, noting that the doctor failed to acknowledge significant gaps in Petitioner's therapy. He also noted that Respondent's examiner, Dr. Cole, agreed with his recommendation of additional therapy. He went on to state:

> "Essentially, it has been my position that the workmen's

> compensation insurance has done harm to Mr. Kokolias by not allowing a usual rehabilitation program. It's been truncated by court battles and very spotty. In addition, he's had decreased range of motion in the periods when therapy has been denied. This was after him making great gains in therapy when it was approved."

He requested reconsideration of the non-certification "to try to restore [Petitioner] to his full duty employment." PX 3.

Petitioner returned to Dr. Hennessy on September 25, 2015, with the doctor indicating not much had changed and referencing his appeals letter of August 31, 2015.

Dr. Hennessy indicated Petitioner was performing light duty, taking Ibuprofen as needed and "doing the home exercise program as best he can." He noted Petitioner's motion was "slightly diminished to 160 degrees on the right versus 180 degree." He indicated Petitioner reported having to ice his shoulder at the end of a workday "even while doing a lot of paperwork" due to having to file papers "at chest and even head level." He again recommended therapy and stated Petitioner should remain on desk duty with no use of a firearm. He recommended that Petitioner return in six weeks. PX 3.

At the next visit, on November 6, 2015, Dr. Hennessy noted that Petitioner was "a little worse with the weather change" and "fighting to get physical therapy." He described Petitioner's motion as "still pretty good" but indicated Petitioner complained of shoulder pain and tightness. He again recommended physical therapy and stated Petitioner should remain off work and return in six weeks. PX 3.

On December 18, 2015, Dr. Hennessy prescribed an MR arthogram and indicated Petitioner could continue light duty, with no lifting over 10 pounds or above chest height and no firing of any weapon until being re-evaluated. PX 3.

Respondent offered into evidence a Claims Eval utilization review report dated January 7, 2016 authored by Dr. Louwenaar, a New York-licensed orthopedic surgeon. Dr. Louwenaar recommended non-certification of the MR arthrogram. He conceded that an MR arthrogram may be preferred over a conventional MRI to detect a labral tear, per ODG guidelines, but did not see a "clear rationale" for such a study in Petitioner's case, since Petitioner had earlier undergone two surgeries involving the labrum. RX 9.

Petitioner offered into evidence a report authored by Dr. Hennessy on February 16, 2016. In this report, the doctor noted a "very unusual" pattern of the workers' compensation carrier approving only a few sessions of therapy at a time, regardless of his and Dr. Cole's recommendation that therapy be provided continuously. He also indicated that Petitioner failed to improve to the level he had anticipated due to the lack of continuous therapy. He described the denial as resulting in a "sub-optimal home exercise program with little guidance

other than what I could instruct once [a month]." He indicated Petitioner began to worsen, both pain- and strength-wise, resulting in the need for a cortisone injection in November 2015. He stated that this injection "did nothing at all" and that, as of December 2015, he became concerned that Petitioner "may have ruptured some of his repairs."

Dr. Hennessy also explained the need for an MR arthrogram rather than a conventional MRI. He stated that, in patients such as Petitioner who have undergone shoulder surgery, a conventional MRI can sometimes falsely show a rotator cuff tear. He also stated that Petitioner's anterior pain was indicative of a labral problem that would best be evaluated via an arthrogram. He added that an arthrogram would provide more detail and increase the likelihood of a successful labral repair. He indicated that Petitioner's restrictions, as outlined on December 18, 2015, remained in place. PX 3.

Petitioner testified he has not undergone the MR arthrogram recommended by Dr. Hennessy because Respondent has not authorized it. Dr. Hennessy is no longer recommending work conditioning because more physical therapy is needed in order to get Petitioner to the point where he could engage in work conditioning. He wants to resume his former job but his right shoulder feels like it did before he underwent any surgery. The shoulder hurts when he reaches for an object, such as a glass of water. He has to extend his arm slowly when reaching for anything. He cannot use his right hand to wipe himself after using the toilet. He wakes up constantly at night due to pain. His current office work assignment is temporary in nature. After he heals, he hopes to qualify for weapons training and resume his old job.

Under cross-examination, Petitioner reiterated that it was after Dr. Cole re-examined him in May 2015 that his group carrier paid for additional therapy. Dr. Cole recommended physical therapy at an earlier examination, in February 2015, but he was not able to complete all of the recommended sessions. When Dr. Hennessy prescribed therapy, those prescriptions were transmitted to adjuster Twanderlyn but he does not know exactly what supporting documents were provided to or requested by Twanderlyn. He received some utilization review denials, as did his attorney. It was not his place to appeal these denials but he asked Dr. Hennessy to appeal. He knows that Dr. Hennessy appealed because he saw replies that utilization review sent to the doctor. He first started discussing light duty with Dr. Hennessy in late April 2015, when Respondent terminated temporary total disability and they discussed the time frame of the remaining treatment.

Petitioner denied being contacted by Shawn Lynch in April 2015. It was he who contacted Lynch, in approximately July 2015. He told Lynch he was not reporting for work because he had not been cleared by his doctor. Lynch responded as follows: "I don't care what your doctor says – you need to report." Lynch did not mention Dr. Cole.

No witnesses testified on behalf of Respondent.

Arbitrator's Credibility Assessment

Petitioner's status as a sworn officer weighs in his favor, credibility-wise. No physician who treated or examined Petitioner noted any symptom magnification. The Arbitrator found Petitioner credible.

Arbitrator's Conclusions of Law

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims he was temporarily totally disabled from April 30, 2013 through July 25, 2015. Respondent disputed this claim but paid $86,218.21 in benefits, per the parties' stipulation. Records in evidence suggest that Respondent discontinued the payment of benefits on or about April 21, 2015.

The Arbitrator, having reviewed all of the evidence and created the foregoing timeline, finds that Petitioner was temporarily totally disabled from April 30, 2013 through March 30, 2015 and from April 30, 2015 (the day after therapy was again discontinued due to lack of authorization) through July 24, 2015 (the day before Petitioner returned to light duty, according to his testimony). As of April 29, 2015, Petitioner had undergone only four of the six to eight weeks of therapy Dr. Cole recommended on February 9, 2015. Dr. Cole recommended four more weeks of therapy when he re-examined Petitioner on May 21, 2015.

The Arbitrator declines to award temporary total disability benefits from March 31, 2015 through April 29, 2015 for the following reasons: 1) there is evidence indicating Dr. Hennessy found Petitioner capable of light duty on March 20 and April 20, 2015; 2) Petitioner attended therapy on a regular basis from March 31, 2015 through April 29, 2015 (at which point additional therapy was again denied); and 3) there is evidence Petitioner declined Respondent's offer of light duty at a time when Dr. Hennessy viewed him as capable of that duty. On April 20, 2015, Dr. Hennessy noted gains secondary to therapy and indicated Petitioner was to "remain on the same work restrictions," implying those restrictions had been in place since the visit of March 20th. The Arbitrator concludes that, as of March and April 2015, Dr. Hennessy, like Dr. Cole, viewed Petitioner as capable of performing light duty while finishing his therapy. In Freeman United Coal Mining Co. v. Industrial Commission, 318 Ill.App.3d 170, 178 (2000), the Appellate Court noted that a "release to return to work, with restrictions or otherwise" is to be considered in determining whether a claimant has reached maximum medical improvement. In Sunny Hill v. IWCC, 2014 Ill.App.LEXIS 454, (3rd Dist. 2014), the Appellate Court held that the ability to work in some capacity may be relevant to whether and to what extent the claimant's condition has stabilized.

The Arbitrator views Petitioner as again becoming eligible for temporary total disability benefits as of April 30, 2015, the day after Respondent discontinued physical therapy yet again, despite the recommendations of its examiner, Dr. Cole. Dr. Hennessy took Petitioner off work altogether on May 8, 2015, citing his and Dr. Cole's agreement as to the need for therapy and the fact that therapy was again being denied. The Arbitrator views it as very reasonable for Dr. Hennessy to take Petitioner off work at that point. Petitioner did not resume therapy until June

3, 2015, at which point he had to go through his group carrier, despite the opinions Dr. Cole reiterated on May 21, 2015. The Arbitrator acknowledges that Dr. Cole again found Petitioner capable of light duty on May 21, 2015 but there is no evidence indicating Respondent offered light duty at that point.

Was the disputed medical care reasonable and necessary?

As noted at the outset, Petitioner's group carrier paid for some of the disputed physical therapy but the bills were not available as of the hearing. The parties agreed to defer the submission of the bills to a later hearing. They asked the Arbitrator to make a finding as to the reasonableness and necessity of the underlying care. The Arbitrator finds that the physical therapy performed to date was reasonable, necessary and related to the undisputed work accident. The Arbitrator elects to rely on Dr. Hennessy with respect to the duration of physical therapy since the doctor has treated Petitioner over an extended period and has had ready access to the therapy notes. Overall, Petitioner's physical therapy was a "stop and start" affair, with significant delays occurring in February and March 2015 and again after April 29, 2015. The Arbitrator finds credible Petitioner's testimony that his shoulder regressed during those periods when he was attempting to self-treat at home. When Dr. Cole, Respondent's examiner, recommended six to eight weeks of therapy in February 2015, and four weeks of specific strengthening in May 2015, he clearly anticipated this treatment would be started promptly and rendered continuously thereafter. In fact, it was not. Dr. Cole never expressed the opinion that Petitioner would require work conditioning after completing therapy but the Arbitrator views Dr. Hennessy's recommendation of work conditioning as reasonable given that the injury involves Petitioner's dominant arm and that Petitioner's regular public safety job requires him to be out on the streets, attempting to serve individuals with legal documents they do not want to receive. When Petitioner was regularly engaged in therapy, he progressed, reaching a point where he was "almost" performing work conditioning, but he backtracked thereafter, per Dr. Hennessy, after therapy was interrupted again.

Is Petitioner entitled to prospective care?

The Arbitrator finds Petitioner is entitled to prospective care in the form of the MR arthrogram that Dr. Hennessy first recommended on December 18, 2015. The Arbitrator assigns greater weight to the opinions and recommendations of Dr. Hennessy, who has treated Petitioner over an extended period, than to those of Dr. Louwenaar, a utilization review physician who has never examined Petitioner. The Arbitrator notes Dr. Louwenaar conceded an MR arthrogram would afford better visualization of labral pathology, which is what Dr. Hennessy suspects, based on Petitioner's complaints of anterior pain, than a conventional MRI.

Is Respondent liable for penalties and fees?

Petitioner seeks penalties and fees based on Respondent's denials of physical therapy and its refusal to pay temporary total disability benefits between approximately April 22, 2015 and July 24, 2015.

The Arbitrator agrees with Petitioner that Respondent acted unreasonably in bringing prescribed/IME-endorsed therapy to an abrupt halt at various points. The Arbitrator lacks statutory authority to award penalties and fees based on this conduct, however, based on Hollywood Casino-Aurora v. IWCC, 2012 Ill.App.LEXIS 187 (2nd Dist. 2012).

The Arbitrator, having considered all of the available evidence, awards Petitioner $8,220.00 in Section 19(l) penalties based on Respondent's refusal to pay temporary total disability benefits for the period May 8, 2015 (the date on which Dr. Hennessy took Petitioner off work altogether) through July 24, 2015 (the day before Petitioner resumed light duty). The Arbitrator bases this award on the 274 days (multiplied by $30/day) that passed between May 21, 2015 (the day after Petitioner filed PX 6, his penalties petition/formal demand for payment) and the hearing of February 18, 2016. The Arbitrator notes that Section 19(l) penalties are in the nature of a mandatory late fee. See McMahan v. Industrial Commission, 183 Ill.2d 499, 514-5 (1998) and Oliver v. IWCC, Ill.App. 2015 LEXIS 946 (1st Dist. 2015). The standard for awarding penalties under 19(l) differs from the standard for awarding Section 19(k) penalties and fees. [In the Oliver decision, the Court emphasized the use of the directive word "shall" in analyzing the statutory language of 19(l).] The Arbitrator also notes that, once a demand for payment has been made, the burden of proof shifts to the employer to explain the basis for its non-payment. In the instant case, Respondent failed to meet this burden.

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

Ricky Lee Belton, Jr.,

Petitioner,

vs.

NO: 15 WC 05909

State of Illinois/Chester Mental Health,

16IWCC0716

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 medical, prospective medical, causal connection, temporary total disability, over payment of extended benefits, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 2, 2016 is hereby affirmed and adopted.

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

16IWCC0716

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 or summons required for State of Illinois cases.

DATED: NOV 4 - 2016

MB/mam
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Mario Basurto

David L. Gore

Stephen Mathis

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

BELTON JR, RICKY LEE
Employee/Petitioner

Case# **15WC005909**

16IWCC0716

SOI/CHESTER MENTAL HEALTH
Employer/Respondent

On 2/2/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.46% 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:

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

FEB 2 - 2016

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

16IWCC0716

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)

Ricky Lee Belton, Jr.
Employee/Petitioner

v.

State of Illinois/Chester Mental Health
Employer/Respondent

Case # **15** WC **5909**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **January 7, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [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. [x] Other **Credit for overpayment of extended benefits, MMI date, 5% credit on right leg**

FINDINGS

On **November 21, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$64,695.52**; the average weekly wage was **$1,244.14**.

On the date of accident, Petitioner was **32** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in nonoccupational indemnity disability benefits and **$28,881.88** for other benefits, for a total credit of **$28,881.88** under Section 8(j) of the Act.

Respondent is entitled to a credit for any bills paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that his current condition of ill-being is causally related to his accident of November 21, 2014. All benefits are denied, including the prospective medical treatment requested by Petitioner; the remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in nonoccupational indemnity disability benefits and **$28,881.88** for other benefits, for a total credit of **$28,881.88** under Section 8(j) of the Act.

Respondent is entitled to a credit for any bills paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act.

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

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

Melinda M. Pope-Sullivan

Signature of Arbitrator

1/28/16

Date

FEB 2 - 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Ricky Lee Belton, Jr.
Employee/Petitioner

Case # **15** WC **5909**

v.

Consolidated cases: **N/A**

State of Illinois/Chester Mental Health
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he is employed by Chester Medical Health Center, that his job title is that of a Security Therapy Aide I and that he has been so employed since April 2004. He testified that he was injured on November 21, 2014 while at work. He testified that he was approached by a violent recipient who attacked him, and that in the process of trying to restrain the recipient his right knee buckled, he fell to the floor, and he struck his right knee. He testified that it was a hardwood floor.

Petitioner testified that he sustained injuries to his right knee prior to November 21, 2014, and that he had made claims for those accidents. He confirmed that he had prior accidents in April 2013, September 2013, and December 2013. He confirmed that all three of those accidents were settled on a voluntary basis, and that his signature appeared on the previously-approved settlement contract. He confirmed that all three accidents were settled for 5% loss of use of the right leg. He confirmed that before the claims were resolved he treated with Dr. Paletta for his injuries, and he confirmed that this was the same physician who treated him after the November 21, 2014 injury as well.

Petitioner testified that after the November 21, 2014 accident, he originally treated at the Steeleville Clinic with Dr. Preuss, his family physician. He testified that Dr. Preuss tried physical therapy, as well as prescribing anti-inflammatory medications. He also confirmed that Dr. Preuss took him off work. He testified that after he was off work for a brief period of time, he was released back to work on a light duty basis. He testified that he worked light duty from approximately December 7, 2014 to June 7, 2015. He testified that while working light duty he was not allowed to have any contact with the recipients, and that he was basically confined to a room.

Petitioner confirmed that between November 21, 2014 and the time of arbitration, he did not sustain any new injuries to his right leg. Petitioner confirmed that after the accident, he returned to see Dr. Paletta and that he had an injection into his right knee as well as having undergone an MRI. He confirmed that he was also continued on light duty. He testified that he has been working full duty since November 3, 2015 as he was informed that he was eligible to go back to work as a result of Dr. Lehman's report. He testified that Dr. Paletta has not released him for anything other than light duty. He testified that Dr. Paletta has recommended a surgical procedure for his right knee, and he confirmed that he wished to have the procedure performed as soon as possible.

Petitioner confirmed that before the first accident of April 12, 2013, he had not undergone any treatment, had not had any MRIs, nor had he undergone any surgeries to his right knee. He testified that

after he was released by Dr. Paletta for the injuries in 2014 and before the accident of November 14th, he was 90-95% improved but admitted that he never felt 100%.

Petitioner first testified that he was not working full duty as of November 21, 2014, but then changed his testimony so as to say that he was working full duty as of the date of accident. He testified that he had not been missing any work due to his right knee problems prior to that time since his release from Dr. Paletta in mid-2014. He denied that he was taking any narcotic pain medication or prescription anti-inflammatories between the time he was released by Dr. Paletta and the time this accident occurred. He further denied undergoing any physical therapy between the time that he was released and the time this accident occurred.

Petitioner confirmed that Dr. Paletta has seen him on numerous occasions both before and after the most recent accident. He further confirmed that he attended an IME with Dr. Lehman. He confirmed that he cooperated with the examination, and he estimated the length of time of the examination to be 5-10 minutes. He testified that Dr. Lehman did not offer any treatment to him, nor did he recommend any. He denied that Dr. Lehman told him anything about his condition.

Petitioner testified that he still was not quite 100%, and that he still experienced pain. He testified that he had significant pain in his right knee at times, but he denied wearing a brace. He testified that he felt that if he wore a brace while performing his job duties, it put a "target" on his back at work. He testified that he takes Advil or another over-the-counter medication when he needs it. Petitioner testified that he has no problems with his left knee.

On cross-examination, Petitioner testified that he has not received any benefits from SRS. He confirmed that he did not present to his doctor until November 26, 2014. He testified that he did not go to his doctor immediately because there were no available appointments. He testified that November 26th was the first date that he could secure with his doctor's office after the injury occurred. He testified that he did not consider going to the emergency room, and that, while he had pain, he preferred to see his own doctor.

On cross-examination, Petitioner agreed that he had a prior claim on April 12, 2013, which was when he began treating with Dr. Paletta. He further agreed that he had an accident in September 2013 as well as another accident in December 2013. When asked if he knew of any reason why Dr. Paletta was not aware of the last two accidents, Petitioner testified that he had already been seeing him for his injuries and he figured they were "minor considerations or whatever that really wouldn't have done anything." When asked if there was a reason why he did not tell Dr. Lehman about the other two accidents, Petitioner testified that they were still "pre-existing" from the time that he saw Dr. Paletta and he just did not think about them.

On cross-examination, Petitioner agreed that the last time he saw Dr. Paletta for his April 2013 accident was on May 16, 2014. He agreed that at that time he complained of discomfort around his kneecap, that he had discomfort with stairs (particularly ascending), that he took Advil as needed, that he noticed stiffness after long periods of sitting or riding in a car and that he started out with stiffness in the morning. He agreed that Dr. Paletta discussed surgery with him, although he did not recommend it at that point in time. He confirmed that Dr. Paletta advised him that surgery was unpredictable at best.

On cross-examination, Petitioner agreed that he first saw Dr. Paletta for this accident on February 25, 2015. He agreed that he told Dr. Paletta that he never returned to feeling 100%. He agreed that at that time, he had complaints of pain in the medial aspect of his knee, pain while ascending stairs and stiffness after sitting for prolonged periods of time, and that these were essentially the same complaints that he had previously in May 2014.

On cross-examination, Petitioner also admitted that he had a prior injury to his right knee in 2008 as well. He testified that it happened at work, but stated that it was not "relevant" to this claim. He agreed that at that time he complained of a tight feeling, soreness and pain with weight-bearing, and that he was taking Motrin for that injury to his knee. He confirmed that between May 2014 and November 2014, he did not miss any time off work with regard to his right knee.

On cross-examination, Petitioner testified that he usually takes Advil at least once a day. He confirmed that every time he takes Advil, it is for his right knee pain. He confirmed that he is currently working full duty for Respondent. He confirmed that he is able to perform his job duties. He agreed that in May 2014, he was at 90-95% but not 100% recovered. He agreed that he was back to 90-95% now as well. Petitioner agreed that Dr. Paletta has again discussed the same surgery with him. He agreed that Dr. Paletta advised him that the results were unpredictable, that he could get better, he could get worse or he could have no improvement. He agreed that even with the risk of potentially being worse afterwards, he still wanted to proceed with surgery. He testified that when he had the injection, he had relief for a brief period of time.

On cross-examination, Petitioner confirmed that Dr. Paletta has not recommended that he wear a brace at work. He denied ever having injured his left knee while at work. He agreed that Dr. Paletta previously diagnosed him with degenerative joint disease, and that Dr. Paletta briefly explained the condition to him.

On redirect examination, Petitioner testified that his injury occurred on November 21, 2014, which was a Friday. He agreed that the 22nd and 23rd would have been Saturday and Sunday, and that the very next week would have been Thanksgiving. Petitioner testified that he wanted to have the surgery because he was tired of being in pain every day and he was willing to take the chance to feel better.

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Medical Records List was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The medical records of Karen Chamness, PA were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Petitioner was seen on November 26, 2014, at which time he presented with complaints of right knee pain. Petitioner was involved in an altercation the past Friday while at work. He was involved in restraining a recipient and was knocked down, landing on his right knee. He was noted to have a previous history of injury to this knee and was last seen by Dr. Paletta in January 2014. He stated his pain was worse with full flexion or full extension, and that he had pain along the medial aspect of his patella. His pain was worsened when weight-bearing. He was assessed with a right medial collateral ligament strain. X-rays were ordered, and he was given prescription medication. It was noted that he was to remain off work until he returned for a recheck. (PX3).

The records reflect that Petitioner was seen on December 1, 2014. Petitioner reported his pain was somewhat decreased, and that he had been non-weight-bearing with crutches. He noticed increased pain when weight-bearing and did not feel that he was ready to be released. The x-rays revealed mild osteoarthritic changes but no fracture. He was assessed with a right medial collateral ligament strain, and was instructed to continue to limit weight-bearing with the use of crutches. He was instructed to remain off work for the rest of the week and to follow-up on Friday with a probable release to return to work in one week. (PX3).

The records reflect that Petitioner was seen on December 5, 2014, at which time Petitioner reported that he was somewhat improved but not recovered. It was noted that he had been walking without crutches for the last two days and had done well unless he tried to climb stairs or plant his right foot to pivot. He was concerned that he would not be able to fully participate in the activities of his job

and was interested in going back on light duty and undertaking additional treatment. His form was completed to allow him to return to work on December 8, 2014 on light duty, and physical therapy was recommended. (PX3).

The records reflect that Petitioner was seen on January 11, 2015, at which time it was noted Petitioner had completed 11 visits at physical therapy. He continued to have pain in his knee that he rated at 7/10, and it was noted he was currently working light duty. The assessment was right knee pain. An authorization was sent for him to continue physical therapy, and it was noted he would continue light duty until he completed physical therapy. (PX3).

The medical records of Chester Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The interpretive report for x-rays of the right knee performed on November 26, 2014 indicated that the interpreting radiologist's impression was that of mild arthritic narrowing both medially and laterally; possible small effusion although this is equivocal; no fracture. (PX4).

The medical records of Apex Physical Therapy were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. Petitioner underwent an initial evaluation on December 11, 2014. He stated that he was involved in a physical altercation with a violent recipient at the Chester Mental Health facility and was taken to the ground, landing on his right knee. He also stated his leg was "trapped under the patient and twisted up." The Chief Complaint was noted to be medial aspect of right knee pain. His discomfort was constant but occasionally spiked with ascending/descending stairs. He also noted occasional popping and clicking in his knee, but noted a prior history of right knee trouble with similar complaints. He underwent a re-evaluation on January 7, 2015, at which time it was noted Petitioner had attended 11 out of 12 scheduled appointments. He reported his level of discomfort was significantly decreased, and he no longer was reporting constant pain and had less significantly popping and clicking in his knee. He still had some discomfort going up/down stairs. He was working modified duty, and reported that he sat in a room his entire shift. (PX5).

The records reflect that Petitioner underwent a re-evaluation on February 12, 2015, at which time Petitioner reported his level of discomfort was grossly unchanged or even slightly worst as compared to his last re-evaluation. He felt better 2-3 days after therapy, then the pain returned. He was no longer reporting constant pain and had less popping and clicking in his knee, and it was noted that he still had some discomfort going up/down stairs. He was scheduled to see Dr. Paletta on February 18, 2015. (PX5).

The records reflect that Petitioner underwent another Initial Evaluation on March 30, 2015, at which time it was noted that Petitioner had pain over the medial aspect of his right knee. He stated that his knee "always hurts a little bit." His pain was worse with going up/down stairs and sitting long periods of time. He stated that a recent injection had helped "a little bit." He underwent a re-evaluation on April 20, 2015, at which time he reported temporary relief from physical therapy, however he stated his knee continued to hurt when he went up/down stairs, sat for extended periods of time or walked a while. It was noted that his pain was in the medial aspect of the knee. (PX5).

The medical records of Dr. George Paletta were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. Petitioner was seen on February 25, 2015, at which time he presented for evaluation of a chief complaint of right knee pain. His history of injury dated back to November 21, 2014, at which time he was dealing with a combative patient. In trying to restrain the patient Petitioner got pushed towards the left with a flexion valgus mechanism to the right knee and was pushed to the floor, and he apparently hit the inside part of the right knee. It was noted that since that time treatment had included 19 therapy sessions, and that he had been taking over-the-counter anti-inflammatories. It was noted that he had continued complaints of pain which he localized mainly to the medial aspect of the knee, and it was noted he had pain ascending stairs. (PX6).

The records reflect that Dr. Paletta noted that Petitioner was seen previously about two years ago for right knee complaints, at which time he was diagnosed with early medial compartment and patellofemoral compartment degenerative changes. He underwent non-surgical treatment, and stated things improved but that he had never returned to 100%. The impression was that of possible medial meniscus tear versus MCL sprain in the setting of pre-existing medial compartment degenerative joint disease. He was recommended to undergo an MRI scan of the knee. Dr. Paletta noted that if the MRI demonstrated no significant structural abnormality and represented a flare of medial compartment arthritis, then Petitioner may benefit from an injection. He noted that it was his opinion that Petitioner's current right knee condition was caused or aggravated by the work injury of November 2014. It was noted that Petitioner had evidence of pre-existing medial compartment degenerative joint disease as was noted with his previous evaluation, and it was his opinion that the need for further evaluation and ongoing treatment was a result of the incident of November 2014. It was noted that Petitioner was working light duty as tolerated but having no interaction with the recipients or the patients, and Dr. Paletta recommended that he continue to do so. (PX6).

The records reflect that Petitioner was seen on April 22, 2015, at which time it was noted the MRI suggested no evidence of underlying meniscal pathology or any ligament injury. It was noted that Petitioner had undergone an injection by Dr. Blake on March 19, 2015, which Petitioner stated did not provide any long term relief of his symptoms. He continued to complain of pain mainly confined to the medial aspect of the right knee, and there was no radiating pain or associated numbness, tingling or paresthesias. He noted some intermittent swelling, but it was mild. Dr. Paletta's impression was that of symptomatic medial compartment degenerative joint disease without evidence of obvious meniscal or ligament injury. It was noted that Petitioner had exhausted non-surgical treatment options, and that he had been symptomatic for about six months. The options were continued expectant observation and symptomatic treatment versus arthroscopy with debridement and chondroplasty. Dr. Paletta recommended that Petitioner remain on the same work restrictions up until the time of surgery. (PX6).

The medical records of Imaging Partners of Missouri were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The interpretive report for an MRI of the right knee performed on March 11, 2015 referenced an impression of: (1) No sign of meniscal or collateral ligament tear; (2) cruciate ligaments and extensor mechanism is intact with focal proximal and distal patellar tendinosis and mild prepatellar subcutaneous edema; (3) medial tibiofemoral joint space narrowing and marginal spurring with grade II chondrosis; (4) mild joint effusion without loose body. (PX7).

The medical records of Dr. Helen Blake/Pain and Rehabilitation Specialists of St. Louis were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. It was noted that Petitioner was injured while working in his usual capacity at Chester Mental Health Center on November 21, 2014, at which time he was attacked by violent patient and was punched. He was attempting to avoid a full-on attack and in his attempted avoidance, he fell. He was noted to fall directly onto his right knee onto the floor. A right knee intra-articular injection was performed on that date, and Petitioner was instructed to follow-up with Dr. Paletta as previously scheduled to advise of his progress with injection. (PX8).

The evidence deposition of Dr. George Paletta was entered into evidence the time of arbitration as Petitioner's Exhibit 9. Dr. Paletta testified that he was an orthopedic surgeon and was board-certified in orthopedic surgery. He testified that he was fellowship-trained in sports medicine, and that his practice was confined primarily to problems of the shoulder, elbow and upper extremity, as well as the knee. He testified that 35-40% of his practice was related to worker's compensation claims and that he also performed 3-4 medical evaluations per week. (PX9).

Dr. Paletta confirmed that Petitioner had been a prior patient of his before February of 2015. He testified that prior to February of 2015, he had last seen Petitioner on May 16, 2014. He testified that he saw Petitioner from June 5, 2013 through May 16, 2014 also for problems related to the right knee. He

testified that he was treating Petitioner for patellofemoral pain and patellofemoral arthritis. He testified that when he last saw Petitioner on May 16, 2014, he was doing much better than when he had originally seen him. He had been treated with physical therapy and injections and at that point his main complaints were some stiffness after prolonged periods of sitting and some occasional stiffness when he first started to get up in the morning, but other than that the knee was doing well. Petitioner stated that it had never quite returned to what it was before he was in injured. Dr. Paletta confirmed that no surgery was recommended at that point in time. He confirmed that Petitioner was released to return to work in a full duty capacity in May 2014, and that he was placed at maximum medical improvement. (PX9).

Dr. Paletta testified that when he saw Petitioner on February 25, 2015, he was seen for complaints of right knee pain. He testified that Petitioner reported that he had a new injury which occurred on November 21, 2014. He testified that Petitioner stated that he worked as a security aide at the Chester Mental Health Facility and was dealing with a combative patient, and that while trying to restrain the patient his right knee somewhat flexed and bent outward. He reported that as he was pushed to the floor, he hit the inner aspect of his right knee on the floor. He testified that at the time that he examined him, Petitioner had a little bit of loss of flexion and a lot of tenderness along the medial joint line. He testified that x-rays were ordered and performed on the same date, which demonstrated that Petitioner had some narrowing of the joint space on the inside of the knee on the right as compared to the left, and that the findings were consistent with some mild to moderate arthritis on the inside of the knee. He testified that the diagnosis was that of medial compartment arthritis of the knee, and he was concerned about a possible meniscus tear versus a sprain of the medial collateral ligament. He testified that he recommended an MRI. (PX9).

Dr. Paletta testified that it was his opinion that Petitioner's right knee condition was caused or aggravated by the work injury of November 2014. He testified that he had seen Petitioner over the course of June 2013 through May 2014, and that Petitioner had improved dramatically but had never returned to his pre-injury baseline but was at the point where he did not need any treatment and his level of symptoms were minimal. He testified that Petitioner had the new injury in November 2014 and had increased symptoms, and despite appropriate treatment by another provider, his symptoms had not resolved. He testified that Petitioner was having ongoing pain and ongoing symptoms that in his opinion warranted further evaluation. He testified that it was his understanding that Petitioner was on restrictions, and he recommended that those continue. He specifically recommended that Petitioner have no interaction with the patients at his work facility. (PX9).

Dr. Paletta testified that he saw Petitioner again on April 22, 2015, which was after the MRI had been performed. He noted that the MRI did not demonstrate either a meniscus or ligament injury, so he recommended that Petitioner undergo an injection of the knee. He testified that when he saw Petitioner in April, Petitioner had already undergone the injection. He testified that Petitioner reported that the injection did not help him significantly and did not provide any long-term relief of his symptoms, and that he continued to complain of pain mainly on the inside of the knee and some intermittent mild swelling. Dr. Paletta noticed on examination that Petitioner did have evidence of some swelling, and that he had some mild motion losses and continued tenderness on the joint line. He testified that he believed that Petitioner had exhausted his non-surgical treatment, which consisted of 19 sessions of physical therapy, an injection, oral medications and activity modification without improvement. He testified that the options discussed included continuing to try to treat it symptomatically if Petitioner found the pain to be at a tolerable level, or for Petitioner to undergo an arthroscopy, debridement and chondroplasty to see if that would help. He testified that the procedure was relatively unpredictable, and he cautioned Petitioner with regard to the expectations as to how much the surgery might help him. He testified that the only other thing Petitioner could reasonably consider was a lubricating injection, which he had already had. (PX9).

Dr. Paletta testified that the work injury of November 21, 2014 had contributed to the need for additional treatment, which was the recommended surgery. He confirmed that as of the last time he saw Petitioner, he recommended the same restrictions which consisted of light duty as tolerated with no interaction with recipients. He testified that he considered Petitioner's prognosis to be fair at best. He testified that Petitioner had failed non-surgical treatment, so without any additional treatment he was probably going to stay the way he was with some waxing and waning of his symptoms. He testified that if Petitioner did elect surgical treatment, it was unpredictable. (PX9).

Dr. Paletta confirmed that he received the deposition and IME report of Dr. Lehman, and that he had opportunity to review both. He testified that he disagreed with Dr. Lehman's causation opinion that the accident did not contribute to Petitioner's condition. He noted that the reason Petitioner needed additional treatment was because of the continued pain and swelling, and that he had developed the symptoms as a consequence of the injury of November 21, 2014. (PX9).

On cross-examination, Dr. Paletta testified that he was aware that Petitioner had seen Dr. Preuss and physician's assistant Karen Chamness, but he did not believe that he actually saw any medical records from those providers. He testified that Petitioner had x-rays performed on June 5, 2013 and that Petitioner also brought with him an MRI of the right knee that had been completed at Cape Imaging dated April 22, 2013. He testified that these were the only imaging studies that he had prior to the February 25, 2015 visit. He testified that the new studies he had were that of the March 11, 2015 MRI as well as the x-rays performed in his office on February 25, 2015. He testified that he had the films for the MRIs that had been performed. He confirmed that he did not have x-rays taken on April 14, 2013, September 10, 2013, or December 20, 2013, nor did he have the x-rays from November 26, 2014. (PX9).

On cross-examination, Dr. Paletta confirmed that he treated Petitioner previously for his right knee condition, and he confirmed that he previously diagnosed Petitioner with degenerative joint disease and chondrosis. Dr. Paletta agreed that when he saw Petitioner on January 29, 2014, he advised him at that time that if he failed conservative treatment then an arthroscopy might be recommended to treat his underlying patellofemoral chondrosis. He confirmed that this was the same procedure that was being recommended at the present time. He also confirmed that at that time, he advised Petitioner that the results could be unpredictable. (PX9).

On cross-examination, Dr. Paletta agreed that when he saw Petitioner on May 16, 2014, he reported ongoing symptoms which included stiffness and occasional discomfort but no swelling or giving way. He confirmed that Petitioner reported that his stiffness was in the morning or after sitting for long periods of time, and that he had discomfort with stairs, particularly ascending. He agreed that when Petitioner presented to him on February 25, 2015, he reported very similar symptoms. (PX9).

On cross-examination, Dr. Paletta testified that when he saw Petitioner on June 5, 2013, Petitioner told him that he had no prior history of significant knee injury. He testified that when he saw him again on February 25, 2015 Petitioner reported the new injury of November 21, 2014, and that over the entire course of time that he saw Petitioner he reported to him only two distinct episodes of injury. He agreed it was a fair statement that Petitioner did not report to him that he also injured his right knee on September 10, 2013 and December 19, 2013. He also confirmed that Petitioner never advised him that he previously injured his right knee in November 2008. (PX9).

On cross-examination, Dr. Paletta agreed that Petitioner never returned to 100% following his release from care in May 2014. He confirmed that in his note of February 25, 2015, he noted that he had seen Petitioner two years prior but agreed that he had actually treated him 9 months prior to February 25, 2015. He confirmed that in his note of February 25, 2015, he stated that if there were no significant structural abnormalities shown on the imaging studies, then he felt that Petitioner's diagnosis would have been a flare of his medial compartment arthritis. He stated that at that point time it was impossible to say

whether it was temporary or whether it was going to be long-term because Petitioner had not undergone any treatment. He testified that if Petitioner's symptoms resolved and he returned to his pre-injury baseline it would have been temporary, but if Petitioner's symptoms persisted then it would be a more chronic or permanent increase in his symptoms. He agreed that besides the history of having a new accident on November 21, 2014, there was nothing that Petitioner presented to him that was different than when he had previously seen him. (PX9).

On cross-examination, Dr. Paletta confirmed that in waxing and waning, when the symptoms flared that did not necessarily mean that the underlying condition had progressed. He agreed that it was fairly common for a patient with arthritis to experience pain doing activities that were not actually furthering their disease. He agreed that the MRI findings from March 2015 were degenerative in nature. He agreed that the conditions did not develop from Petitioner's November 21, 2014 accident, and he agreed that he did not see any acute findings, processes or tears. (PX9).

On cross-examination, when asked to assume that the radiologist noted that the narrowing of the medial and lateral joint space had progressed from April 2014 to November 2014 and whether that would potentially change his opinion with regard to whether or not the incident of November 21, 2014 aggravated his uncle on underlying condition, Dr. Paletta testified it would not. When asked to assume no accident of November 21, 2014 and whether he could have foreseen Petitioner needing further care and treatment, Dr. Paletta testified that his experience was that, in light of the clinical scenario described, the likelihood was high at some point in Petitioner's future that he was going to need further care. He agreed that his opinion on the cause of Petitioner's aggravation was based upon his subjective complaints and his history. He testified that there was objective evidence on the x-rays from 2013 to 2015 of some progression of his disease, but there was no evidence of any new or acute injury. He agreed that there was nothing to indicate that the progression was caused by an acute injury, so it could have been a progression solely of a degenerative condition. (PX9).

On cross-examination, Dr. Paletta testified that he assumed after he released Petitioner in 2014 he returned to full duty without restrictions, and that if he did have any problems they were minor. He testified that when he released Petitioner he was complaining of some mild symptoms, but he did not think they were enough to prevent him from doing his full duty. When asked if in the interim from May 2014 until right before the injury in November 2014 Petitioner missed work for problems with regard to his right knee and whether that could potentially change his opinion, Dr. Paletta testified that if Petitioner's symptoms were as severe and unremitting as they were after the November 2014 injury, it could potentially change his opinion. When asked if it was possible that the cause for his increase in pain or symptoms could be his weight or an increase in his BMI, Dr. Paletta confirmed that a 70-80 pound weight gain in a two year time span could contribute. He testified, however, that he would still be of the opinion that the incident that was reported was a contributing factor, as well as the weight gain being a contributing factor. (PX9).

On cross-examination, Dr. Paletta agreed that the surgery was unpredictable. He agreed that Petitioner could potentially do another injection of a lubricating nature, which was called hyaluronic acid. He testified that as opposed to a corticosteroid injection, it was an injection that tried to normalize the joint fluid environment in the knee. He testified that Petitioner received a corticosteroid injection by Dr. Blake. He testified that in Petitioner's previous course of treatment, he had undergone a cortisone injection and a viscosupplementation injection, which apparently provided several months' worth of improvement as noted in the May 16, 2014 office note. (PX9).

On cross-examination, Dr. Paletta testified that the best case scenario was that post-operatively Petitioner would likely be off work for four weeks, and that the long range would be eight weeks after surgery. He testified that he was unable to accurately predict how long the surgery would give Petitioner relief. He testified that in the best case scenario it may give him long-term relief on the order of a number

of years, but it was not going to give him a lifetime of relief. He testified that Petitioner was certainly on the younger side and only in his 30's to have that much degeneration in his knee, and that he had fairly typical medial compartment osteoarthritis that was a multi-factorial condition. He testified that there could be genetic-related components, weight-related components, and injury-related components. (PX9).

On cross-examination, Dr. Paletta agreed that the fact that Petitioner had three additional knee injuries that he was not aware of was something that could change his opinion. When asked what information he would need in order to know whether or not that would change his opinion, he testified that he would need the nature of the injury or mechanism of injury, what symptoms resulted and whether those symptoms resolved based on the treatment he received as a consequence of those injuries. He agreed that Petitioner never reported to him either the September 2013 or December 2013 injuries. (PX9).

On cross-examination, Dr. Paletta testified that at the time of the April 22, 2015 visit, Petitioner described that he was continuing to have pain in the medial aspect of the knee that was basically unchanged, and that he also noted some intermittent swelling. He testified that his pain was unchanged from February to April. He testified that when he saw Petitioner in June 2013, Petitioner had a level of pain that was treated and that the pain was significantly reduced, but was never completely eliminated. He testified that Petitioner had been living with that pain and had a tolerable level of pain until the injury in November 2014. He testified that at that point in time, Petitioner had increasing pain that did not resolve and that he did not return to his pre-injury baseline. He confirmed that he has not seen Petitioner since April 22, 2015, and that if Petitioner was in unrelenting pain and wanted treatment for his condition, he would potentially take his group health insurance in order to undergo the surgery. (PX9).

On redirect examination, Dr. Paletta testified that he did not know if Petitioner would get paid if he was off work for a surgery that worker's compensation had not approved, but his assumption was that Petitioner would not be paid. He testified that if Petitioner sustained the additional injuries before the last time he saw him for the initial course of treatment, it would not change his opinion because Petitioner's status was well-established when he was discharged. He indicated that if Petitioner had those injuries during the course of that treatment, they did not ultimately materially affect his status because as of May 16, 2014, he was having mild symptoms and felt that he could return to full duty. (PX9).

The Workers Compensation Employee's Notice of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The document identified a date of injury or illness of November 21, 2014, and that right knee pain was noted. Petitioner admitted that he submitted previous claims for injury/illness to the right knee in 2012 and 2013. (RX1).

The Supervisor's Report of Injury or Illness was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The date of accident/incident was noted to be November 21, 2014, and it was noted that Petitioner was attempting to restrain a combative recipient. Petitioner was struck in the face and twisted his right knee. (RX2).

The Initial Worker's Compensation Medical Report was entered into evidence the time of arbitration as Respondent's Exhibit 3. The report was dated November 21, 2014. The date of accident was noted to be November 21, 2014, and this was also the date of examination. Petitioner landed on his right knee in a tussle with a recipient. (RX3).

The IME report of Dr. Richard Lehman dated July 9, 2015 was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The IME report indicated that Petitioner gave a history of being injured twice. Petitioner stated that he was injured in 2013 and was subsequently injured on November 21, 2014 as well. Petitioner stated that he was trying to restrain a patient and the patient fell on him. His right knee hit the floor when he was involved in the altercation. He stated that he had two courses of

physical therapy. The Past Medical History was noted for being positive for being treated by Dr. Paletta, and Petitioner stated that he did injure the right knee prior. On physical examination, he had evidence of pain over the medial aspect of the knee but it appeared to be more in the medial column which was along the medial collateral ligament and then along the saphenous nerve area. He had mild medial joint line tenderness, and he also had soreness in the area of the saphenous nerve. He had tenderness to palpation in the area of the saphenous nerve, but had no instability of the knee. There was no evidence of instability of the patellofemoral joint. (RX4).

The IME report reflected that x-rays performed on the date of the examination revealed some mild joint space narrowing. Dr. Lehman indicated that the MRI showed some degenerative changes on the medial aspect of the knee, but on physical examination the objective exam was normal. He noted that the diagnosis was degenerative joint disease medial aspect of the knee and irritation of the saphenous nerve. He opined there was no causal relationship between Petitioner's current objective findings and the reported accident, and he believed that the findings were more consistent with a degenerative process. He did not believe that the accident created degenerative arthritis in the medial aspect of Petitioner's knee. He noted that there did appear to be chondrosis medially, but Petitioner did have some irritation along the saphenous nerve. (RX4).

The IME report indicated that Dr. Lehman opined that Petitioner's medical treatment had been reasonable and necessary as it related to his degenerative arthritis, and he believed that further medical treatment was reasonable. He suggested that Petitioner would be a candidate for a series of hyaluronic acid injections for his degenerative arthritis, but he did not believe that this would in any way be related to his work injury. He further suggested that if he did not improve with a series of hyaluronic acid injections, he was a candidate for an arthroscopy. Dr. Lehman noted that Petitioner's prognosis was fair due to the irritation along the medial aspect of the knee, which was not consistent with intra-articular pathology but more along the saphenous nerve. He indicated that Petitioner was able to work without restrictions, and he believed that petitioner was at maximum medical improvement as it related to his joint. Based on the Sixth Edition of the *AMA Guides to the Evaluation of Permanent Impairment*, he opined that Petitioner had a 0% permanent partial disability rating for his work injury. (RX4).

The evidence deposition of Dr. Lehman was entered into evidence at the time of arbitration as Respondent's Exhibit 5. Dr. Lehman testified that he was an orthopedic surgeon and that he was board-certified in sports medicine and orthopedic surgery. He testified that his practice was primarily surgical and was comprised mostly of sports-related injuries, including the knee, shoulder, elbow and ankle. He noted that the majority of the surgeries he performed were arthroscopic knee and shoulder injuries, with a significant number of elbow reconstructions. He testified that his practice was primarily surgical, and that the number of IMEs and medical/legal patients that he saw was less than 1%. He testified that approximately 50-60% of his practice was devoted to the care and treatment of knee conditions, and that the majority of knee conditions were treated conservatively. (RX5).

Dr. Lehman confirmed that he reviewed various medical records as part of the performance of the IME. He testified that he had the interpretive report as well as the MRI films, but was not sure if he had the x-ray films. He confirmed that he obtained a history from Petitioner, that he stated he was at work trying to restrain a patient at Chester Mental Health, and that he was involved in an altercation and basically fell and hit his right knee. He testified that Petitioner told him he had a previous injury in 2013, and he agreed that if Petitioner actually had three previous injuries to his right knee in 2013, that was contrary to what was reported to him. (RX5).

Dr. Lehman testified that Petitioner was complaining of soreness on the inside or medial aspect of his right knee. When asked if he would be surprised if Petitioner previously had complaints of right knee pain in a similar manner prior to the November 21, 2014 accident, Dr. Lehman said that he would not be. He testified that based on the medical records, it appeared that Petitioner stated that he never completely

resolved his pain from his previous incident. He testified that if you looked at his MRI and x-rays, Petitioner had degenerative arthritis in his knee. He testified that it would not surprise him that Petitioner had some discomfort prior because degenerative arthritis took a long time to develop and basically was an indolent process that was long-term in nature. (RX5).

Dr. Lehman confirmed that he performed a physical examination, which revealed pain on the inside or medial aspect of the knee which he characterized as medial column along the medial collateral ligament and along the saphenous nerve. He noted it was not isolated to joint center pain. He testified that Petitioner did not have significant acute pain like one would see in someone who might have a meniscus tear or an acute process. He testified that he believed Petitioner had degenerative joint disease of the medial aspect of his knee and irritation of the saphenous nerve. (RX5).

Dr. Lehman testified that he did not believe that Petitioner's condition was caused or aggravated by his alleged work accident of November 21, 2014. He testified that the most objective evidence or information he had was the MRI that Petitioner had subsequent to his incident. He testified that Petitioner had what appeared to be long-term chronic changes, but there was nothing on the MRI that suggested an acute process (such as a medial meniscus tear) that would suggest that something happened to his knee or that there was an alteration of his knee in this incident. He further testified that in looking at the medical records, it appeared that this was the same exact problem and same exact anatomical area for which Petitioner had similar complaints previously. (RX5).

Dr. Lehman testified that all of Petitioner's complaints appeared to be referable to the same medial area. He testified that spurring took a long time to develop, and that it was a process that occurred over many years. He further testified that to get true narrowing of the joint space it took years and was not an acute or even a semi-acute process. He testified that grade II chondrosis was part and parcel of the same degenerative process. He testified that the fact that Petitioner had narrowing and grade II chondrosis suggested a chronic or long-term process, and these were not something that he would expect to have seen develop from the time of the November 21, 2014 accident to when the MRI was performed on March 11, 2015. (RX5).

When asked to assume that Petitioner had an MRI of the right knee on April 22, 2013 that showed effusion and medial and patellofemoral compartment chondrosis, Dr. Lehman testified that he believed that was consistent with the current MRI as well as the medical records. He testified that, as Dr. Paletta stated, Petitioner did not return to 100% which suggested the case of degenerative arthritis. He testified that he agreed that the arthroscopy with debridement and chondroplasty was unpredictable at best, and that some patients had dramatic relief while some did not get any significant improvement. He further testified that he suggested that Petitioner might try a series of hyaluronic injections to treat his degenerative changes, and that he believed that would be a reasonable course of treating the degenerative arthritis. He confirmed, however, that he did not believe that the treatment recommendations were related to the alleged November 21, 2014 accident. Dr. Lehman confirmed that at the time he saw Petitioner, he believed that he was at maximum medical improvement. He testified that he believed that Petitioner was able to work without restrictions. (RX5).

On cross-examination, Dr. Lehman testified that he was performing one IME every two weeks and maybe one or two depositions every two weeks, and that this was a small part of his practice. He agreed that this number was smaller than it was previously, as he had been doing more sports-related traveling. He agreed that in 2013 he gave 110 depositions in connection with performing IMEs, and that of those 110, he gave 10 on behalf of the State of Illinois. (RX5).

On cross-examination, Dr. Lehman agreed that Petitioner gave a history of injuring himself on November 21, 2014, and that he also indicated that he had some prior injury in 2013 to the same knee. Dr. Lehman agreed that the history Petitioner gave to all of the providers was consistent in terms of the

November 2014 injury, and he testified that he took him for his word as to whether the accident actually occurred. He agreed that he was not provided with any medical records prior to the date of the November 21, 2014 accident to review. He agreed that he was familiar with Dr. Paletta professionally in the community, and that he thought he was a good doctor and surgeon. (RX5).

On cross-examination, when asked whether he would agree that Dr. Paletta had more information than him with regard to Petitioner's right knee given that he treated petitioner both before and after the November 21, 2014 injury, Dr. Lehman responded that he did not believe that Dr. Paletta had any more information as he had the same MRIs, the same x-rays, and the same physical examination. He testified that if one wanted to ask Dr. Paletta about what happened two years ago he might be in a better position to answer questions about that, but Dr. Paletta clearly stated his situation in the medical records in this case. He agreed that he did not have the opportunity to review any prior imaging studies before the November 2014 accident, but admitted that he did not know if Dr. Paletta had. (RX5).

On cross-examination, when asked whether he disagreed with Dr. Paletta's causation opinion as contained in his February 25, 2015 note, Dr. Lehman pointed out that the causation opinion contained in the note pre-dated the MRI so he was of the position that his opinion was made without the benefit of the most objective criteria. He testified that the MRI did not show any acute meniscus tear nor did it show any acute damage, and he suggested that every orthopedic surgeon that looked at that MRI was going to suggest that the problems were degenerative. He agreed that he and Dr. Paletta both interpreted the x-rays of Petitioner's right knee as demonstrating a little bit of medial joint space narrowing. (RX5).

On cross-examination, Dr. Lehman testified that Petitioner told him that he was injured in 2013, but he agreed that subsequent to the November 2014 injury Petitioner did not report to him any other injuries or traumas to the right knee. When asked if he would agree that the characterization of Petitioner's condition as symptomatic medial compartment degenerative joint disease and that the only thing that they had to blame for that was the November 2014 injury, Dr. Lehman responded that Petitioner told Dr. Paletta he never resolved his symptoms from his last incident. He testified that it was clear from the medical records that Petitioner had symptoms prior to the November 2014 accident, and this was coupled with a gentleman who weighed 300 pounds that had noted degenerative arthritis in 2013. When asked if he knew when was the last time Petitioner sought any medical care and treatment for his right knee before the November 2014 accident, Dr. Lehman responded that he did not know the specific dates other than the care and treatment he received in 2013 as referenced in Dr. Paletta's note. He agreed that from the medical records he reviewed, the next time Petitioner appeared to seek treatment with any medical provider was after his November 2014 accident. (RX5).

On cross-examination, Dr. Lehman confirmed that when Petitioner was in his office in July 2015, he continued to have complaints. He testified that Petitioner had symptoms in the same area and the same type of symptoms, so he believed that Petitioner had been symptomatic all the way through. He agreed that Petitioner would be in the best position to tell about what the level of symptoms were both prior to and after the November 2014 injury. Dr. Lehman agreed that he had no reason to think that Petitioner was magnifying his symptoms or malingering. (RX5).

On cross-examination, Dr. Lehman confirmed that the settlement agreement between him and the Missouri Board of Healing Arts contained his signature on the last page, and that he signed the document at the request of his attorney. (RX5).

On redirect examination, Dr. Lehman described standing x-rays as those that were performed while weight-bearing to see what the knee was doing when it was loaded. He agreed that the more views you had on x-rays, the more information you were going to have. He testified that in rendering causation opinions, he thought objective information was more important than subjective information because everyone's threshold of subjective information was different. He agreed that, concerning Petitioner's

arthritis in his knee, he can experience pain performing different activities that actually did not progress his underlying arthritic condition. He agreed that pain did not automatically equate to a worsening of the condition, and that pain was a manifestation of the underlying problem. (RX5).

The medical records of Steeleville Clinic were entered into evidence the time of arbitration as Respondent's Exhibit 6. Petitioner underwent an MRI of the right knee on April 22, 2013, the impression of which was that of (1) mild right medial and patellofemoral compartment chondrosis with small knee effusion; (2) minimal right superficial infrapatellar bursitis. The History noted right knee pain after an injury on April 12, 2013. Also included within the records was an interpretive report for x-rays of the right knee performed at Sparta Community Hospital on April 14, 2013, which were interpreted as revealing no acute of bony abnormality identified; mild degenerative arthritis; if pain persists, consider MRI for further evaluation of occult meniscal pathology. (RX6).

The records reflect that Petitioner was seen on November 25, 2008 complaining of an injury to his right knee that happened three days ago at work. He reported a tight feeling and soreness. He was able to bear weight, but with some pain. He stated that somehow he wound up on the bottom of a pile in a struggle of multiple workers and a violent, unruly patient. No previous injury was reported. The assessment was that of right knee injury, possible internal derangement. He was recommended to undergo an MRI. X-rays were performed at Memorial Hospital on November 26, 2008, which were interpreted as revealing no evidence of radiographic abnormality. Petitioner was seen on December 2, 2008, at which time he indicated he did not know exactly how it happened on November 22, 2008 but he was in a pile of workers and a recipient who had been fighting them. He reported he did not know if he twisted his knee, and he did not really think he hit the knee but complained more of pain on the inside portion. He stated he was back at work and was running, and then had sudden pain again. He stated that he had some pain with weight-bearing, but not anything regular. The assessment was that of right knee injury, possible meniscal tear versus MCL sprain strain. He was again recommended to undergo an MRI, and was allowed to return back to light duty starting the following day. (RX6).

The records reflect that Petitioner underwent an MRI of the right knee at Sparta Community Hospital on December 5, 2008, which was interpreted as being a normal magnetic resonance imaging of the right knee. Petitioner was seen on December 9, 2008 in follow-up for his right knee injury. It was noted that the mechanism of injury was not clear. Petitioner had some medial pain on the right knee over the joint space toward the patella. He was assessed with a right knee strain and was allowed to return to work regular duty. (RX6).

The records reflect that Petitioner was seen on April 12, 2013, at which time it was noted he injured his right knee while at work at mental health at approximately 1 p.m. Petitioner was trying to restrain a violent recipient and others came to help. He was thrown or fell backwards and twisted his right knee. He noted he had been finding it hard to bear weight after that. He denied previous injury. It was noted that he hurt mainly over the medial joint space and tibial plateau. The assessment was that of right knee injury, could be medial meniscal tear with twisting although he had not been able to walk to know if it locked or caught, and it was noted that he could possibly have a tibial plateau fracture. He was placed in a knee immobilizer, and given medications. X-rays were also ordered and performed at Sparta Community Hospital on April 12, 2013, which were interpreted as revealing no acute bony abnormality, mild degenerative arthritis, and consider MRI if pain persists. Petitioner returned on April 15, 2013, at which time he stated he was still having trouble with weight-bearing. It was noted to hurt more medially. On exam tenderness was noted over the tibial plateau/medial joint space. He was assessed with a right knee injury, possible meniscal tear, doubtful tibial plateau fracture. An MRI was ordered, and he was told to try to keep range of motion of the knee. (RX6).

The records reflect that Petitioner underwent an MRI of the right knee on April 22, 2013 at Cape Imaging. The impression of the interpreting radiologist was that of: (1) mild right medial and

patellofemoral compartment chondrosis with small knee effusion; (2) minimal right superficial infrapatellar bursitis. Petitioner was seen on April 25, 2013, at which time it was noted that his MRI showed just osteoarthritis under the patella more on the right side, and perhaps mild effusion. He reported difficulty with weight-bearing, but denied locking and catching. He was assessed with a contusion knee/sprain, possible exacerbation pre-existing osteoarthritis. An injection was performed, and a work slip was issued. (RX6).

Included within the records was that of an Orthopedic Center of St. Louis note of June 5, 2013, at which time Petitioner presented for evaluation of a chief complaint of right knee pain dating back to an incident which occurred on April 12, 2013. Petitioner reported that one of the patients/clients struck another worker and that he tried to restrain him, and in doing so the patient fell directly on top of him. He described the patient landing on the anterior aspect of the knee as he fell backwards. He had immediate pain in the right knee but no swelling. He complained of persistent pain in the knee, and it was noted he had pain with stairs. He noted pain and stiffness after long periods of sitting. He denied any locking or mechanical symptoms, and denied significant clicking. There was no prior history of significant knee injury, and it was noted he was currently working full duty but did miss a few days of work after the initial injury. Dr. Paletta's impression was that of (1) post-traumatic patellofemoral pain in the setting of early medial and patellofemoral compartment chondrosis; (2) no evidence of significant structural abnormalities such as meniscus tear or ligament tear. He was recommended to consider a viscosupplementation injection, and it was noted there was no indication for surgical treatment at that point in time. (RX6).

Included within the medical records was an interpretive report for x-rays of the right knee taken at Memorial Hospital on September 10, 2013. The impression of the interpreting radiologist was that of no radiographic evidence to suggest acute bony fracture. The findings were compared to November 26, 2008. The Indication was noted to be knee pain, injury. (RX6).

The records reflect that Petitioner was seen on September 12, 2013, at which time he presented with complaints of right knee pain after he was involved in an altercation at his work on September 10, 2013. He was noted to be attempting to restrain a combative patient, and he was pushed down. His right leg was pinned laterally and his right knee was twisted. He was referred to the emergency room at Chester Hospital, and x-rays were read as negative. It was noted that on September 9th he had an injection by Dr. Blake at St. Luke's Orthopedics, and it was noted he had a previous history of an injury to the knee earlier in April but had been doing better since that time. He was assessed with a right knee strain, and he was instructed to ice his knee and use Aleve. It was noted that any further treatment would be pending his response to the conservative therapy. (RX6).

The records reflect that Petitioner was seen on September 16, 2013, at which time he stated that he was improved. Despite having some residual pain, he stated he would like to return to work. He was assessed with a right knee strain, and he was to return as needed. Petitioner was next seen on October 31, 2013, at which time he presented with complaints of persistent right knee pain. It was noted he had injured his knee in April, and that an MRI did not reveal any ligamentous injuries or meniscal injuries. He had an injection in the knee which gave him some temporary relief, but one week after the injection he injured his knee again. He continued to work and indicated that the knee was still giving him problems, and reported some crepitus and occasional locking but no instability or effusion. He was assessed with persistent right knee pain. He was to contact the workers' compensation orthopedist for re-evaluation. Petitioner next returned on December 20, 2013, at which time it was noted he had had a new injury to his right knee the day prior while at work. It was noted that he had previous injuries to the same knee while at work dating back to May and September, and that he saw Dr. Paletta in Chesterfield. He was dealing with a violent patient/recipient and was trying to help handcuff him, and he landed on his knee directly on the floor at the kneecap area. He stated it was more painful and harder to get around. The assessment was that of right knee injury rule out patella fracture not too likely, more likely contusion with perhaps

exacerbation of his chondromalacia patella. X-rays were ordered, and Petitioner was instructed to remain off work and to see Dr. Paletta. (RX6).

The records reflect that Petitioner underwent x-rays of the right knee at Memorial Hospital on December 20, 2013, which were interpreted as revealing no evidence of acute fracture. Comparison was made to September 10, 2013, and the indication was knee pain, injury. The records reflect that Petitioner was next seen on January 3, 2014, at which time it was noted he still had some pain but was taking Ibuprofen and was overall better. He had been on light duty and wished to return. He had been diagnosed with chondromalacia patella, and he had previous injuries all related to work. He still hurt mostly under the kneecap and medial to it. He felt he could do his regular job now. The assessment was that of likely chondromalacia patella exacerbation/contusion, and Petitioner was recommended to follow up with Dr. Paletta for further treatment. He returned on January 14, 2014, at which time it was noted he had been seen in the emergency room on January 9, 2014 and given a shot for pain and instructed to be off work. He was assessed with chondromalacia patella, apparent exacerbation. He was returned to light duty work, and it was noted he needed to see Dr. Paletta for the next step in treatment. (RX6).

Included within the Steeleville Clinic records was an interpretive report for x-rays of the right knee performed at Memorial Hospital on April 20, 2014. The impression of the interpreting radiologist was that of mild arthritic narrowing laterally; no acute fracture; if clinical symptoms persist, recommend consideration for further evaluation with knee MRI study. The indication was that of trauma, knee pain. (RX6).

Included within the records was a handwritten note dated May 23, 2013, indicating that Petitioner called for an appointment because his knee was still bothering him. He was given an appointment for May 30, 2013. He called back on the same date, indicating that he wanted an off work slip until his appointment on May 30, 2013. He was offered an appointment that same day at 4:00 p.m. due to a cancellation, but he did not accept the appointment. He indicated he was going to call his attorney and see what he should do, and the office representative indicated that his attorney would not be able to keep him off work and that he needed to have his doctor make that determination. On May 30, 2013, Petitioner called and canceled his appointment for that date, indicating that "something came up." (RX6).

Included within the medical records from Steeleville Clinic was that of an interpretive report for x-rays of the right knee taken at Memorial Hospital on November 26, 2008. The x-rays were interpreted as revealing no evidence of radiographic abnormality. (RX6).

The medical records of The Orthopedic Center of St. Louis were entered into evidence at the time of arbitration as Respondent's Exhibit 7. The records reflect that Petitioner was seen on January 29, 2014, at which time he returned for continued follow-up. It was noted he had not been seen since June 2013, at which time he was diagnosed with patellofemoral pain in the setting of pre-existing patellafemoral and medial compartment chondrosis. A recommendation had been made at that time for viscosupplementation injection. Petitioner noted that he underwent the injection in September, but it did not provide any significant improvement in his symptoms. Over the last four months he had had continued intermittent pain, and he complained of pain under the kneecap and on the inside of the knee. Pain was mainly activity-related, and it was noted he had been on light duty for the last month. Dr. Paletta's impression was that of persistent patellofemoral pain in the setting of known patellafemoral chondrosis. It was noted that Petitioner had not fulfilled all the recommendations for treatment, and that he had not had any physical therapy as per the patellofemoral rehab protocol. It was noted that arthroscopy was highly unpredictable in the setting of patellofemoral pain and patellofemoral chondrosis. Dr. Paletta did not recommend any surgery at that time, but noted this would be the last resort if he were to fail all other options. Dr. Paletta noted that Petitioner could work full duty, and he recommended that he undergo six weeks of physical therapy twice weekly as per the patellofemoral rehab protocol. He was also recommended to take a prescription nonsteroidal anti-inflammatory. It was noted that if he ultimately

failed a comprehensive non-surgical treatment, then one could consider arthroscopy but it would be highly unpredictable. Dr. Paletta further recommended a repeat MRI scan to evaluate for any progression of his chondrosis or other change in the knee status. (RX7).

The records reflect that Petitioner was scheduled to see Dr. Paletta on July 22, 2013, but he failed to keep the appointment and did not call to cancel or reschedule. (RX7).

The records reflect that Petitioner was seen on June 5, 2013, at which time he presented for the first visit with Dr. Paletta for evaluation of a chief complaint of right knee pain dating back to an incident which occurred on April 12, 2013. He noted that apparently one of the patients/clients struck another worker, the patient tried to run away and Petitioner tried to restrain him, and in doing so the patient fell directly on top of Petitioner. He described the patient landing on the anterior aspect of the knee as he fell backwards. He had immediate pain in the right knee but no swelling. He had complaints of persistent pain in the knee, and it was noted he had pain with stairs. He also noted pain and stiffness after long periods of sitting. He denied any locking or mechanical symptoms, and there was no significant clicking per se. There was no prior history of significant knee injury, and it was noted he was currently working full duty but did miss a few days of work after the initial injury. Dr. Paletta's impression was that of (1) post-traumatic patellofemoral pain in the setting of early medial and patellofemoral compartment chondrosis; (2) no evidence of significant structural abnormalities such as meniscus tear or ligament tear. Dr. Paletta recommended that he consider a viscosupplementation injection. Dr. Paletta noted no indication for surgical treatment at that point in time, and that there was no evidence of significant structural abnormalities such as meniscus tear or ligament injury. (RX7).

Included within Dr. Paletta's records was that of a physical therapy re-evaluation performed on April 8, 2014, which noted that since the initiation of therapy treatment, Petitioner had attended 10 out of 16 scheduled appointments and that his compliance with the therapy schedule had been problematic. It was noted that his subjective complaints of pain appeared to be somewhat vague. (RX7).

The Orthopedic Center of St. Louis office note dated May 16, 2014 was entered into evidence at the time of arbitration as Respondent's Exhibit 8. The records reflect that Petitioner returned on that date for continued follow-up of his right knee. It was noted that he was previously diagnosed with patellofemoral pain in the setting of patellofemoral chondrosis. It was further noted that past treatment had included viscosupplementation which provided several months of improvement in his symptoms. Petitioner stated overall things were somewhat better, and that he finished his physical therapy. He still had some discomfort around the kneecap, and he still had some discomfort with stairs particularly ascending. He also noted stiffness after long periods of sitting or riding in the car, and he also noted start-up stiffness in the morning. Dr. Paletta's impression was that of mild residual patellofemoral pain in the setting of patellofemoral chondrosis. He noted that Petitioner still had some mild symptoms related to his underlying patellofemoral arthritis, however he did not recommend any surgical intervention at that time. It was noted that arthroscopy for patellofemoral pain was unpredictable at best. It was further noted that if he had worsening of symptoms one could consider repeating the viscosupplementation injection, however at that point he recommended he continue with a home exercise program and continue with Advil as necessary. He did not recommend any additional formal therapy, and he noted he could work without restrictions and placed him at maximum medical improvement. (RX8).

The Workers Compensation Employee's Notice of Injury pertaining to an accident date of April 12, 2013 was entered into evidence the time of arbitration as Respondent's Exhibit 9. The form indicated that Petitioner was counting patients out in unit C, that the patients were lined up for gym, and that Petitioner sustained injury while restraining a recipient. He reported right knee pain as a result of the accident. (RX9).

The Worker's Compensation Employee's Notice of Injury pertaining to an accident date of September 10, 2013 was entered into evidence as Respondent's Exhibit 10. The form indicated that Petitioner was performing a physical hold of a violently struggling recipient at the time of the accident, and that he sustained injury to his right knee. (RX10).

The Worker's Compensation Employee's Notice of Injury pertaining to an accident date of December 19, 2013 was entered into evidence at the time of arbitration as Respondent's Exhibit 11. The form indicated that Petitioner was attempting to restrain a violent recipient, at which time he landed on his right knee. He described right knee soreness. (RX11).

The Settlement Contract Lump Sum Petition and Order for case numbers 13 WC 17505, 14 WC 6027 and 14 WC 6028 was entered into evidence at the time of arbitration as Respondent's Exhibit 12. The dates of accident referenced on the Contract were that of April 12, 2013, September 10, 2013 and December 19, 2013. The body part affected was noted to be that of the right knee/leg. The Settlement Contract reflected that Petitioner received a lump sum amount representing 5% loss of use of his right leg in full, final and complete settlement of the claims. The Contract specifically noted that Respondent reserved its right to its 8(j) credit. The Settlement Contract was approved on October 15, 2014. (RX12).

The Application for Adjustment of Claim pertaining to the April 12, 2013 accident was entered into evidence at the time of arbitration as Respondent's Exhibit 13. Petitioner alleged that he sustained injury to his right knee/leg as a result of restraining a combative patient on that date. Petitioner signed the Application on May 22, 2013. (RX13).

The Application for Adjustment of Claim pertaining to the September 10, 2013 accident was entered into evidence at the time of arbitration as Respondent's Exhibit 14. Petitioner alleged that he sustained injury to his right knee/leg as a result of restraining a combative patient on that date. Petitioner signed the Application on February 14, 2014. (RX14).

The Application for Adjustment of Claim pertaining to the December 19, 2013 accident was entered into evidence at the time of arbitration as Respondent's Exhibit 15. Petitioner alleged that he sustained injury to his right knee/leg as a result of restraining a combative patient on that date. Petitioner signed the Application on February 14, 2014 for this claim as well. (RX15).

CONCLUSIONS OF LAW

The parties stipulated at the time of hearing that on November 21, 2014, Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent.

With respect to disputed issue (F) pertaining to causal connection, the Arbitrator finds that Petitioner's current condition of ill-being is not causally related to the injury of November 21, 2014. In so finding, the Arbitrator notes that Petitioner admitted in his direct testimony that after he was released in May of 2014 by Dr. Paletta for treatment related to his previous accident and before the accident at issue which occurred on November 14, 2014, he was 90-95% improved and never felt 100%. (T.21). The Arbitrator further notes that Petitioner admitted on cross-examination that when he first saw Dr. Paletta for this particular accident on February 25, 2015, he told Dr. Paletta that he never returned to feeling 100%. (T.32). The Arbitrator notes that Petitioner indicated that he had complaints of pain in the medial aspect of his knee, pain while ascending stairs, and stiffness after sitting for prolonged periods of time, which he agreed on cross-examination were essentially the same complaints that he had previously back in May of 2014 when he was released by Dr. Paletta for his prior claim. (T.29-30). Perhaps most significantly, the Arbitrator notes that Petitioner testified on cross-examination that he was back to 90-95% now as well. (T. 32). That said, the Arbitrator finds that Petitioner made an admission against

interest by virtue of his testimony that he has returned to his baseline condition as of May 2014, and, as a result thereof, has failed to prove that his current condition of ill-being is causally related to the November 21, 2014 accident.

The Arbitrator is suspicious of the credibility of Petitioner by virtue of his failure to advise not only the IME physician but also his treating physician, Dr. Paletta, of the additional accidents that he had involving his right knee on September 10, 2013 and December 19, 2013. When asked if he knew of any reason why Dr. Paletta was not aware of the last two accidents, Petitioner testified that he had already been seeing him for his injuries and he figured they were "minor considerations or whatever that really wouldn't have done anything." (T.27-28). When asked if there was a reason why he did not tell Dr. Lehman about the other two accidents, Petitioner testified that they were still "pre-existing" from the time that he saw Dr. Paletta and he just did not think about them. (T.28). These additional accidents, when coupled with Petitioner's failure to disclose to either Dr. Lehman or Dr. Paletta that he had also sustained yet another accident in November of 2008 involving the right knee while under the employ of Respondent, causes the Arbitrator to find Petitioner's credibility to be highly suspect. The Arbitrator notes that Petitioner did not tell Dr. Paletta about his September 10, 2013 and December 19, 2013 accidents while he was treating with him, yet Petitioner signed the Applications for Adjustment of Claim while under Dr. Paletta's active care and treatment. (RX14; RX15). As such, the Arbitrator finds that Petitioner's credibility is compromised.

With respect to the various medical testimony proffered in the case, the Arbitrator notes that Dr. Paletta agreed that when he saw Petitioner on January 29, 2014, he advised Petitioner at that time that if he failed conservative treatment then an arthroscopy might be recommended to treat his underlying patellofemoral chondrosis, and that this was the same procedure that was being recommended at the present time. The Arbitrator notes that on cross-examination, Dr. Paletta agreed that when he saw him on May 16, 2014, Petitioner reported ongoing symptoms which included stiffness and occasional discomfort but no swelling or giving way; that his stiffness was in the morning or after sitting for long periods of time; that he had discomfort with stairs, particularly ascending; and that when he presented to him on February 25, 2015, Petitioner reported very similar symptoms. Dr. Paletta agreed it was a fair statement that Petitioner did not report to him that he also injured his right knee on September 10, 2013 and December 19, 2013, and he also confirmed that Petitioner never advised him that he previously injured his right knee in November 2008 either. (PX9). The Arbitrator finds Dr. Paletta's testimony on these issues to be persuasive and concordant with that proffered by Dr. Lehman.

The Arbitrator further notes that Dr. Lehman testified that Petitioner had what appeared to be long-term chronic changes, but there was nothing on his MRI that suggested an acute process that would suggest that something happened to his knee or that there was an alteration of his knee in this incident. The Arbitrator finds to be significant Dr. Lehman's testimony that in looking at the medical records, it appeared that this was the same exact problem and same exact anatomical area for which Petitioner had similar complaints previously, and that when Petitioner was in his office in July 2015 for the IME, Petitioner had symptoms in the same area and the same type of symptoms as well. The Arbitrator agrees with Dr. Lehman that Petitioner would be in the best position to tell about what the level of symptoms were both prior to and after the November 2014 injury, and notes that Petitioner himself admitted at the time of hearing that he was 90-95% both at the time of his release in May of 2014 as well as at the time of the arbitration hearing. (RX5; T.28).

As the Arbitrator finds that Petitioner failed to prove that his current condition of ill-being is causally related to his accident of November 21, 2014, all benefits are denied, including the prospective medical treatment requested by Petitioner. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

16IWCC0717

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mary Thomas,
Petitioner,
vs. NO: 14 WC 42763

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 15, 2016 is hereby affirmed and adopted.

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

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

No bond or summons required for State of Illinois cases.

DATED: NOV 4 - 2016

MB/mam
o:10/6/16
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

THOMAS, MARY
Employee/Petitioner

Case# **14WC042763**

16IWCC0717

SOI DEPT OF HUMAN SERVICES
Employer/Respondent

On 1/15/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1580 BECKER SCHROADER & CHAPMAN
MATTHEW R CHAPMAN
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

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

3291 ASSISTANT ATTORNEY GENERAL
DIANA E WISE
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JAN 15 2016

Ronald A. Rascia, Acting Secretary
Illinois Workers' Compensation Commission

16IWCC0717

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

MARY THOMAS
Employee/Petitioner

Case # 14 WC 42763

v.

Consolidated cases: N/A

SOI; DEPARTMENT OF HUMAN 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 **MICHAEL NOWAK**, Arbitrator of the Commission, in the city of **COLLINSVILLE, IL**, on **NOVEMBER 24, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0717

FINDINGS

On **8/15/2014**, 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 **$82,373.00**; the average weekly wage was **$1,584.10**.

On the date of accident, Petitioner was **64** years of age, ***single*** with **0** dependent children.

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

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

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

Respondent is entitled to a credit for any amount paid through Group under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $2,605.00, as provided in Sections 8(a) and 8.2 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 **$735.37**/week for **46.125** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **22.5 % loss of the right hand**.

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

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

Signature of Arbitrator — Date: 1/3/16

JAN 15 2016

FINDINGS OF FACT

On August 15, 2014, Petitioner was employed as a Rehabilitation Counselor Senior with the Division of Rehabilitation Services (DORS). DORS is a division of the State of Illinois Department of Human Services and administers a home services program for persons with disabilities. Petitioner's duties as a rehabilitation counselor include performing evaluations to determine if disabled persons are eligible for home services, rather than being institutionalized in a nursing home. Petitioner's office is located in East Alton, Illinois, but approximately half of her job is spent traveling to various homes in a three county area in southern Illinois for the purpose of performing eligibility evaluations. Petitioner worked for the State for 30 years and retired in 2015.

On the day of the accident, Petitioner was injured while traveling away from the office to perform a home services evaluation at 803 Birch Street in Collinsville, Illinois. Petitioner testified that she arrived at the home and tripped as she was stepping up on the porch, which threw her forward into the front wall of the home, injuring her right hand and knees. At the time of the accident, Petitioner was carrying a packet of paperwork, a calculator and a pen, all in her left hand. According to the Notice of Injury (PX9), the incident occurred at 1:10 p.m. Petitioner testified that there were two concrete steps leading to a concrete porch. Petitioner explained that the front of the home was heavily shaded by trees. Petitioner testified that she misjudged where the step was and tripped when her right foot did not clear the level of the porch. A photograph of the accident scene was admitted as Respondent's Exhibit 7. Petitioner testified that RX7 accurately depicts the scene of the accident. The accident scene depicted in RX7 is consistent with Petitioner's testimony. Petitioner slammed into the front wall of the home, extending her right hand to break her fall. She then fell on her knees and rolled onto her back. She stayed on her back for some time as the occupants of the home came to attend to her.

Petitioner's testimony is consistent with the Employee's Notice of Injury (RX 1), and witness statements from Kristyon Bolden and Mahogany Bolden (RX 2, 3). For example, RX 1 states that Petitioner was injured while performing a "home services home visit to conduct redetermination."

Petitioner testified that, prior to this accident, she had never sought treatment for her right hand or left knee. Petitioner further testified that at the time of the accident, she was working full duty with no physical restrictions.

Later that day, Petitioner sought treatment at Anderson Hospital Urgent Care (PX1). X-rays were performed, which revealed a non-displaced fracture of the right distal radius and an avulsion fracture of the distal pole of the triquetrum (PX 2). Petitioner also complained of a contusion and abrasions to both knees (PX1, 1). An x-ray of the left knee revealed mild left knee osteoarthritis (PX3).

On August 25, 2014, Petitioner saw Dr. James Sola for an orthopedic consult (PX4). At this visit, Petitioner reported discomfort and pain in her left knee and wrist. Dr. Sola placed Petitioner in a short-arm cast for the wrist and instructed Petitioner to restrict use of the hand to help prevent displacement. She was also instructed to use a sling when out of the house (PX 4, 1). Dr. Sola diagnosed Petitioner with a contusion of the left knee. Dr. Sola also restricted Petitioner from all work (PX4, 3).

On September 4, 2014, x-rays revealed good position of the distal radius fracture (PX 4, 4). Dr. Sola also released Petitioner back to work beginning September 8, 2014 (PX 4, 5). On September 18, 2014, x-rays showed good healing of the distal radius fracture. Dr. Sola transferred Petitioner from an air cast to a cock-up wrist splint. On October 9, 2014, Petitioner reported occasional ache with discomfort in the wrist. Dr. Sola believed that Petitioner's fracture had healed and released her from care (PX 4, 7). Petitioner testified she experienced numbness and tingling when the cast was removed.

After obtaining approval from TriStar (Respondent's workers' compensation administrator), Petitioner was able to see Dr. David Brown for a second opinion with respect to her continued wrist complaints (PX 5). On February 4, 2015, Dr. Brown noted that "she was referred by TriStar for evaluation and treatment for a problem with her right wrist." Dr. Brown noted Petitioner's job duties as a rehabilitation counselor. Dr. Brown noted that Ms. Thomas works 9 to 9 ½ hours a day, 37 ½ hours a week, making home visits. Dr. Brown noted that Petitioner will drive 200 to 400 miles a month (PX 5, 1). Petitioner reported a dull ache over the volar wrist that radiates proximally and some weakness with lifting. Dr. Brown noted that Petitioner had no therapy following her distal radius fracture. Dr. Brown observed that Petitioner had symptoms and findings suggestive of a diagnosis of right carpal tunnel syndrome (PX 5, 2). Dr. Brown recommended a nerve conduction velocity and EMG test, which was performed on April 6, 2015 (PX 6). In the meantime, Dr. Brown recommended that Petitioner wear a wrist splint at night. Dr. Brown noted that his office would schedule Petitioner for nerve conduction studies once he obtained the appropriate approvals. (PX 5, 2)

In the note, Dr. Brown explained that carpal tunnel syndrome following distal radius fractures has been well described in the medical literature. "Therefore, the need for further evaluation and treatment for a diagnosis of carpal tunnel syndrome would be casually related to the distal radius fracture with that fracture being at least a contributing factor." (PX 5,2).

On April 6, 2015, Dr. Brown reviewed the results of the nerve conduction studies, which confirmed severe right carpal tunnel syndrome with axonal involvement, "which makes it a more severe injury," as well as evidence of denervation on her EMG (PX 5, 8). Due to the severity of her nerve conduction studies, Dr. Brown recommended a right carpal tunnel release. Dr. Brown noted that he would schedule her for surgery once he obtained the appropriate approvals. Alene Adams, a claims adjuster for TriStar, was copied on the medical note.

On May 29, 2015, Petitioner underwent a right carpal tunnel release (PX 7). On June 15, 2015, Petitioner reported that the numbness and tingling in her hand was much improved (PX 5, 16). On July 6, 2015, Dr. Brown noted that Petitioner was still reporting soreness around the volar wrist and palm (PX 5, 18). Dr. Brown noted that Petitioner had some mild tenderness over the scar. Dr. Brown released Petitioner full duty with no restrictions.

The parties stipulated that Petitioner missed three weeks of work immediately after the accident and that all TTD was paid. On the record, the parties stipulated that TTD was not in issue. As for medical bills, Petitioner submitted as Exhibit 8 a medical bills checklist, with corresponding medical bills attached thereto. In this exhibit, it is reflected that workers' compensation has paid $6,292.56 on Petitioner's medical treatment, including payment for Dr. Brown and Dr. Sola's orthopedic treatment. $2,605.00 remains unpaid.

As of the date of hearing Petitioner still had pain and discomfort on the top and bottom of her wrist, which radiates toward her elbow. Petitioner testified that her grip strength is impaired and she has difficulty opening containers. Petitioner also testified that she has dropped items due to her impaired strength.

CONCLUSIONS

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

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 DORS. At the time of her injury, Petitioner was traveling to perform a home services evaluation in Collinsville, Illinois. She arrived at the home and tripped as she was stepping up onto the porch, which threw her forward into the front wall of the home, injuring her right hand and knees. At the time of the accident, Petitioner was carrying a packet of paperwork, a calculator and a pen, all in her left hand. The front of the home was heavily shaded by trees. Petitioner testified that she misjudged where the step was and tripped when her right foot did not clear the level of the porch.

Petitioner credibly testified that approximately half of her job is spent traveling to various homes in a three county area in southern Illinois for the purpose of performing eligibility evaluations. Clearly Respondent was aware that she traveled to multiple sites in order to perform evaluations daily, driving by car from one to another. No reasonable argument can be made that the Petitioner's conduct in traversing porch steps as she walked to the applicant's home was neither reasonable nor foreseeable. The only legitimate issue for analysis in this case is whether the claimant's injuries arose out of her employment.

For an injury to "arise out of" the employment, its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection. *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 tripped on a porch step. There is no evidence in the record tending to show that the she suffered from some physical condition which caused her to fall. Nor is the risk associated with traversing a steps distinctly associated with employment as a Rehabilitation Counselor. Accordingly, the risk associated with her traversing the step is neutral in nature. See *Metropolitan Water Reclamation District of Greater Chicago*, 407 Ill. App. 3d at 1014.

The determination of whether an injury suffered by a traveling employee, such as Petitioner in this case arose out of and in the course of her employment is governed by different rules than are applicable to other employees. *Hoffman v. Industrial Comm'n*, 109 Ill. 2d 194, 199, 486 N.E.2d 889, 93 Ill. Dec. 356 (1985). However, the fact that a claimant is a traveling employee does not relieve her of the burden of proving that her injury arose out of her employment. *Hoffman*, 109 Ill. 2d at 199.

Injuries resulting from a neutral risk, such as the injury here, 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. (emphasis added)

Nothing in the record suggests that some aspect of the Petitioner's employment contributed to the risk of climbing steps. Although there is evidence that the claimant carried a packet of paperwork, a calculator and a pen, there is no evidence that carrying these items caused, or contributed to her tripping on the step. However, because her left hand was full she

had only one free arm with which to break her fall. Petitioner indicated the area at which she was injured was shaded by trees, but she did not indicate this caused her fall. The question then is whether Petitioner was exposed to the risk of tripping on a step more frequently than the general public.

The risk of tripping on a step is a risk to which the general public is exposed daily. Under the "street risk" doctrine, however, when, as in this case, the claimant's job requires her to travel the streets, the risks of the street become one of the risks of her employment. *Potenzo*, 378 Ill. App. 3d at 118 (citing *C.A. Dunham Co. v. Industrial Comm'n*, 16 Ill. 2d 102, 111, 156 N.E.2d 560, 156 N.E.2d 929 (1959); see also *Metropolitan Water Reclamation District of Greater Chicago*, 407 Ill. App. 3d at 1014-15. In *C.A. Dunham Co.*, 16 Ill. 2d at 111, the Supreme Court held "where the street becomes the milieu of the employee's work, he is exposed to all street hazards to a greater degree than the general public."

While steps, and the risk attendant to traversing them, confront all members of the public, when a traveling employee, such as Petitioner is exposed to the risk while working, she is presumed to have been exposed to a greater degree than the general public. *City of Chicago v. Industrial Comm'n*, 389 Ill. 592, 601, 60 N.E.2d 212 (1945); see also *C.A. Dunham Co.*, 16 Ill. 2d at 111; *Mlnarczyk v. Illinois Workers' Compensation Comm'n*, 2013 IL App. (3rd) 120411WC, 999 N.E.2d 711, 376 Ill. Dec. 536; *Metropolitan Water Reclamation District of Greater Chicago*, 407 Ill. App. 3d at 1014-15.

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.

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 parties stipulated that the treatment received by Petitioner was both reasonable and necessary. Respondent disputed its liability to pay the charges based on the issue of accident. Respondent submitted evidence of the following unpaid medical expenses:

Anderson Express Care -	$1,647.00
Uptown ER Physicians -	$ 20.00
DMB Hand -	$ 168.00
Premier Anesthesia -	$ 770.00
Total	$2,605.00

(PX8) Based upon the foregoing and the record taken as a whole, Respondent shall pay reasonable and necessary medical services as set forth above pursuant Sections 8(a) and 8.2 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 was employed as a rehabilitation counselor but is now retired. Petitioner still suffers pain and discomfort in her right hand and arm while performing her activities of daily life. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 64 at the time of her injury. No evidence was presented as to how Petitioner's age impacts/affects any disability. The Arbitrator therefore gives *no* 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 x-rays revealed a nondisplaced fracture of the distal radius, an avulsion fracture of the dorsal pole of the triquetrum, and mild osteoarthritis of the 1st metacarpal joint. The distal radius fracture resulted in severe carpal tunnel syndrome, which necessitated a right carpal tunnel release. Petitioner's testimony as to her continued disability is corroborated by Dr. Brown's treatment notes. As for the left knee contusion, there is no evidence of continued disability in the medical records. The Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner's hand and wrist condition was traumatically induced, and not due to repetitive trauma, the Arbitrator concludes that Petitioner has been permanently partially disabled to the extent of 22.5% loss of the right hand, as provided in Section 8(e) of the Act. The Arbitrator concludes that Petitioner has not been permanently partially disabled with respect to her healed left knee contusion and, therefore, no disability is awarded for that injury.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GARY J. ROBLES,

Petitioner,

vs.

16IWCC0718

NO: 03 WC 14361

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION PURSUANT TO SECTIONS 19(h) and 8(a)

This claim comes before the Commission on Petitioner's Petition for Review under Sections 19(h) and 8(a), filed March 18, 2015. Commissioner Lamborn conducted a hearing in this matter on April 9, 2015 at which time counsel for Petitioner and Respondent were present and a record was made.

After considering the issues, including whether or not Petitioner's condition has changed, medical expenses, and permanent partial disability as it relates to Petitioner's left knee, right knee and lumbar spine, and being advised of the facts and law, the Commission Denies Petitioner's Petition for Review under Sections 19(h) and 8(a) finding that Petitioner failed to prove a material increase in his disability since the date the Commission modified the decision of the Arbitrator on November 14, 2011 and that Petitioner failed to prove his current condition of ill-being is causally related to his work injury of August 6, 2002. Petitioner's demand for an award of medical expenses, permanent partial disability and increased disability is denied. Respondent shall get credit for all amounts paid.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. On March 21, 2003 Petitioner filed a worker's compensation claim alleging accidental injuries arising out of and in the course of his employment with Respondent on August 6,

2002. On May 20, 2008 this matter, and three consolidated cases, proceeded to arbitration before Arbitrator Lee pursuant to a 19(b) Petition. Petitioner was represented by counsel at the time of the hearing.

2. On August 6, 2002, Petitioner, a 50 year old construction laborer sustained injury to his left knee when he when he stepped on piece of blocking, twisting his left knee, and felt a "pop." On August 8, 2002, Petitioner was seen at Mercy Works and gave a history of having left knee problems with intermittent pain and swelling for eight years predating his injury. (4/9/15 Hearing, Px1, p. 2)

3. An August 15, 2002 an MRI of Left Knee showed his ligament was intact and revealed degenerative changes involving the posterior horn of the medial meniscus; a superimposed tear could not be excluded. There was small effusion present; early osteoarthritic changes were also present in the knee joint predominantly involving the medial femoral tibial compartment. A September 4, 2002 Addendum to the MRI and additional axial MRI imaging of the Left Knee showed a focal nodule present having narrow signal characteristics in the posteromedial aspect of knee compatible with a loose body plus a small popliteal cyst within the posteromedial aspect of the left knee and two loose bodies within the small popliteal cyst. Arthroscopic surgery was recommended by Dr. Krieger. Dr. Miller confirmed a walnut sized Baker's cyst posteromedially that corresponded to the lesion on the MRI; x-rays and MR scan showed the presence of moderate osteoarthritis of the left knee. Dr. Miller diagnosed a Baker's cyst second to osteoarthritis and a minor strain that triggered this entire episode. Dr. Miller did not think arthroscopy was likely to help; he attempted to aspirate the cyst, but the fluid was too thick. He injected the left knee with Cortisone and placed Petitioner on Vioxx. Petitioner could return to work without restrictions. (5/20/08 Hearing, Px1)

4. On October 9, 2002, when Dr. Krieger recommended arthroscopic surgery to assess a possible posterior horn tear, he further stated Petitioner will need a knee replacement in the future. (5/20/08 Hearing, Rx1)

5. Petitioner treated for problems with his left knee intermittently until 2004 and he had no additional left knee treatment until January 2008. (5/20/08 Hearing T, pp. 24-26); Petitioner had treated with Supartz and Cortisone injections, medications and physical therapy and Petitioner continued to have pain and disability. X-rays showed severely advanced degenerative changes within the left knee joint. On January 10, 2008, Dr. Redondo opined that Petitioner needed a left total knee replacement. (5/20/08 Hearing, Px1)

6. On July 31, 2008, Arbitrator Lee entered Decision 03 WC 14361, finding that that Petitioner sustained accidental injuries arising out of and in the course of his employment on August 6, 2002, that Petitioner's current condition of ill-being with respect to his left knee was causally connected to that work injury, and ordering Respondent to authorize

the prescribed total knee replacement. The Arbitrator noted that while Petitioner suffered subsequent accidents on February 11, 2004, March 23, 2004 and July 29, 2004, (case numbers 04 WC 20451, 07 WC 10318, and 07 WC 14361 consolidated) those accidents were merely temporary aggravations of the condition that resulted from Petitioner's initial injury of August 6, 2002.

7. Respondent sought review of the July 31, 2008 Arbitrator's Decision in 03 WC 14361. On March 6, 2009, the Commission affirmed and adopted the Arbitrator's Decision. No further appeal was taken with respect to the 19(b) Decision.

8. Petitioner had a left knee replacement on June 12, 2009 and a subsequent manipulation on July 17, 2009. January 15, 2010 Physical Therapy Progress Report released Petitioner to return to pre-injury job without restrictions. (4/20/11 Hearing, Px1) On January 21, 2010, Petitioner was released to return to work with one restriction, to avoid kneeling. (4/9/15 Hearing, Px1) Petitioner returned to work one year later on February 1, 2011. (4/9/15 Hearing, T, pp. 15, 25,) On February 10, 2011, Petitioner returned to his surgeon with complaints of left knee instability. (4/9/15 Hearing, Px2)

9. Petitioner proceeded to an arbitration hearing on April 20, 2011 on the issue of the nature and extent of his disability. On May 10, 2011, Arbitrator Lammie awarded 45% LOU of the left Leg.

10. Petitioner returned to Dr. Redondo on June 9, 2011 with left knee complaints of instability and he reported occasional back spasms. Petitioner reported no trauma or injuries to account for the instability. (4/9/15 Hearing, Px2, p.5)

11. Petitioner appealed the Decision of Arbitrator Lammie finding that Petitioner sustained accidental injuries arising out of and in the course of his employment on August 6, 2002, and finding that Petitioner permanently lost 45% of the use of his left leg under Section 8(e) of the WC Act.

12. On appeal, the Commission modified the award to 50% loss of use of the left leg on November 14, 2011. No further appeal was taken until Petitioner filed Petitions pursuant to §§19(h) and 8(a) on March 18, 2015.

13. November 17, 2011 Dr. Redondo noted that Dr. Branovacki examined Petitioner and did not think the knee was unstable or loose; the left knee showed excellent alignment and fixation of the total knee replacement. (4/9/15 Hearing, Px2, p. 29)

14. On April 9, 2015, a hearing on Review was held before Commissioner Lamborn, at which time both parties were present and a record of the proceedings was made.

15. Petitioner had (previous) right knee surgery in 1990. (4/9/15 Hearing, T, p. 20)

16. Petitioner had a revision left knee surgery on September 18, 2012 consisting of exchange of the tibial plate polyethylene liner and a lateral release. (4/9/15 Hearing, Px2, pp. 42-43)

17. At his office visit on November 14, 2012, Dr. Redondo documented that Petitioner had complaints of right knee pain "ever since his injury to the left knee." [1] (4/9/15 Hearing, Px2, p. 60)

18. On January 24, 2013 Petitioner had a Lumbar spine MRI. Thereafter, he had three (3) lumbar spine injections. (4/9/15 Hearing, T, p. 12)

19. Petitioner underwent a physical therapy initial lower back evaluation on January 24, 2013 and gave a history of having chronic lower back pain for ten years with symptoms increasing. (4/9/15 Hearing, Px2, p. 79)

20. Advocate Christ Medical Center pain management center progress nurse notes document that on January 25, 2013 Petitioner reported that he fell on his right knee the prior week after hitting a coffee table. (4/9/15 Hearing, Px3)

21. On January 31, 2013, Dr. Redondo noted that Petitioner had minimal to no pain and range of motion from 0° to 125° in his left knee. Dr. Redondo documented Petitioner's history of known osteoarthritis to the right knee, his conservative treatment and at that time, Petitioner developed more pain and instability in the right knee and he recommended a right total knee replacement. Dr. Redondo documented he believed the patient's left knee injury aggravated a pre-existing osteoarthritis to the right knee over a several-year period of time. Dr. Redondo kept him off work. (4/9/15 Hearing, Px2, p. 84)

22. Petitioner underwent a Section 12 examination with Dr. Troy at Respondent's request; Dr. Troy authored a report dated April 2, 2013. Dr. Troy reviewed Petitioner's history of treatment at Mercy Works. On August 8, 2002, Petitioner admitted he had been having left knee problems with intermittent pain and swelling for eight years predating his injury. (4/9/15 Hearing, Rx1, p. 2)

23. Dr. Troy opined that Petitioner suffered a strain to his left knee on August 6, 2002 and any treatment after his release to return to work full-duty as of August 8, 2002 for his left knee is not workers' compensation related. (4/9/15 Hearing, Rx1, p. 11)

24. In regard to Petitioner's left knee, Dr. Troy opined that the need for total knee replacement is secondary to his pre-existing degenerative changes to his knee as well as

[1] This statement is not supported by the medical records.

the natural progression of these degenerative changes. He was at maximum medical improvement as of August 8, 2002. (4/9/15 Hearing, Rx1, pp. 12, 13)

25. In regard to his right knee, Dr. Troy opined that Petitioner's complaints are secondary to the natural preexisting degenerative process to his knee and the natural progression of these degenerative changes. In regard to his low back, Petitioner suffered no injury. Any exacerbation of degenerative changes to his low back are non-workers' compensation related. ((4/9/15 Hearing, T, Rx1, p. 12) From the back standpoint, the Petitioner has a degenerative process to the lumbosacral spine. The Petitioner is significantly overweight for his height. Petitioner is at MMI for his work-related condition as of August 8, 2002. (4/9/15 Hearing, Rx1, p. 13)

26. Dr. Troy opined the Petitioner may have work restrictions in place in regards to his left knee, such as no kneeling. (4/9/15 Hearing, Rx1, p. 13)

27. On May 23, 2013 Petitioner saw Dr. Redondo for right knee. Dr. Redondo noted that his patient at this time failed conservative management and needed a right total knee replacement. (4/9/15 Hearing, Px2, p. 93)

28. On May 28, 2013 Petitioner presented to Dr. Lim for evaluation of leg pain. Dr. Lim noted he took care of Petitioner in 2000. Petitioner's new history documented that he sustained an industrial related injury where his leg gave out on him and there was an eccentric contraction of his lower back, with the weight pulling him down while he was trying to standup straight. He had epidural injections in June of last year at Christ Hospital. He had an MRI recently which shows a left-sided L4-L5 disc herniation. Dr. Lim's "Assessment and Plan" stated that Petitioner's symptoms were more associated with the arthritis in his knee than the disc pathology. He opined that Petitioner did not have what appear to be clear radicular components and he did not believe that acute treatment was needed for back or his leg. He was to follow-up as needed. (4/9/15 Hearing, Px2, p. 94)

29. On June 18, 2013, Petitioner had a right total knee replacement; the Operative report procedure note documents advanced right knee arthrosis "Total knee replacement, complex secondary to morbid obesity." (4/9/15 Hearing, Px2, p.96)

30. On July 5, 2013 Petitioner presented for his physical therapy initial evaluation for his right knee at Advocate Christ Medical Center. Primary diagnosis is impaired ADLs, gait dysfunction, mobility dysfunction, Secondary diagnosis is osteoarthritis of right knee, status post right total knee arthroplasty The Subjective history states that Petitioner reported that he started having issues with his Right knee around September 2011 when he was at work. He banged his right knee while working and once the pain began it started to affect his ability to function in the home and with work duties. (4/9/15 Hearing, Px2, p.104)

31. July 23, 2013 physical therapy Updated Plan of Care, Advocate Christ Medical Center shows 9 visits and as of August 13, 2013 he had completed 14 with two no-shows. (4/9/15 Hearing, Px2, pp. 101, 109).

32. August 28, 2013 Dr. Redondo office visit confirms right knee pain was 3/10; doing physical therapy and Petitioner attends twice in a week with four weeks left. At that time he had no back complaints. (4/9/15 Hearing, Px2, p. 113)

33. On September 19, 2013 Petitioner complained to Dr. Redondo of lower back pain with left lower extremity radicular symptoms. Dr. Redondo planned to get a repeat MRI and to hold off on physical therapy for his knees, because "they are aggravating his lower back pain and radicular symptoms." (4/9/15 Hearing, Px2, p. 115)

34. Petitioner underwent a new Lumbar spine MRI on September 24, 2013 which showed degenerative changes of the lumbar spine with central canal stenosis most notable at L4-L5 with disc extrusion. (4/9/15 Hearing, Px2, p. 117)

35. On October 1, 2013 Petitioner saw Dr. Lim and gave a history of knee replacement about 12 weeks prior; he reported that he was about eight weeks into rehab for his knee and they were pushing on his knee vigorously when he felt something in his back and he started having new left sided radiculopathy in almost identical location to what he had in the past. [2] (4/9/15 Hearing, Px2, p. 118)

36. On October 1, 2013 Dr. Lim compared the MRI to his previous MRI and there was clearly a new extruded disc fragment at the left hand side at L4-5 causing significant nerve root impingement. Looking at the films side by side, Dr. Lim noted a change in the condition since his previous MRI. (4/9/15 Hearing, Px2, p. 118)

37. On December 12, 2013 Petitioner went to Advocate Christ Medical Center for a colonoscopy. (4/9/15 Hearing, Px3)

38. On December 13, 2013 Petitioner saw Dr. Lim and reported that he had a 3rd epidural and felt at least 60 or 70% better. Dr. Lim prescribed physical therapy for the knee and noted that "Apparently, he initially injured his low back when he was doing therapy for his left knee."[3] (4/9/15 Hearing, Px2, p. 120)

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[2] This is inconsistent with Dr. Lim's opinion on May 28, 2013, only four months prior, that there was no clear cut radiculopathy.

[3] The tendered therapy notes preceding this visit were for Petitioner's right, not left, total knee replacement and are devoid of any contemporaneous back complaints before his treatment with Dr. Lim in October 2013.

39. Physical therapy Initial Evaluation note at Midwest Orthopaedic Consultants on December 23, 2013 for left knee.[4] (4/9/15 Hearing, Px2, pp.121-125)

40. Dr. Redondo's January 2, 2014 office visit Interval history documents that the Petitioner was following up for his left knee replacement and that Petitioner had not been able to do physical therapy because of back issues being treated by Dr. Lim and he had not been able to physical therapy for his left knee or his right knee. The physical examination showed no tenderness, no instability in the left knee. In his plan, Dr. Redondo noted that he was sending Petitioner to do physical therapy for both knees and to do treatment for his lower back and that he spoke to the rehab nurse regarding focusing on everything before he will be able to be recovered at maximum medical condition. Dr. Redondo opined that "because of his back issues and right knee issues, he cannot return back to work because of his left knee."[5] (4/9/15 Hearing, Px2, p. 127)

41. On February 13, 2014 Dr. Redondo documented Petitioner's range of motion in his left knee was 0° to 120°. (4/9/15 Hearing, Px2, p. 130)

42. Results of the March 5, 2014 functional capacity evaluation (FCE) document near full, though not entirely full, effort on Mr. Robles' behalf. Overall test findings suggest some minor inconsistency with respect to the reliability/accuracy of Mr. Robles' subjective reports of pain/limitation. (4/9/15 Hearing, Px2, p. 131)

43. On March 12, 2014 Petitioner was assigned permanent restrictions by Dr. Redondo which prevented him from returning to work as a construction laborer. (4/9/15 Hearing, T, p. 36)

44. On July 10, 2014, Advocate physical therapy records reflect that in mid-June Petitioner was carrying an empty cabinet, his right knee buckled, he felt a pull/"rip" in his left shoulder when preventing the cabinet from falling. He received a cortisone injection in June. (4/9/15 Hearing, Px3, p. 13 of 52)

45. On July 29, 2014, Advocate physical therapy records reflect that Petitioner was referred for left rotator cuff tear, that he had been to the doctor and his left shoulder was 50% better. (4/9/15 Hearing, Px3, p. 39 of 52)

46. The Respondent was able to accommodate his restrictions in his position as a watchman which he began on August 1, 2014. (4/9/15 Hearing, T, p. 15)

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[4] Petitioner had previously been doing therapy for his right knee following his June 18, 2013 right total knee replacement; Dr. Lim was treating Petitioner for his lumbar back; therefore, the Commission finds this request appears to be at the bidding of Petitioner.

[5] The Commission finds Dr. Redondo's statement is not only unintelligible, but not credible; the Petitioner's left knee revision surgery was on September 18, 2012 and as of January 31, 2013 Dr. Redondo's office note documented that Petitioner had minimal to no pain and range of motion from 0° to 125° in his left knee. Ironically, that is the same date, that Dr. Redondo recommended Petitioner have a right total knee replacement.

47. Petitioner was off-work June 16, 2011 through July 31, 2014. (4/9/15 Hearing, T, p. 17)

The Commission concludes it has no jurisdiction to review this award under Section 19(h) of the Act or to issue additional temporary total disability or permanent partial disability benefits given that the Petition for Review under Section 19(h) was not filed until 40 months after the Commission decision was entered, which was clearly well beyond the 30 months set out by the Act for an award providing compensation in installments. Section 19(h) provides that an award providing for compensation in installments "may be at any time within 30 months, or 60 months in the case of an award under Section 8(d)1, after such agreement or award be reviewed by the Commission at the request of either the employer or the employee on the ground that the disability of the employee has subsequently recurred, increased or diminished or ended. 820 ILCS 305(19(h)) 11/16/2005.

The Appellate Court addressed the limitations imposed by Section 19(h) in *Weaver v. Illinois Worker's Compensation Comm'n.* The purpose of section 19(h) is to set a period of time in which the Commission may consider whether a disability has recurred, increased, diminished, or ended. *Cuneo Press, Inc., v. Industrial Comm'n*, 51 Ill. 2d 548, 549, 283 N.E.2d 880, 881 (1972). The 30-month period set out in section 19(h) "is a jurisdictional requirement that may be raised at any time." *Eschbaugh v. Industrial Comm'n*, 286 Ill. App. 3d 963, 968, 677 N.E.2d 438, 442 (1996). "It is an absolute and unconditional restriction on the right of review." *Id.* Therefore, the Commission is divested of its review jurisdiction for change of disability 30 months after an award of compensation. *Id.* The 30-month period for filing a section 19(h) petition runs from the date of filing of the Commission's decision, and judicial review of the Commission's decision does not toll the 30-month period. *Cuneo Press, Inc.*, 51 Ill. 2d at 549, 283 N.E.2d at 881. *Weaver v. Illinois Worker's Compensation Comm'n.* 2016 IL App (4th) 150152WC

Based upon a review of the record as a whole, the Commission finds Petitioner failed to prove his left knee, right knee or lumbar back conditions are causally related to his August 6, 2002 work-related injury. Accordingly, the Commission finds Petitioner is not entitled to the relief requested under Section 8(a) for his left knee or right knee or lumbar back conditions. Regarding the Petitioner's left knee, the Commission relies upon the Petitioner's testimony in which he failed to assert any relationship between his then current left knee condition and his work injury and based upon the Petitioner's treating records. Regarding the Petitioner's right knee and lumbar spine conditions, the Commission relies upon the Petitioner's testimony and the treating records which confirm that the Petitioner had preexisting degenerative lumbar spine and right knee conditions that accelerated during the period of time Petitioner was off-work; Petitioner failed to prove a nexus between his work accident and the right knee and lumbar spine conditions. The Commission also relies upon the opinion of Dr. Troy regarding these degenerative conditions.

The Petitioner testified that his right knee and lumbar spine conditions were a result of shifting his weight, however, a thorough review of the medical records reveals that the Petitioner's testimony regarding his right knee and lumbar spine problems is inconsistent with the treating records.

The Petitioner had a prior right knee surgery in 1990. Petitioner testified on direct examination that he was not sure what date he started having problems with his right knee. On cross-examination he testified he first started having problems in 2012. The medical records reflect that Petitioner had a right knee injection on July 28, 2011. The Petitioner had been off work for seven weeks at the time he first had right knee complaints and received the right knee injection. The Advocate Christ Medical Center's July 5, 2013 physical therapy Initial Evaluation documents a different date and a different causation history; Petitioner reported that he started having issues with his right knee around September 2011 when he was at work. Petitioner testified that he was off work between June 8, 2011 and July 31, 2014, thus he was not working for Respondent either on July 28, 2011, when he had the right knee injection, or in September 2011, thus there is inconsistency regarding both facts and the timeline. The history in the Advocate therapy records comports with the onset of right knee symptoms in 2011 approximately at the time that Petitioner first had an injection. However, Petitioner could not have been referring to his employment with Respondent when he told the therapist that he hurt his right knee at work in September 2011because he was off work between June 8, 2011 and July 31, 2014.

Petitioner testified at the 2015 hearing that he could no longer do "rehabs" with his brother-in-law. An Advocate physical therapy note dated July 9, 2014 documents Petitioner's report that he was carrying a cabinet as recently as June 2014 when his right knee buckled and he hurt his left shoulder, possibly sustaining a left shoulder rotator cuff tear. Other corresponding treating medical records were not tendered, nonetheless, the Commission finds that the therapy records documenting this new injury to Petitioner's left shoulder is evidence that Petitioner was participating in physical activities at a time when he had not yet returned to work for Respondent. The Commission finds that the cabinet that he dropped had to be sufficiently heavy to cause a left shoulder rotator cuff tear.

Dr. Redondo, Petitioner's knee surgeon, authored office notes which, in some instances, contained various broad statements regarding the Petitioner's right knee condition. On November 14, 2012, Dr. Redondo's office note states that Petitioner had complaints of right knee pain "ever since his injury to the left knee" and that he thought his right knee was related to the injury to the left knee. The Petitioner's initial injury to his left knee was in 2002, yet the treating records are devoid of right knee pain complaints until Petitioner had a right knee cortisone injection on July 28, 2011. Given that Petitioner's recent right knee complaints were in July 2011, two years after the Petitioner's June 2009 left total knee replacement and while Petitioner was off-work, Dr. Redondo's statement is without merit or basis.

Surgery was not recommended for Petitioner's right knee until January 31, 2013 following Petitioner's fall on his right knee after hitting a coffee table on January 25, 2013, an incident which was well documented in the Advocate pain management medical records. On January 31, 2013 Dr. Redondo noted that the Petitioner had developed more pain and instability in the right knee, however, made no mention of the intervening fall on January 25, 2013. At the January 31, 2013 office visit when Dr. Redondo recommended a right total knee replacement, he noted that Petitioner's left knee injury aggravated a preexisting osteoarthritis to the right knee over a several year period of time. Dr. Redondo's statement is not consistent or persuasive and was given without the knowledge of the intervening accident. In addition, the right knee operative report stated that Petitioner's procedure was for total knee replacement complex secondary to morbid obesity. Therefore, the Commission gives no deference to Dr. Redondo's opinion.

The Commission finds that the causal connection opinion of Respondent's Section 12 evaluator, Dr. Daniel Troy, that Petitioner's right knee condition was degenerative and not work related, is more persuasive than Petitioner's doctor, Dr. Redondo.

With respect to Petitioner's low back claim, Petitioner's testimony was not forthright. Petitioner denied prior problems with his back several times until he was given the name of his former employer on cross-examination. Petitioner then admitted that he had a prior workers' compensation lumbar back case that settled in 1990 when he worked for another employer as a trailer mechanic for which he received a settlement. The January 24, 2013 physical therapy notes from Midwest Orthopaedic Consultants Therapy Department, titled "Physical Therapy Initial Evaluation-Back" contain a history of "Chronic history of lower back pain for 10 years, symptoms progressing." Petitioner's credibility was significantly tainted in light of this therapy note as he clearly had a long history of low back pain. Petitioner had lumbar back complaints on June 9, 2011. Dr. Redondo notes that x-ray showed mild degenerative disc disease. He had more lumbar back complaints approximately one year later while he was off work and which precipitated the first lumbar spine MRI prescription.

Petitioner presented no causal opinion regarding his lumbar condition and moreover, the medical records contain no corroborating evidence relating his lumbar back condition to his August 6, 2002 injury. Eventually after Petitioner's right knee replacement, he gave a history to Dr. Redondo and Dr. Lim of increased lumbar back pain after approximately eight weeks of right knee therapy. The Commission notes that the corresponding therapy records following the right knee replacement are devoid of evidence of a causal relationship between the Petitioner's knee therapy and his low back pain and moreover that the complete set of Petitioner's physical therapy records from Advocate Christ Hospital were not tendered. Among those missing are those Advocate Christ Hospital therapy records after August 13, 2013 and before Petitioner's visit with Dr. Redondo on September 26, 2013 which would correspond with the alleged timeline precipitating the back pain. Dr. Lim noted a significant change between the January 24, 2013 lumbar spine MRI and the September 2013 lumbar spine MRI. These records support Dr.

Troy's opinion that the Petitioner's lumbar spine degenerative condition could have been accelerated by any number of factors.

With regard to Petitioner's left knee, Petitioner tendered no causal connection opinion relating the need for revision left knee surgery to Petitioner's August 6, 2002 work accident nor did Petitioner's testimony shed any light regarding the instability recorded in his left knee as early as his office visit with Dr. Redondo in February 2011. Petitioner testified on April 9, 2015 that that he had instability at the time of his prior April 15, 2011 hearing and he was compensated for his medical, lost time and permanent partial disability. The Commission notes that after the 2009 left knee replacement surgery Petitioner was released to return to work on January 21, 2010, however, he did not return to work for one year after his release, in February 2011. Therefore, the Petitioner did not meet his burden of proving that the need for revision left knee surgery was causally related to his original work injury. In light of Petitioner's mendacities, the Commission finds that the left knee revision surgery was not related.

The Commission finds Petitioner failed to prove any causal connection for his left knee, right knee or lumbar spine condition to his August 6, 2002 work injury. With regard to Petitioner's Section 8(a) Petition, the Commission denies Petitioner's demand for an award of medical expenses for his left knee, right knee and lumbar spine conditions based upon Petitioner's failure to prove his current condition of ill-being is causally related to his August 6, 2002 work injury. The Commission finds that the Petitioner is not credible based upon the many inconsistencies between his testimony and the medical evidence.

Finally, Petitioner made no complaints at the time of hearing on Review which differed from those he described at the April 20, 2011 hearing. In fact, at the April 20, 2011 hearing Petitioner testified that he was taking Tylenol or Advil up to three pills, 500 mg. each, two times per day, before work and before bed. At the 2015 hearing, Petitioner testified that he takes Advil two times per day. At the 2015 hearing, the pertinent exchange regarding Petitioner's left leg was as follows:

Q. "in between 2011, your trial, and 2013, has your leg remained the same or have you noticed any difference?"

A. "It varies, depends on what activity I am doing that, you know, how my knee is. If I do a lot, overdo it, then I suffer for it.

Q. "Okay. Did you have any pain that you experienced in your knee in 2011?

A. "Just, yes, just the regular pain that I always have had."

Q. "Okay, so the pain that you have had has been consistent throughout the years?"

A. "Yes, yes." (T, pp. 33, 34)

The Commission notes on February 13, 2014 Dr. Redondo documented that Petitioner's left knee range of motion was 0° to 120°; on January 21, 2010 his left knee range of motion was 0° to 120° which is also consistent. Given Petitioner's testimony that his left knee pain was consistent over the years, and the Petitioner failed to prove his left knee, right knee and lumbar back conditions were causally related under Section 8(a), the Petitioner would not have met his burden under 19(h) even if timely filed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition under Section 8(a) is denied as it relates to Petitioner's left and right knee and lumbar back conditions.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Petition under Section 19(h) 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove a causal relationship exists between the accident of August 6, 2002 and Petitioner's condition of ill-being as it relates to his left knee, right knee and his lumbar spine, his claim for compensation is hereby denied.

The probable cost of the record to be filed as return to Summons is the sum of $35.00, payable to the Illinois Workers' Compensation Commission in the form of cash, check or money order therefor and deposited with the Office of the Secretary of the Commission.

DATED: NOV 4 - 2016
KWL/bsd
O: 9/12/16
42

Kevin W. Lamborn

Michael J. Brennan

Specially Concurring

I agree with the majority's finding that the Commission lacks jurisdiction to review this award pursuant to §§19(h)/8(a) in light of the fact that the Petition for Review was filed more than 30 months after the Commission's Decision and Opinion on Review dated 11/14/11, given that said Petition was filed by Petitioner on 3/18/15. As a result, I see no need to rule on the merits of the §§19(h)/8(a) Petition itself and would dismiss same outright as being untimely.

Thomas J.Tyrrell

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GARY DIEBOLDT,

Petitioner,

16IWCC0719

vs.

NO: 13 WC 2971

ST. PAUL'S UNITED CHURCH OF CHRIST,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission notes that in its Petition for Review, Respondent preserved the issues of causal connection, temporary total disability benefits, and medical expenses both current and prospective. However, during oral argument on October 26, 2016, the parties represented to the Commission that Respondent had accepted causal connection to Petitioner's current condition of ill-being and liability for medical expenses both currently outstanding as well as for prospective treatment recommended by Dr. Wolin. Therefore, the only issue now before the Commission is the duration of Petitioner's temporary total disability. Accordingly, the Commission affirms and adopts the portions of the Decision of the Arbitrator regarding causal connection and medical expenses.

16IWCC0719

Findings of Fact and Conclusions of Law

1. Petitioner worked for Respondent as a maintenance supervisor. The parties stipulated prior to arbitration that Petitioner suffered an injury to his right shoulder in a work-related accident on January 2, 2013, while he was moving air conditioning units.

2. Petitioner eventually was treated by Dr. Raab, an orthopedic surgeon. On June 18, 2013, Dr. Raab performed right shoulder arthroscopy and debridement of a partial-thickness rotator cuff tear, debridement of type I SLAP tear, subacromial bursectomy/subacromial decompression, and resection of the distal clavicle for partial-thickness rotator cuff tear, SLAP lesion, impingement syndrome with bursitis, and degenerative AC joint arthritis.

3. Petitioner progressed well in post-surgery physical therapy. In Dr. Raab's notation from October 18 2013 he indicated that Petitioner reported he was much improved with some intermittent soreness. X-rays were normal except for postoperative changes. Dr. Raab placed him at maximum medical improvement and released him to work at full duty.

4. On June 23, 2014, Petitioner returned to Dr. Raab. He reported intermittent shoulder pain with overhead activities and at night. X-rays and Dr. Raab's clinical examination were normal. Petitioner was given a home exercise program, advised to take over-the-counter medication, and advised to return if needed.

5. On August 18, 2014, Petitioner presented to Dr. Wolin for an examination on referral from his lawyer. Petitioner reported the accident after which he felt immediate cramping in the right shoulder along the clavicle. He had physical therapy, a cortisone injection, and eventually surgery. Petitioner felt the surgery helped the superior pain but he still had lateral pain. Dr. Wolin noted that he was released to work and discharged from treatment in October of 2013, but did not return to work because he had been terminated.

6. Dr. Wolin reviewed the February 18, 2013 MRI which he interpreted as showing a partial-thickness rotator cuff tear. Dr. Wolin administered an injection. He noted that the reaction to the injection indicated a "persistent intra-articular pathology." He restricted Petitioner to general lifting restriction of 15 lbs with no repetitive or overhead lifting and indicated Petitioner was only able to perform sedentary work.

7. Dr. Wolin testified by deposition on January 2, 2015 that he performed an examination of Petitioner on August 18, 2014 which showed less "flexion in the scaption" on the right even though he was right-hand dominant. Dr. Wolin considered that result to be objective. He also noted Petitioner had impingement and he reviewed the 2013 MRI which showed a partial rotator cuff tear. Dr. Wolin believed that Petitioner was still suffering from the partial tear in the rotator cuff, which was his preliminary diagnosis of Petitioner's current condition of ill-being.

8. Dr. Wolin also testified he believed the condition was present when Dr. Raab performed surgery but he chose to treat it with debridement; "basically cleaning it up." The condition was consistent with the reported mechanism of injury and Dr. Raab noted the partial tear in his operative report. Dr. Raab decided to debride rather than repair the partial tear because it was not a full-thickness tear.

9. Dr. Wolin further testified he administered a diagnostic/therapeutic injection. The pain was markedly alleviated within minutes of the injection. That indicated to Dr. Wolin that there was still something wrong with Petitioner's shoulder. He believed an MRA was indicated. He explained that plain MRIs are known to miss rotator cuff tears, which was the radiologist's interpretation of the 2013 MRI but which was also at odds with Dr. Wolin's. If the MRA showed a significant partial-thickness tear, surgical repair would be required. Dr. Wolin also explained that a certain percentage of patients who have debridement of a partial-thickness tear will continue to experience pain and weakness.

10. On cross examination, Dr. Wolin testified he had no criticism of the treatment provided by Dr. Raab and that his treatment was reasonable. Dr. Wolin would expect some residual effects from an injury after surgery including loss of strength and range-of-motion. He agreed that in the last treatment note from June 23, 2014, Dr. Raab found full range-of-motion, with some pain on extension. That could be expected postoperative symptoms. Dr. Raab basically released Petitioner from treatment with no restrictions at that time.

11. After the deposition, Petitioner returned to Dr. Wolin after an MRA was authorized. The MRA was interpreted to show mild tendonosis of the supraspinatus and infraspinatus with no evidence of rotator cuff tear, mild tendonosis of the intra-articular portion of the biceps tendon, and mild degenerative changes of the AC joint. Dr. Wolin recommended surgery consisting of arthroscopy, possible rotator cuff repair, and possible open biceps tenodesis.

As noted above, the Arbitrator found that Petitioner current condition of ill-being of his right shoulder related back to his accident on January 2, 2013. She awarded Petitioner temporary total disability benefits for 128 weeks, representing the entire period of time from the date of accident to the date of arbitration. The Commission accepts the opinion of Dr. Wolin and the determination of the Arbitrator that Petitioner's current condition of ill-being is a continuation of his work injury. Nevertheless, that does not necessarily indicate that Petitioner was totally disabled from the time of accident to the time of arbitration. The Commission notes that Dr. Raab, the orthopedic surgeon who actually performed the surgery, found Petitioner to be at maximum medical improvement and released him to work at full duty on October 18, 2013.

16IWCC0719

Petitioner has not presented any evidence that he was unable to work after he was released from treatment and to full duty by Dr. Raab on October 18, 2013, until the time he saw Dr. Wolin on August 18, 2014, at which time he was prescribed new restrictions. The record indicates that Petitioner did not return to work after his release by Dr. Raab because his employment had been terminated and not because he was physically unable to work.

The Commission also notes that Dr. Raab's decision to perform a debridement rather than full rotator cuff tear may have resulted in the need for the prospective procedure recommended by Dr. Wolin. However, Dr. Wolin had no criticism of the treatment Dr. Raab provided. The Commission concludes that Dr. Raab's surgery relieved Petitioner's condition temporarily but simply was not successful in resolving his condition permanently.

The Commission accepts the opinion of both of Petitioner's treating orthopedists. We accept the opinion of Dr. Raab, the surgeon who performed the arthroscopic surgery, that Petitioner was able to work as of October 18, 2013. The Commission also accepts the opinion of Dr. Wolin, Petitioner's current orthopedic surgeon, that he was unable to work as of August 18, 2014. Therefore, the Commission concludes that Petitioner has not sustained his burden of proving he was totally incapacitated from working between the date of Dr. Raab's release on October 18, 2013, and Dr. Wolin's reinstitution of restrictions on August 18, 2014. The Commission modifies the Decision of the Arbitrator accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $438.18 per week for a period of 84&3/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §8(e) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for prospective treatment recommended by Dr. Wolin pursuant to §8(a) of the Act, subject to the applicable medical fee schedule.

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

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

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

16IWCC0719

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: NOV 4 - 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-10/26/16
46

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

16IWCC0719

DIEBOLDT, GARY
Employee/Petitioner

Case# **13WC002971**

ST PAUL'S UNITED CHURCH OF CHRIST
Employer/Respondent

On 1/4/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.55% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0222 GOLDBERG WEISMAN & CAIRO LTD
JAMES NAWROCKI
1 E WACKER DR SUITE 3900
CHICAGO, IL 60601

2837 LAW OFFICES JOSEPH MARCINIAK
JAMES J MIRRO
2 N LASALLE ST SUITE 2510
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

GARY DIEBOLDT
Employee/Petitioner

v.

ST. PAUL'S UNITED CHURCH OF CHRIST
Employer/Respondent

Case # **13** WC **02971**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago** , on **June 16, 2016** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **January 2, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$34,179.08**; the average weekly wage was **$657.23**.

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

The issue of medical expenses is reserved.

Respondent shall be given a credit of **$18,406.54** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$18,406.54**.

Respondent has also paid $33,908.08 in medical expenses to date.

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

ORDER

Respondent is ordered to authorize and pay all reasonable, necessary and related costs associated with the arthroscopic surgery prescribed by Dr. Wolin as well as any associated aftercare.

Respondent shall be given a credit of $18,406.54 for TTD, $0 for TPD, and $0 for maintenance benefits, for a total credit of $18,406.54.

Respondent shall be given a credit of $33,908.08 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 $438.18/week for 128 weeks commencing January 3, 2013 through June 16, 2015, as provided by 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.

16I[illegible]719

Deborah L. Simpson

Signature of Arbitrator

December 30, 2015
Date

ICArbDec19(b)

JAN 4 – 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gary Dieboldt,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 13 WC 2971**
	)	
St. Paul's United Church,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on January 2, 2013, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that on that date the Petitioner sustained accidental injuries that arose out of and in the course of the Petitioner's employment with the Respondent and that the Petitioner gave the Respondent notice of the accident which is the subject matter of the dispute within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $34,179.08, and that his average weekly wage was $657.29.

At issue in this hearing is as follows: (1) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (2) Is the Petitioner entitled to any prospective medical care; and (3) Is Petitioner entitled to TTD.

STATEMENT OF FACTS

On January 2, 2013, Petitioner was working as a maintenance worker at Respondent, St. Paul United Church of Christ. He described his job duties as requiring him to often move heavy furniture, set up stages and scaffolds, and be able to lift up to 100 lbs. on a regular and repetitive basis. Petitioner is right hand dominant. He was working at the church moving air conditioner units down to the basement. He was carrying an air conditioning unit down the stairs and got to the second floor landing when he noted a lot of pain in his right shoulder region. As he was carrying the air conditioner, he felt a sudden pain in his shoulder and dropped the air conditioner unit. He was taken to Illinois Masonic Hospital emergency room that day where x-rays were taken and he was referred to an orthopedic surgeon.

On January 14, 2013, Petitioner was seen by Dr. Garapati at Illinois Bone & Joint Institute (ILBJ). He mainly complained of pain in the trapezoid and right shoulder area. He stated the pain went from the shoulder area up to his neck, with no significant midline neck pain.

He had never had an injury to this area of his body before. He had not had any previous history of pain in the shoulder. He complained of moderate throbbing pain, going on for about 10 days that would get worse if he laid down, but improved when he was sitting. He also had difficulty with overhead activity. "It feels like it is getting a little bit better but not significantly." He denied numbness, tingling, fever, chills or sweats. He was tender from the anterolateral right shoulder to the trapezial area of the neck. He had passive full range of motion. Actively, he guarded at about 90°, 5/5 external and internal rotation strength, 5/5 abduction strength. The doctor noted that "He does have impingement signs."

X-rays of the right shoulder were taken on this day with the impression being right shoulder tendonitis and irritation. He was placed on a stronger anti-inflammatory, and told to use compression, elevation, physical therapy program, and an arm sling. Follow up was in 2 weeks. He was kept off work. If the pain continued, Dr. Garapati believed he may need an MRI and possible cortisone injection. (Px 1)

On February 1, 2013, Petitioner was seen by Dr. Garapati at ILBJ. He had only been able to attend one physical therapy session due to an illness that month. He had been using anti-inflammatories that helped slightly, and had not been using the sling but he stated he had been protecting his right shoulder. He stated that his pain was the same to slightly worse, described as interscapular pain that radiated up to his neck and down to the shoulder. He also described pain with overhead activities and aching shoulder pain when he wakes up in the morning, all of which significantly limited his activity. The impression was right shoulder tendonitis, now with some weakness in external rotation. Recommendations included an MRI evaluation for possible ligamentous injury, an additional prescription for Physical Therapy 2-3 times per week for 4 weeks to work on range of motion and strengthening as well as rotator cuff strengthening. He was to continue taking anti-inflammatory medications, remain off work, and follow up after the MRI scan. (Px 1)

On February 18, 2013, Petitioner had an MRI of his right shoulder at Suburban Radiologists. The MRI showed prominent edema surrounding the right AC joint raising suspicion for possible direct contusion and mild sprain of the joint capsule, with a history of trauma to the AC joint. Other findings included mild right supraspinatus and infraspinatus tendinosis, no full-thickness rotator cuff tear. A superior labral tear on this and not arthrographic study but could not be excluded and is clinically suspected, and MR arthrogram should be considered for future evaluation of the labrum. (Px 1)

On February 25, 2013, Petitioner was seen by Dr. Garapati at ILBJ. He continued to have a lot of pain. The February 18, 2013 MRI was reviewed. Petitioner stated that the shoulder was feeling a bit worse than it was before and that he had not been going to physical therapy because of the pain. He was weak in abduction and forward motion secondary to pain, with positive impingement signs. He had pain over the AC joint as well as over the anterolateral shoulder and the trapezial muscle area. The MRI was reviewed that showed contusion over the AC joint, some supraspinatus and infraspinatus tendinosis but no focal full-thickness rotator cuff tear. The impression was right shoulder rotator cuff tendonitis, AC joint sprain and pain, right shoulder. The doctor believed a continued course of conservative care was appropriate as he did not believe the Petitioner's condition warranted surgical intervention. Dr. Garapati recommended that Petitioner continue to use MOBIC and anti-inflammatories as well as encouraging Petitioner

to get back into physical therapy. Petitioner was kept off work. He was also given a cortisone injection, which the doctor notes, he tolerated well. (Px 1)

On April 8, 2013, Petitioner was seen by Dr. Garapati at ILBJ, about two and a half months status post injury. He had done some therapy and taken anti-inflammatories without any relief. Dr. Garapati reviewed an MRI that showed some tendonitis and a contusion over the acromioclavicular joint but no full-thickness rotator cuff tear or fracture. He had a cortisone injection and continued with therapy, but Petitioner stated he was still having significant pain especially with overhead activity and a lot of trapezial as well as AC joint pain. His strength was 5/5 to external rotation and abduction. He did have positive impingement signs. The impressions were right shoulder tendonitis and right acromioclavicular joint contusion. Due to the persistent pain that was unimproved by conservative therapy, Dr. Garapati prescribed work restrictions including lifting less than 10 pounds, and referred Petitioner to Dr. Raab, another physician at ILBJ for a second opinion. (Px 1) Petitioner was released to work with restrictions per Dr. Garapati at ILBJ. The restrictions included no overhead activity with right arm, no lifting more than 10 pounds. However, no light duty was available with Respondent. (Px 1)

On April 19, 2013, Petitioner was seen by Dr. Raab at ILBJ, unimproved by treatments to date. He was off work and had pain at night. He presented on this date with an MRI, showing some edema of his AC joint and some tendinosis of the rotator cuff, with no evidence of rotator cuff tear. The examination revealed acromioclavicular joint tenderness and subacromial impingement. X-rays were repeated and found to be unremarkable. The impression was edema of the AC joint and impingement syndrome. He was given a right shoulder subacromial steroid injection. He was instructed to ice and modify his activities for the next few days, and was given a prescription for physical therapy and anti-inflammatory medication. He was to remain off work until follow up in one month. (Px 1)

Petitioner resumed physical therapy on April 23, 2013 at ILBJ. He stated that therapy and medication led to little improvement.

On May 17, 2013, Petitioner was seen by Dr. Raab at ILBJ. He stated the injection given at the last visit did help slightly. He had gone back to physical therapy, and his symptoms were exacerbated. He was experiencing significant pain and taking Norco. He was quite tender along the AC joint, with positive cross body abduction stress test and positive impingement sign. The impression was rotator cuff tendonitis/bursitis of the right shoulder, painful right AC joint. The plan was possible continued conservative treatment including further cortisone injections and physical therapy, as well as NSAIDs. He was unable to go back to work. Petitioner agreed to a surgical plan including a right shoulder arthroscopy, subacromial decompression, excision of the distal clavicle, possible rotator cuff repair. He would be scheduled pending insurance carrier approval. (Px 1)

On that same day, Petitioner's right shoulder x-rays were reviewed by Dr. Garapati and were "fairly unremarkable." His work restrictions for this date included primarily seated work, and no use of the right arm. (Px 1)

On May 23, 2013, Petitioner was seen by Dr. Atluri at Hand to Shoulder Associates for an examination pursuant to section 12 of the Act. The mechanism of injury and medical history was described. The treating doctor recommended a shoulder arthroscopy. Petitioner described a

"deep pain" at the superior aspect of his shoulder associated with burning. He stated he could not sleep at night due to the pain and burning, and that the pain extended into the upper arm anteriorly. He stated "I can move it ok." His shoulders had no atrophy. There was flattening of the trapezius on the right compared to the left and the right shoulder was lower than the left. Forward flexion was to 170, abduction to 130. The shoulder had some tenderness over the trapezius as well as the AC joint, subacromial space. Maximal tenderness is at the bicipital groove. Rotator cuff strength was 5/5 bilaterally. X-rays taken on that day revealed degenerative changes at the acromioclavicular joint, there was type 3 acromion, and the glenohumeral joint was well-reduced, otherwise unremarkable. The MRI of the right shoulder from February 18, 2013 demonstrated signal changes in the anterior labrum suspicious for an anterior labral tear. The impression was right shoulder derangement. Based on all the records Dr. Atluri reviewed, he believed that Petitioner had on-going pain involving his right shoulder which likely represents a superior labral tear. He considered the condition work-related. Dr. Atluri agreed with the treating physician that surgical intervention should be considered, to include a right shoulder arthroscopy with a possible biceps tenodesis or tenotomy. Any other intra-articular pathology, such as a rotator cuff injury, would be addressed at that time. Postoperatively, supervised therapy per the surgeon's usual protocol, would be appropriate, depending upon the specific procedure performed. Dr. Atluri believed the temporary restrictions were reasonable, including avoiding overhead use of the right upper extremity as well as heavy lifting, and a 20 pound lifting restriction. He believed Petitioner had not yet reached MMI. It would be expected that he would reach MMI approximately six months postoperatively. Restricted work duty would be expected for approximately four weeks postoperatively, light duty would be reasonable with no use of the right arm. Light use of the right arm would be expected by 2-3 months postoperatively. Full duty would be expected approximately five months postoperatively. No permanent disability was expected as a result of the injury although some residuals such as stiffness or discomfort in the shoulder was expected. (Rx 3)

On June 18, 2013, Petitioner had right shoulder surgery performed by Dr. Raab at ILBJ. The preoperative diagnoses were impingement syndrome, right shoulder, possible rotator cuff tear, and AC degenerative arthritis. The procedure was right shoulder arthroscopy and debridement of partial-thickness rotator cuff tear, debridement of type I SLAP lesion, arthroscopic subacromial bursectomy, subacromial decompression, and arthroscopic distal clavicle resection. The postoperative diagnoses were partial thickness articular sided rotator cuff tear, type I SLAP lesion, and right shoulder impingement syndrome with associated subacromial bursitis and acromioclavicular degenerative arthritis. (Px 1)

On June 28, 2013, Petitioner was seen by Dr. Raab at ILBJ, ten days status post surgery. The doctor noted he was "doing quite well." He already had about 120° of forward flexion. X-rays of the distal clavicle showed decompression type I acromion, distal clavicle restriction, but the view of the distal clavicle was of poor quality. The impression was subacromial decompression, debridement of partial-thickness rotator cuff tear, and distal clavicle resection. The plan was to follow up in 4-5 weeks, start physical therapy, and restricted duty to a sedentary position with no use of the right arm. (Px 1)

Petitioner testified that Respondent fired him from his job about this time.

On August 16, 2013, Petitioner was seen by Dr. Raab at ILBJ six weeks status post surgery. He stated he felt 80% better. He told the doctor that he lost his job, stating he had been

fired about a week before surgery. He had good ROM, lacking some subtle internal and external rotation. Repeated x-rays showed post surgical changes. The plan was to continue Physical Therapy, and allow him to work restricted duty no lifting more than 10 pounds, and no overhead lifting. (Px 1)

On September 13, 2013 Petitioner was seen by Dr. Raab at ILBJ, three months status post surgery. He stated he was 75% better. The plan was to continue physical therapy, and allow restricted work duties, no lifting more than 20 pounds, no overhead lifting, and follow up in one month. (Px 1)

From April 23, 2013 through October 18, 2013, Petitioner continued physical therapy at ILBJ.

On October 18, 2013, Petitioner was seen by Dr. Raab at ILBJ, 4 months status post surgery. He was working restricted duty. He stated he was still experiencing some intermittent soreness. Examination revealed minor weakness. He had full ROM of the shoulder without pain. Repeat x-rays showed normal postsurgical changes. Petitioner testified he told the doctor that his shoulder was still sore. Dr. Raab released him to work full duty, at MMI, with follow up as needed. Petitioner testified that he tried looking for work but was limited due to shoulder pain and because prospective employers did not like the fact he had been injured at work.

On February 25, 2014, Petitioner was seen by Dr. Jeffrey Coe at Occupational Medicine Associates of Chicago for an examination pursuant to Section 12 of the Act and an impairment rating. The mechanism of injury and medical history were described. Petitioner complained of pain along the back surface of his right shoulder made worse by lifting, postoperative scarring of this right shoulder, and right shoulder stiffness and weakness (for example, when throwing or reaching with his right arm). There was mild, residual tenderness over the right shoulder anterior glenohumeral and acromioclavicular joints, no tenderness over the left shoulder joints. Shoulder impingement signs were negative bilaterally. There was slight crepitus from each shoulder with ROM testing. Muscle strength was 4+/5 on the right for resisted forward elevation, and 4+/5 on the right for isolated supraspinatus, otherwise normal. The diagnosis was right shoulder acromioclavicular joint injury, right shoulder internal derangement, partial thickness rotator cuff tear, glenoid labral tear, and acromioclavicular joint injury. Status post surgery included distal clavicle excision. Dr. Coe believed Petitioner had reached MMI and the impairment rating was 12% of the right upper extremity. (Rx 2)

On June 23, 2014, Petitioner was seen by Dr. Raab at ILBJ for a follow-up evaluation of his right shoulder about a year status post surgery. He stated that since then he had intermittent shoulder pain with overhead activities and at night. He denied any new injury or trauma. He was not working at that time. He was taking ibuprofen for his pain. He essentially had full ROM of the shoulder with some pain at full flexion. Dr. Raab found he was tender over the anterior cuff and biceps tendon and nontender over the AC joint. The plan was to take over-the-counter medications, start a home exercise program, and follow up as needed.

Petitioner testified that he was frustrated by the continuing shoulder pain. So, he spoke with his attorney who arranged an "IME" with Dr. Preston Wolin.

On August 18, 2014, Petitioner was seen by Dr. Wolin. The mechanism of injury and medical history were described. Dr. Wolin reviewed the 2/18/13 MRI and noted a partial thickness rotator cuff tear, and AC joint edema. On physical exam, Petitioner had tenderness over his glenohumeral joint, his subacromial space, and the biceps groove. Minimal tenderness over his AC joint with decreased strength in flexion, bringing the arm forward, and scaption, bringing the arm out to the side, on the right side as compared to the left. He had a positive Neer Test, positive Supraspinatus Test, and a positive Whipple Test. Petitioner was status post surgery but with persistent pain, and Dr. Wolin believed the pain generator was the partial thickness rotator cuff tear, because in some cases, "debridement alone may not alleviate symptoms." An injection into the right shoulder joint with ultrasound guidance to visualize the affected body part and to improve accuracy in the administration of the injection was recommended and performed on this date. The injection indicated that there was persistent intra-articular pathology and an MRI arthrogram was ordered. Gary was allowed back to work a sedentary job on this date, and a follow-up was scheduled post-arthrogram. (Px 2)

On January 2, 2015, Dr. Wolin was deposed. Dr. Wolin's medical treatment of Petitioner was described, beginning with the 8/18/14 IME. In the IME, Dr. Wolin reviewed the records of Dr. Garapati, Dr. Raab, and the radiographic studies during the IME. On physical exam at the IME, Dr. Wolin found Petitioner had tenderness over his glenohumeral joint, his subacromial space, and the biceps groove, with minimal tenderness over his AC joint, decreased strength in flexion. Petitioner had a positive Neer Test, positive Supraspinatus Test, and a positive Whipple Test. The meaning of "tenderness" was explained; it is reproducible discomfort/pain by pushing on an area. The significance of the comparison of muscle strength was explained. Dr. Wolin noted that flexion should be greater on the dominant side versus the non-dominant side; and Petitioner is right-handed but his right arm had less strength than the left. Dr. Wolin explained that strength testing is objective because they record the best of three outcomes. The positive test findings were explained. The Neer Impingement Test is where the arm is placed in neutral rotation, brought to shoulder level and then above to see if that produces pain. The Supraspinatus Test is done with the thumb down, lifting up against resistance to see if that produces pain in the supraspinatus (part of the rotator cuff). The Whipple Test evaluates the front part of the supraspinatus, done with the arm out in front with pain produced when the patient tries to flex the shoulder with resistance.

The x-rays obtained by Dr. Wolin at the August 18, 2014 IME were consistent with the surgery performed by Dr. Raab, the removal of the end of the clavicle. Dr. Wolin personally reviewed the February 18, 2013 MRI films and believed they showed a partial-thickness rotator cuff tear. Based on everything reviewed at the IME, Dr. Wolin diagnosed Petitioner with a partial thickness rotator cuff tear. He believed it was not a recurrent tear of the January 2, 2013 tear, but that the tear was always there and seen by Dr. Raab who elected to treat it with debridement, "basically cleaning it up." Dr. Wolin believed this diagnosis was consistent with the mechanism of injury and Dr. Raab's operative report from June 18, 2013 on page 2, second paragraph which states "extending laterally there was a partial-thickness tear in the articular side of the rotator cuff," that Dr. Raab probed it, and Dr. Raab said it was not full thickness so he decided to debride it. According to Dr. Wolin, this diagnosis was also consistent with the positive supraspinatus and Whipple Test, his decreased strength on the right dominant shoulder compared to the left, and his response to a diagnostic/therapeutic injection into the shoulder which gave him decreased pain. The injection was directly in the joint, confirmed by ultrasound,

and was given 10 cc Lidocaine and 2 cc Kenalog. So the persistent pain was most likely a problem inside the shoulder and the problem inside the shoulder was most likely a partial-thickness rotator cuff tear. Dr. Wolin believes that Petitioner was a credible patient and his description of the location of the pain, the outside portion of the shoulder, is where the rotator cuff is located. Based on all this, Dr. Wolin believed an MRI arthrogram was medically indicated because a plain MRI is known to miss partial-thickness rotator cuff tears. If the arthrogram is positive for a partial-thickness rotator cuff tear, Dr. Wolin believed that Petitioner would need an arthroscopy followed by a course of care involving physical therapy for approximately 20-24 weeks. Without further treatment, and with only a debridement, Dr. Wolin believed the natural progression of Petitioner's type of injury, a "known percentage of patients… will continue to have pain. They will continue to have weakness… if the rotator cuff is not repaired" (20). This is the type of injury that will not fix/cure/repair itself. (Px 3)

Dr. Wolin believed that Petitioner was not at MMI, and could only work a sedentary job. Dr. Wolin explained that although at Dr. Coe's physical examination in February of 2014 Petitioner had negative impingement signs, Petitioner could still have a partial thickness rotator cuff tear because "impingement signs" are designed to produce pain by the process of pinching the superior portion of the rotator cuff under the acromion, and if the problem was not on the top part of the shoulder but on the bottom part of the shoulder, you could have a negative impingement sign due to the location of an under surface rotator cuff tear. (Px 3)

On cross-examination, Dr. Wolin believed that Dr. Raab's treatment was reasonable based upon the diagnosis. Dr. Wolin believed that if the MRI arthrogram were negative, it was possible that Petitioner could be at MMI, and that it was also possible that the MRI arthrogram could be positive but still not warrant surgery. Dr. Wolin believed that the shoulder would never go back to 100 percent function after Dr. Raab's surgery. That he would expect some residual effects including some loss of strength, pain with over-shoulder activities, and possible decreased range of motion. Dr. Wolin agreed that on June 23, 2014, Dr. Raab noted full ROM with some pain at full flexion which could be an expected post-surgical change. At that time, Dr. Raab noted tenderness, 5 minus/5 strength, and he recommended OTC medication, a HEP, and to be seen as needed, essentially discharging him PRN with no work restrictions. (Px 3)

On re-direct, Dr. Wolin stated the post-surgery x-rays showed normal post-surgical changes and were otherwise unremarkable, this is not indicative of the diagnostic opinion given at this deposition. This is because x-rays only show bone or bony changes. Dr. Wolin also saw a partial thickness rotator cuff tear on the February 2013 MRI despite the fact that Dr. Atlurie and the interpretive radiologist did not see it, and that Dr. Raab saw the same partial-thickness rotator cuff tear during surgery. Dr. Wolin believed that he could read the MRI better than an interpretive radiologist because he sees thousands of MRIs of the shoulder and it is not unusual that he has findings that a radiologist has missed. Dr. Wolin testified that he would expect Petitioner to have pain, tenderness, and weakness following Dr. Raab's surgery because the partial thickness rotator cuff tear was only debrided, and not repaired. (Px 3)

On February 5, 2015, Petitioner had an MRI arthrogram of the right upper arm joint at Weiss. The findings included mild intermediate signal intensity of the distal supraspinatus and infraspinatus tendons compatible with mild tendinosis, no partial or full thickness rotator cuff tear, mild tendinosis of the intra-articular portion of the biceps tendon, mild degenerative

changes at the acromioclavicular joint with small subchondral cyst in the distal clavicle, type II acromion. (Px 2)

On February 17, 2015, Petitioner was seen by Dr. Wolin at Center for Athletic Medicine for an MRI follow up. His pain continued anteriorly and laterally on the right shoulder, with weakness. The MRI was reviewed and changes in the biceps tendon and the rotator cuff were noted. His pain was localized to the anterior aspect of the shoulder and the proximal aspect of his arm with radiation into the anterior upper arm. Dr. Wolin believed the only options were to accept the persistent pain, or consider surgery including arthroscopy of the right shoulder, possible rotator cuff repair, and possible open biceps tenodesis, to which Petitioner was agreeable. His work restrictions included no repetitive or over shoulder lifting and a 15 pound weight lifting restriction for the right arm. (Px 3)

On March 3, 2015 Petitioner was seen by Dr. Wolin at Center for Athletic Medicine. He continued to have pain around the posterior superior aspect of the shoulder with radiation anteriorly. There was tenderness about both the anterior and posterior glenohumeral joints as well as the biceps groove. He continued to have the following provocative tests: apprehension relocation, rotation shear test, speeds. The O-Brien sign was positive in position 1 and negative in position 2. The MRI arthrogram was reviewed with Dr. Kapur. Dr. Kapur believed that there was diminished size of the labrum consistent with a prior repair with attempting healing, and this was consistent with the initial complaint of posterior shoulder pain on the date of the injury, also consistent with persistent positive findings, and consistent with relief of pain with intra-articular injection of lidocaine both in this office and during the MRI arthrogram. Dr. Kapur is quoted as saying, "There was substantial evidence that the primary problem is a glenoid labrum tear. There was also found to be a partial-thickness rotator cuff tear at surgery, this was debrided. Although an MRI may be grossly normal, once debrided there may well not be evidence of a tear. However, it is clear that it was present at the time of surgery." Dr. Wolin continued to recommend that the patient undergo arthroscopy with possible biceps tenodesis. Dr. Wolin opined "He will not improve without surgery." (Px 2)

On May 6, 2015, Petitioner had an examination pursuant to Section 12 of the Act with Dr. Nicholson. The mechanism of injury and medical history were described. Petitioner stated that "after surgery, his pain never changed." His pain on this date was localized with his whole palm over the posterior aspect of the scapula and the axilla along his rib cage and then down the lateral and posterior aspect of the arm down the triceps to the elbow and the lateral aspect of the arm. The arthrogram MRI was not available, but the official radiologist results were reviewed. Petitioner noted that the lidocaine injection in and around the shoulder "really helped his pain for a short period of time." The recommendation of surgery was noted. On physical examination, Petitioner had 5/5 external rotation strength, 5/5 belly press strength, and 5/5 supraspinatus abduction strength. The AC joint resection margin was even and nontender. He could abduct to cross the body and scratch the back of his other shoulder. He could internally rotate behind the back to T11 without pain. There was no evidence of scapular dysrhythm, no evidence of winging scapula and no evidence of scapular crepitation. Cervical spine extension was 20 degrees, flexion 25 degrees, and rotation each way to 30 degrees. Speed's test and Yergason's sign were negative. Provocative test for instability, SLAP lesions, long head of biceps tendon lesions are negative. "With all the different things that we did today, we did not provoke pain in the subacromial distribution in the axilla" but he stated he had a lot of pain over the posterior aspect of the

shoulder. Load shift test, dynamic shear test, and abduction, external rotation, pronation test and O'Brien's test were negative for superior labral type pathology. (Rx 1)

Dr. Nicholson believed that the MRI arthrogram, which showed tendinosis of the distal supraspinatus, had "no evidence of a partial undersurface rotator cuff tear, full thickness tear nor evidence of labral pathology." Dr. Nicholson believed that the injury was causally connected to the work accident that required treatment, injections, and subsequent surgery. Dr. Nicholson noted that "Petitioner has essentially full ROM, normal strength and I cannot provoke specific injury and his MRI does not show a structural injury or a surgical indication." Dr. Nicholson believed that "although he has pain, it is more in a radicular distribution, neurologic distribution than anything in the subacromial space or the labral pathology." Based on this, his recommendation was an FCE to determine functional capacity. Although the injection did relive the pain significantly, Dr. Nicholson could not provoke pain or localized specific pathology. (Rx 1) Respondent then authorized an FCE.

On June 3, 2015, Petitioner performed a valid FCE at ATI Physical Therapy. He demonstrated capabilities consistent with a Medium physical demand level. He was able to lift 36.8lbs above the shoulder, 77.8lbs desk to chair, 65.6lbs chair to floor, unilaterally 21.8lbs with his right arm above the shoulder, 28.4lbs with his left arm above the shoulder, 30.6lbs with right arm desk to chair, 39.4lbs with left arm desk to chair, and carry 42lbs with his right arm and 52lbs with his left arm. He had several reports and behaviors regarding his left shoulder throughout the assessment. Crawling, neck flexion and rotation were recommended on an occasional basis. His pre-injury rob is considered a Heavy physical demand level with occasional lifting of up to 100lbs, so Petitioner fell below this demand level.

CONCLUSIONS OF LAW

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

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

There is no dispute that Petitioner sustained a right shoulder injury as a result of carrying a heavy air conditioner on January 2, 2013. Dr. Raab's June 18, 2013 operative report indicated he debrided a partial thickness rotator cuff tear and a type I SLAP lesion, and he also performed a bursectomy and distal clavicle resection. However, it is apparent that Petitioner still suffers disabling right shoulder/flank pain following this surgery and subsequent discharge by Dr. Raab. This is confirmed by Petitioner's testimony, his continued pain complaints with every physician, and his valid FCE.

The Arbitrator is notes that the February 25, 2015 MRI, with contrast, was read as being normal. Dr. Wolin addresses this in his March 3, 2015 chart note which states, in part:

I reviewed his MRI arthrogram once again with Dr. Kapur. He believes that there is diminished size of the labrum consistent with a prior repair with attempted healing. This is consistent with the initial complaint of posterior shoulder pain on the date of the injury. It is also consistent with persistent positive findings including those described above. In addition it is consistent with relief of pain with intra-articular injection with lidocaine. Of note this happened not only in my office but when the patient had an MRI arthrogram.

Assessment: There is substantial evidence that the primary problem is a glenoid labrum tear. There was also found to be a partial-thickness rotator cuff tear at surgery. This was debrided. Although an MRI may be grossly normal, once debrided there may be evidence of a tear. However, it is clear that it was present at the time surgery as described in the operative report.

Plan: I continue to recommend that the patient undergo arthroscopy with possible biceps tenodesis. He will not improve without surgery.

The Arbitrator finds that Petitioner testified credibly. His testimony regarding continued complaints of pain and difficulty were documented in the medical records. The Arbitrator also finds Dr. Wolin's opinions as to the generator of Petitioner's persistent and disabling pain to be more persuasive than that offered by the other physicians. After considering all of the evidence adduced at hearing, the Arbitrator finds that Petitioner has met his burden to establish by a preponderance of credible evidence that his current condition of ill-being is causally related to the work injury of January 2, 2013.

In support of the Arbitrator's decision with regard whether the Petitioner is entitled to prospective medical care, the Arbitrator makes the following conclusions of law:

The Arbitrator has found that the Petitioner's current condition of ill-being is causally related to the work injury sustained on January 2, 2013, and that the medical opinion of Dr. Wolin regarding the need for additional treatment, including surgery is sufficient to sustain the Petitioner's burden of proof regarding the need for additional treatment. Pursuant to the case of *Plantation Mfg. vs. Indust. Comm.* 294 Ill.App3d 705, 691 N.E. 2d 13, 229 Ill. Dec 77 (2d Dist 1997), Respondent is ordered to authorize and pay all reasonable, necessary and related costs associated with the arthroscopic surgery prescribed by Dr. Wolin as well as any associated aftercare.

In support of the Arbitrator's decision with regard to the amount due for temporary total disability, the Arbitrator makes the following conclusions of law:

The Arbitrator has found that Petitioner's current condition of ill-being is causally related to the January 2, 2013 work accident and that Petitioner was not at MMI when he was released by Dr. Raab in October 2013 and still in need of care for his right shoulder injury.

Accordingly, Respondent shall pay Petitioner temporary total disability benefits of $438.18/week for 128 weeks commencing January 3, 2013 through June 16, 2015, as provided by Section 8(a) of the Act. Respondent is entitled to a credit of $18,406.54 in TTD benefits previously paid.

ORDER OF THE ARBITRATOR

Respondent is ordered to authorize and pay all reasonable, necessary and related costs associated with the arthroscopic surgery prescribed by Dr. Wolin as well as any associated aftercare.

Respondent shall pay Petitioner temporary total disability benefits of $438.18/week for 128 weeks commencing January 3, 2013 through June 16, 2015, as provided by Section 8(a) of the Act. Respondent is entitled to a credit of $18,406.54 in TTD benefits previously paid.

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

Deborah L. Simpson

Signature of Arbitrator

December 30, 2015

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nakia Jackson,

Petitioner,

16IWCC0720

vs.

NO: 14 WC 26577

Ford Motor Company,

Respondent.

DECISION AND OPINION ON REVIEW

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

As indicated above, this matter was arbitrated under §19(b) of the Act. The Arbitrator found that Petitioner failed to meet her burden of proving a compensable accident. The Commission affirms that finding. However, in the "ORDER" section of the decision, the Arbitrator included the language that "in no instance shall this award be a bar to subsequent hearing and determination of any additional amount of medical benefits or compensation for a temporary or permanent disability, if any." Because the claim was denied in its entirety, the matter will not be remanded for determination of any additional benefits and therefore the decision does bar subsequent awards. Therefore, the Commission strikes the above quoted language from the "ORDER" section of the Decision of the Arbitrator.

16IWCC0720

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 13, 2016, is hereby affirmed and adopted with the changes noted above.

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

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

DATED: NOV 4 - 2016
o10/26/16
RWW/rm
46

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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

16IWCC0720

JACKSON, NAKIA
Employee/Petitioner

Case# **14WC026577**

FORD MOTOR COMPANY
Employer/Respondent

On 1/13/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4788 HETHERINGTON KARPEL ET AL
ANDREW PIPPEN
120 N LASALLE ST SUITE 2810
CHICAGO, IL 60602

0075 POWER & CRONIN LTD
ADAM F RETTBERG
900 COMMERCE DR SUITE 900
OAK BROOK, IL 60523

16IWCC0720

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)

NAKIA JACKSON
Employee/Petitioner
v.

Case # 14 WC 26577

FORD MOTOR COMPANY
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **11/16/15 and 12/15/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS 16IWCC0720

On the date of accident, **7/12/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$49,094.94**; the average weekly wage was **$926.32**.

On the date of accident, Petitioner was **38** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$12,252.93** for other benefits, for a total credit of **$12,252.93**.

Respondent is entitled to a credit of **$12,252.93** under Section 8(j) of the Act.

ORDER

Respondent shall be given credit for $3,589.18 for medical benefits paid under Section 8(j) of the Act.
Respondent shall be given credit for $8,663.75 for non-occupational indemnity benefits paid under Section 8(j) of the Act.

As no accident was found to have occurred on 7/12/14, no benefits are awarded.

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

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

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

David A. Kane
Signature of Arbitrator

January 11, 2016
Date

ICArbDec19(b)

JAN 13 2016

NAKIA JACKSON v. FORD

14 WC 26577

STATEMENT OF FACTS

Petitioner's testimony:

As of May 7, 2012, Petitioner Nakia Jackson was employed by Respondent Ford Motor Company. (TX, p. 8) Her job title was "body assembler." (Id.) This position involved work with the bare metal pieces of cars prior to assembly, and Petitioner performed work at various stations around the plant as part of this job. (Id.)

On May 7, 2012, Petitioner was working at the "floor pan" job." (TX, p. 9) This was not part of her prior usual rotation, and she had started at this position two days prior. (Id.) Floor pans are sheets of metal approximately 4 feet high by two feet wide. (Id.) They arrived at the work station stored horizontally in a rack, with about two or three hundred pieces per rack. (Id.) Petitioner would take five to seven pieces at a time out of the rack, lifting them vertically, then take two and place them onto a robot arm for further robotic assembly. (Id.) Petitioner estimated that each piece weighed between five and seven pounds. (TX, p. 10)

Petitioner typically worked ten-hour shifts for Respondent, and when assigned to a position, she would work it for the entire shift. (Id.) She estimated that over the course of a day working at the floor pan position she would lift "about 1200" floor pans. (Id.)

Petitioner testified that on May 7, 2012, she was lifting between five and seven floor pans out of the rack, and she "pulled" her back when standing up with the pans in her hands. (Id.) This occurred approximately six hours into her shift that day. (TX, p. 11) She contacted her supervisor, Lou Townsend, and told him what had happened. (TX, p. 11-12) Townsend sent her home and advised her that he would send her to the medical clinic if she still had pain the following morning on her return to work. (TX, p. 12)

The following morning, her back was hurting more than it had the previous day. (Id.) She informed Townsend, and he sent her to the Ford Medical Clinic. (Id.) They provided her with ibuprofen and a heating pad. (Id.) Petitioner testified that she did not see a doctor at the clinic, but did see a nurse. (TX, p. 13) She testified that she was not allowed to schedule a visit with a doctor. (Id.) The ibuprofen and heating pad did not help her lower back pain. (Id.)

For the next several months, into September 2012, she was reassigned to the "cowl top" job. (Id.) This involved installing dashboards in the vehicles. (TX, p. 14) There were two pieces for the cowl top – a larger one that was maneuvered with the aid of a mechanical hoist, and a smaller one that was maneuvered manually. (Id.) Petitioner testified that between May and September 2012 she felt her back would get "jerked" when using the mechanical hoist, but when installing the smaller pieces manually her back pain was unaffected either way. (TX, p. 14-15) She primarily worked without the hoist on the small cowl top pieces. (TX, p. 15) These pieces weighed about 15 pounds. (Id.) She typically installed 300 pieces per day. (TX, p. 15-16)

On September 1, 2012, Petitioner returned to seek treatment from the Ford Medical Clinic for lower back pain. (TX, p. 16) She was again provided with ibuprofen and a heating pad. (Id.) These were unhelpful. (Id.)

Petitioner testified that she continued to have low back pain from September 1, 2012 through November 21, 2013. (TX, p. 16-17) This pain increased over that period, and she started feeling pain in her left buttock. (TX, p. 17) During this period, she was seen again at the Ford Medical Clinic on July 24, 2013, and received ibuprofen and a heating pad, which were again not helpful regarding her lower back pain. (Id.)

On November 21, 2013, Petitioner was working at the cowl top position, installing the larger cowl tops. (Id.) She was performing this job that day because her partner who ran the mechanical hoist was out. (TX, p. 18) While using the hoist to lift the larger cowl top off the rack, Petitioner testified that the entire hoist fell from the ceiling, pulling her right shoulder and back down. (Id.) She experienced right shoulder pain and testified that she had increased pain in her lower back. (Id.) She contacted her supervisor, "Theresa." (TX, p. 19) She was sent to the plant medical clinic. (Id.)

Petitioner testified that upon arrival at the clinic, she specifically advised them that she was having pain in her right shoulder and lower back. (Id.) She did not receive treatment that day for her lower back. (Id.)

Petitioner sought treatment at Ford Medical Clinic again on several occasions over the following months: January 29, February 18, and May 29, 2014. (Id.) These visits were because her low back pain was getting

worse, and the pain in her left buttock was "shooting" down her left leg. (TX, p. 19-20) On these occasions, she again received ibuprofen and heating pads for her low back, which again did not help. (TX, p. 20) During this time, she continued to work at the cowl top position. (Id.)

During the period from May 8, 2012 through May 29, 2014, Petitioner also sought medical care from the Ford clinic for unrelated conditions, including stomach cramps and migraines. (TX, p. 21) She did not discuss her lower back, the pain in which she alleged continued to worsen, at these visits because she felt the clinic's provision of ibuprofen and heating pads wouldn't help. (TX, p. 21-22) Petitioner "just went for the matters at hand." (TX, p. 22)

On July 12, 2014, Petitioner consulted with Dr. John Wu, a primary care physician. (Id.) She did not have a primary care physician prior to that date. (Id.) She was referred by a co-worker to Dr. Wu. (Id.) Dr. Wu prescribed pain medication, x-rays, and an MRI of the lower back. (Id.) He also recommended that Petitioner be taken off-work. (Id.) Petitioner testified that she communicated this work status to Respondent by faxing the doctor's written statement to Unicare, which she then understood would inform Respondent. (TX, p. 24)

Petitioner obtained the x-rays that Dr. Wu had prescribed at Advocate Trinity Hospital. (TX, p. 22-23) The MRI was obtained on July 15, 2014, at Preferred Open MRI. (TX, p. 23) She returned to see Dr. Wu on July 22, 2014. (Id.) She felt pain in her lower back that was continuing to worsen, with pain in the left buttock and leg that was radiating to her right buttock. (Id.) Dr. Wu referred her to Dr. Mark Sokolowski, a back specialist. (Id.)

Petitioner told Dr. Wu that she wanted to return to work, so he provided restrictions that were accommodated by Ford. (TX, p. 23-24)

Petitioner was seen by Dr. Sokolowski on August 12, 2014. (TX, p. 24) At that visit, in addition to her prior symptoms she noted numbness in her toes. (TX, p. 25) Dr. Sokolowski recommended physical therapy and light duty work restrictions. (Id.) She remained on light duty at work, and attended physical therapy at ATI from August 20 through October 23, 2014. (Id.) This therapy helped her by 50%. (Id.)

She returned to Dr. Sokolowski on October 27, 2014. (TX, p. 25-26) She again reported worsening low back pain, pain in both buttocks, pain in the left leg, and numbness in her toes. (TX, p. 26) Dr. Sokolowski recommended injections. (Id.) She continued to follow up with Dr. Sokolowski through May 14, 2015, but did not receive the injections because they were not authorized by workers' compensation. (Id.)

On May 14, 2015, she returned to Dr. Sokolowski. (Id.) She had continued to work during this interval up until May 11, 2015. (TX, p. 27) She stopped working after May 11, 2015 because it had become difficult to stand, sit, or be at work that long. (Id.) Dr. Sokolowski took her off-work. (Id.) She scheduled an injection and planned to pay for it via her group insurance. (Id.) The first injection was administered on May 22, 2015, and followed up afterward with Dr. Sokolowski on June 25, 2015. (Id.) On that occasion she felt the injection hadn't worked. (TX, p. 28) Dr. Sokolowski kept her off-work, and recommended surgery. (Id.) Thereafter she continued to follow up with Dr. Sokolowski through the most recent visit prior to trial, on October 12, 2015. (Id.) As of that date, Dr. Sokolowski continued to keep

her off-work and recommend surgery to address her symptoms. (Id.) He additionally recommended that she begin seeing a chiropractor. (TX, p. 29)

Petitioner was seen at Southland Chiropractic & Rehabilitation on October 26 and 27, 2015. (Id.) She obtained stretching and massage as treatment. (Id.) These did help her pain while being administered, but the relief was not lasting. (Id.)

At the time of trial, Petitioner testified that she still felt worsening pain in her lower back, both buttocks, the left leg, and had numbness in her toes. (TX, p. 30) She did wish to undergo the surgery proposed by Dr. Sokolowski, because she still felt it was hard to sit or stand too long, and to get in and out of bed, and she just wanted relief. (Id.) She had never experienced low back pain prior to May 7, 2012, and had never sought professional medical consultation regarding such symptoms prior to that date. (Id.) Prior to the November 21, 2013 incident, she had never experienced leg or buttock pain similar to that currently reported, and had never sought professional medical treatment regarding such symptoms. (TX, p. 31)

Petitioner testified that she had been off-work from May 11, 2015 through the date of trial, and that she had received short-term disability benefits from Unicare amounting to 65% of her income during that period. (Id.)

On cross-examination, Petitioner testified that she had begun working for Respondent on or about February 6, 2012. (TX, p. 32) Following the floor pan incident of May 7, 2012, she reported to the Ford Medical Clinic and confirmed that she had filled out a Report of Injury form there. (TX, p. 33) Petitioner agreed that between May and September of 2012 she had not

sought any medical treatment for her lower back. (TX, p. 34) She agreed that when she returned to Ford Medical Clinic in September 2012, it was not due to any specific incident causing a resurgence of low back pain. (Id.) She confirmed that for approximately nine months after that visit she had not sought any medical treatment for her lower back. (TX, p. 34-35)

Petitioner additionally testified under cross-examination that her alleged injury of November 21, 2013 had involved an increase in low back pain as well as an onset of pain in the right shoulder. (TX, p. 36) She immediately reported to Ford Medical Clinic, and confirmed that she had filled out a Report of Injury on that occasion. (Id.) The Report of Injury contained an area marked "Nature and location of injury," and in that area, Petitioner wrote "pulled shoulder right side." (TX, p. 37; see also Respondent's Exhibit 2) There was no mention of any back injury on that date. (Id.) Petitioner agreed that she did not immediately seek any treatment for her back following this alleged injury. (TX, p. 38)

Petitioner confirmed under cross-examination that she had returned to Ford Medical Clinic a few days later, complaining of right shoulder pain. (TX, p. 38-39). Petitioner testified that she reported her low back pain on each of these occasions. (TX, p. 39) She returned to the clinic in January of 2014, and testified that she had complained then of right shoulder and low back pain. (Id.) She confirmed and agreed that there had been no specific injury to her low back on July 12, 2014, and that she had not filled out any Report of Injury for any incident occurring on or about that date. (TX, p. 41) She testified that she had been referred to Dr. Wu by a friend, and then by Dr. Wu to Dr. Sokolowski. (TX, p. 41-42)

Petitioner also confirmed having been examined by Dr. Bryan Neal at Respondent's request. (TX, p. 42) She testified that she had been truthful in her reporting to Dr. Neal, and that she had told Dr. Neal there had been two injuries to her back at work, one on May 7, 2012, and another on November 21, 2013. (Id.)

Petitioner testified, still under cross-examination, that she had experienced continual low back pain between May 7, 2012 and November 21, 2013, that she had seen Ford Medical Clinic on several occasions during this period, and that on each of those occasions she had complained of low back pain. (TX, p. 42-43)

She confirmed that in early 2013 she had been referred by Ford Medical Clinic to a physical therapy provider called "PTSIR" regarding an unrelated wrist issue. (TX, p. 43) On February 5, 2013, she completed a "Patient History Questionnaire" while at PTSIR. (TX, p. 44; see also Respondent's Exhibit 5) On this document she wrote that her main complaints were her right wrist and ring finger. (Id.) On the second page of this form there was a section marked "General Health," and in this section was an option for "chronic back pain." (TX, p. 44-45; see also Respondent's Exhibit 5) She did not check this option. (TX, p. 45; see also Respondent's Exhibit 5) Another option presented was for "Back Injury"; Petitioner confirmed that she had not checked that option either. (Id.) Below these options was another box that stated "I currently do not have any of the above health conditions", and this box was checked. (Respondent's Exhibit 5) Petitioner confirmed that she had signed this document having read the accompanying statement noting "To the best of my knowledge, the above

information is complete and factual." (TX, p. 6; see also Respondent's Exhibit 5)

Petitioner agreed that she had submitted some portion of her medical bills through a group insurance policy partially paid for by her employer. (TX, p. 46-47) Petitioner agreed that while she had testified she had difficulty sitting or standing for a long period of time, she had provided the entirety of her testimony under both direct and cross-examination while sitting. (TX, p. 47-48)

Under redirect examination, Petitioner testified that when visiting PTSIR on February 5, 2013, she had done so due solely to a wrist problem, and that she had not been there for treatment to her lower back. (TX, p. 49) Under re-cross examination, Petitioner admitted that she had not noted any other health conditions on the questionnaire despite the questionnaire specifically asking her to note any other health conditions. (TX, p. 51)

RECORDS

On May 8, 2012, Petitioner completed a form titled "Injury/Accident Investigation" provided by Respondent. (RX 1) On this form, Petitioner wrote that on May 7, "I was working on front floor panels. I may have picked up too many. I felt a little pain but none too major. I continued work, got up this morning, now the pain is a little intense."

Petitioner was seen at Ford Medical Clinic on May 8, 2012. (RX 4) Her history of injury provided is identical to that stated on the Injury/Accident Investigation form. She was assessed as having sustained a strain to the

lower back. No swelling, bruising, or edema was noted. The report indicates that heat and cold packs, and pain medications were presented, and that Petitioner reported upon discharge that her pain level had been reduced. Petitioner also noted that she could transfer from sitting to standing with less pain than on arrival.

Petitioner was subsequently seen at Ford Medical Clinic on July 24, 2012, for an unrelated nauseous condition. No mention is made of any low back complaints. She then returned to the clinic on September 1, 2012, stating "my back has been hurting every (sic) since I first came here for it. They took me off the job where I first hurt it, but it still hurts. I feel pulling in my back." She displayed limited range of motion from side to side. A hot compress was provided, as well as Tylenol, and she was advised to return to the clinic if needed.

She did not return to the clinic until November 28, 2012. On this occasion, she complained of right thumb and wrist pain following lifting a cowl top from a rack. No mention is made of any low back symptoms. Another "Injury/Accident Investigation" form is present on this date, and indicates complaints limited to the right wrist and thumb without mention of any low back complaints or symptoms.

Petitioner next presented to the Ford Medical Clinic on January 9, 2013. Her complaints were limited to the right wrist and thumb, and ring finger, and no mention is made of any low back complaints or symptoms. She returned on the following day with unchanged complaints.

Petitioner then was seen at Physical Therapy & Sports Injury Rehabilitation ("PTSIR") on February 5, 2013. Her "Patient History Questionnaire" indicates complaints are limited to the right wrist and ring finger, and any acute, ongoing, or chronic low back complaints or symptoms are specifically denied. (RX 5) She was also seen at the Ford Medical Clinic on February 5, 2013, and was found fit to work. (RX 4)

Petitioner returned to the Ford Clinic on May 14 and June 4, 2013 for unrelated maladies, and no mention is made of low back complaints or symptoms on either occasion.

Petitioner later completed another Injury/Accident Investigation form on July 23, 2013, on which she alleged a low back injury in May 2012 while picking up floor panels. (RX 4) She was seen in the Ford Clinic, and indicated that since May 2012 she had problems "once in a while" with her low back. She stated that her back began hurting on this date when picking up a floor pan.

Petitioner then returned to the Ford Clinic on August 7, August 20, September 26, and September 30, 2013, for unrelated conditions. On each of these occasions, no mention of low back complaints or symptoms is seen.

Petitioner then returned to Ford Clinic on November 21, 2013. On this occasion, she noted an injury on that date when a hoist fell from its post onto the floor, pulling on her right shoulder and arm. No mention is made of any complaints or symptoms other than to the right shoulder. An associated Injury/Accident Investigation form of the same date also

indicates "pulled shoulder right side" as the only complaint of injury, with no mention of any low back involvement. (RX 3) She returned to the Ford Clinic on November 26 and 27, again with complaints limited solely to the right shoulder.

She returned to the Ford Clinic on January 29, 2014, with complaints of pain in the right shoulder and low back. (RX 4) She stated the low back pain is constant and "never goes away", and that the right shoulder pain began that day. The low back pain is rated in intensity at 10/10. She denied any recent trauma. She returned to the Ford Clinic again with identical low back complaints on February 18, 2014, and did not relate any onset date or history, but did deny any recent falls or trauma.

Petitioner was seen at the Ford Clinic on April 9 and May 14, 2014, for unrelated complaints. No low back pain or symptoms are noted.

She then returned to the Ford Clinic on May 29, 2014, this time with low back complaints of pain. She denied any radiating pain. An appointment was made to be seen by the plant physician on June 2, but the visit does not appear to have taken place. She was observed to have a slow gait, and to be able to bend and twist at the waist with pain. She returned to the Ford Clinic on June 21, 2014, with complaints of low back pain, but was observed to have a normal gait and ability to bend and extend at the waist. Another appointment with the plant physician was set for June 27, 2014, but a later note from Dr. Patricia Lewis indicates that Petitioner would continue to see her primary doctor due to the denial of the associated workers' compensation claim. Petitioner returned to the clinic on July 12,

indicating that she had seen her primary physician and that an MRI had been ordered.

Petitioner saw a primary care physician, Dr. Henry Wu, on July 12, 2014. (PX 2) She noted a history of low back pain for 1 ½ years after picking up large metal pieces. On July 15, 2014, Dr. Wu recommended an MRI of the low back. On a return visit on July 22, 2014, Dr. Wu provided a referral to a spine surgeon. Dr. Wu's note indicates the MRI revealed a lumbar disc bulge. Dr. Wu provided work restrictions.

The MRI report, dated July 15, 2014, indicates a finding of L4-5 spondylosis with disc dehydration, bulging, and a small posterior central annular tear, with mild right and borderline left foraminal stenosis. (PX 3)

She then returned to the Ford Clinic on July 16, 2014. (RX 4) She noted a history of "recurrent low back pain for several years," and that "this time pain has lasted for weeks." A straight leg raise test was specifically noted to be normal. Several subsequent notes through March 30, 2015, indicate several returns to the Ford Clinic for paperwork processing regarding her then-ongoing treatment with outside physicians for low back pain.

Dr. Mark Sokolowski saw Petitioner on August 12, 2014. (PX 7) She complained of lumbar pain with radiation to the buttocks and lower extremities. She related this to an acute onset of low back pain on May 7, 2012 while at work when she was lifting floor pans from a rack. She noted that she required "regular Naprosyn to keep symptoms sufficiently manageable to allow her to continue at work." She advised that she had then been moved to a different position, and on September 21, 2013 had

aggravated her low back when a hoist jerked, pulling her shoulder. Her symptoms progressed and became intolerable by June of 2014, and she was placed on modified duty by Dr. Wu. Dr. Sokolowski prescribed a Medrol dosepak, Naprosyn, and physical therapy. He applied work restrictions of 5 pounds maximum lifting, no bending or squatting, and no prolonged standing or walking. He issued Petitioner a "semi-rigid lumbosacral orthosis."

Petitioner thereafter underwent a course of several physical therapy visits at ATI Physical Therapy. (PX 4) It was noted by ATI on October 24, 2014 that she had missed 6 visits, but had otherwise demonstrated improved lumbar range of motion and body mechanics.

Petitioner returned to Dr. Sokolowski on October 27, 2014. Her complaints from the prior visit remained. She reported no significant benefit to her symptoms from her ongoing treatment, and an epidural injection was recommended, with surgery to follow if the injection proved unhelpful.

She was seen again several times by Dr. Sokolowski, including visits on December 8, 2014, January 8, and February 10, 2015. Dr. Sokolowski noted positive straight leg raise tests on these occasions.

Petitioner was examined by Dr. Bryan Neal at Respondent's request on February 11, 2015. (RX 3) Dr. Neal reviewed the medical records to that point. Petitioner advised Dr. Neal that her average low back pain during the prior four to six weeks had been 7/10, and as high as 8-9/10. She needed to keep adjusting her position frequently to go from sitting to standing, and complained of pain radiating into the left hamstring. Her

bilateral toes had episodes of numbness. She reported an incident several weeks prior where she had become unable to walk or put any pressure on her right leg.

Dr. Neal performed an examination of Petitioner, finding her gait reciprocal but stiff. Her spinal range of motion was "tremendously limited", with minimal extension or lateral bending. Dr. Neal found straight leg raise tests positive for low back pain only, and found no "true" radicular pain. His diagnosis was nonradicular low back pain secondary to lumbar spondylosis.

Dr. Neal opined that this condition was not related to any injuries while working on either May 7, 2012, November 21, 2013, or July 12, 2014, and also not related to Petitioner's work activities in general. He noted that the diagnosis was based on Petitioner's reports of pain dead center in the midline of the low back, and lack of true radicular or sciatic pain. He found no evidence of neurologic involvement. He reviewed the MRI of 7/15/14, and opined that the L4-5 degenerative disc findings were chronic, long-standing imaging findings. He also noted that this opinion was based on review of the medical records to that point and the history provided by the Petitioner. Dr. Neal ruled out the incident of November 21, 2013 as having any relation to a low back condition, given the relevant medical records at that time contained complaints only regarding the right arm and shoulder.

Dr. Neal then concluded that therefore the only potential date of injury involving work was the initial claim of injury on May 7, 2012. He felt that the concurrent complaints at that time could be plausibly consistent with a low back strain, or with a pre-existing condition of lumbar spondylosis

becoming symptomatic with normal activities of daily life. He noted no apparent medical treatment for more than three months thereafter, indicating that the symptoms were well-tolerated or even resolved. He noted an additional three-month absence of medical treatment after the next visit of September 1, 2012, and that several instances of medical treatment after that time were unrelated to the low back. He noted the PTSIR questionnaire of 2/5/13 that noted no low back complaints whatsoever, supporting a history of resolution of any prior back problem. He continued to review the remainder of the treatment history to the time of his examination, noting multiple lengthy gaps in treatment and finding these to be consistent with a resolution of symptoms subsequent to the event of May 7, 2012, and consistent with degenerative processes.

Taking the totality of the history, records, and examination, Dr. Neal opined that Petitioner had an intrinsic ongoing condition without significant injury on May 7, 2012, and that the medical records did not support any low back injury on November 21, 2013 or July 12, 2014. Dr. Neal opined that no specific work incident or work activity in general had caused, permanently worsened, or accelerated Petitioner's pre-existing degenerative lumbar spondylosis. He felt that the treatment she had received had been reasonable and necessary given her complaints and findings, but was not related to any work incident or activity. He felt that prospective treatment for her symptoms could be considered, but would not be related to any work incident or activity. No current work restrictions were necessary based upon any safety issue or prevention of injury, but could be considered based upon subjective complaints of pain. Potential work restrictions would not be related to any work incident or activity.

Petitioner returned to Dr. Sokolowski on March 25, 2015. (PX 7) Dr. Sokolowski disagreed with Dr. Neal, finding the subsequent symptoms and conditions in Petitioner's low back related to the incident of May 7, 2012. He continued to recommend an epidural injection and work restrictions.

An epidural steroid injection was administered on May 22, 2015. Following this, Petitioner returned to Dr. Sokolowski on June 25, 2015. She reported no lasting benefits from the injection, and continued symptoms as before. He recommended proceeding with lumbar decompression surgery at L4-5, but noted that this was unlikely to provide any relief to the low back symptoms. It would only address the radicular symptoms. He recommended an updated MRI prior to surgery.

The MRI was performed, and Petitioner returned to Dr. Sokolowski on July 21, 2015. Dr. Sokolowski noted "clear disc desiccatory changes at L4-5 with an associated annular tear and left greater than right lateral recess stenosis and foraminal stenosis." Dr. Sokolowski opined that an x-ray of the lumbar spine found no spondylolisthesis or hip pathology.

The surgery was scheduled for August 5, 2015, but Petitioner was apparently found to be severely anemic, and it was postponed. She returned to Dr. Sokolowski on August 19, 2015, and the plan to proceed with surgery was unchanged, pending rebound of Petitioner's hemoglobin levels. She returned again to Dr. Sokolowski on October 12, 2015, and her hemoglobin level was improved. Surgery was re-scheduled for December 15, 2015. Chiropractic therapy for incremental pain relief was prescribed.

TESTIMONY OF DR. MARK SOKOLOWSKI

Dr. Mark Sokolowski testified at deposition on September 9, 2015. (PX 6) He testified as to the medical records he had reviewed prior to Petitioner coming under his care, and then to his own impressions. He noted that his surgical recommendation was one of two approaches, and was the more conservative of the two. He testified that his diagnoses of Petitioner were lumbar pain and radiculopathy secondary to an annular tear at L4-5. This opinion was based on objective examination findings as well as MRI imagery. He opined that this diagnosis was related to work accidents on May 7, 2012 and November 21, 2013. This opinion was based upon the reported temporal correlation of symptoms and events by Petitioner. He could not determine which event was the primary cause. He agreed with Dr. Neal that there were degenerative symptoms to an extent, based on the MRI findings, but felt that these were asymptomatic prior to May 7, 2012 and the work injury reported by Petitioner. Thereafter, he felt that her reports of ongoing pain were consistent with a previously-asymptomatic condition having been accelerated into a symptomatic state.

On cross-examination, Dr. Sokolowski noted that his impressions regarding the history of Petitioner's symptoms was based in part on the history provided to him by Petitioner. He noted that he had not reviewed the records of the Ford Medical Clinic. His opinion was unchanged by the fact that Petitioner had initially presented for low back pain on only two occasions in the first year following the May 7, 2012 event, based on the statements by Petitioner that her back had been hurting "ever since she was first seen." He agreed that a sprain or strain of the lower back would

likely have resolved within the three-month period that had elapsed between May 7 and September 1, 2012, but his opinion was unchanged because of Petitioner's subjective report on September 1, 2012 that her low back pain had continued throughout that period. He felt this refuted the possibility of a low back sprain or strain. His opinion was unchanged by the subsequent periods of time during which no treatment was sought and where low back complaints were only sporadically voiced by Petitioner, based in part upon an impression that Petitioner had complained of back pain to the Ford Medical Clinic approximately ten times between 2012 and 2014.

The Arbitrator incorporates and adopts the Conclusions of Law in the associated cases numbered 14 WC 26578 and 14 WC 26579.

CONCLUSIONS OF LAW

Issues:

C. Accident and

F. Causal Connection

The medical records are entirely absent any indication of a new or specific work injury occurring on July 12, 2014, and both Dr. Neal and Dr. Sokolowski appear to be in agreement that there was no specific event

alleged as of that date. The only point at which that date is mentioned within the medical records is that it appears to have been the occasion when Dr. Wu first applied work restrictions that were not accommodated by Respondent, and it is the first date for which Petitioner claims entitlement to temporary total disability benefits. The theory put forth by Petitioner claiming an accident on this date would therefore appear to be based on a repetitive or cumulative trauma rather than a specific event, and the Arbitrator will approach this analysis in that vein.

Beginning with her Dr. Wu visit on July 12, 2014, Petitioner's low back complaints and records of treatment become relatively regular and consistent in temporal terms. On July 12, 2014, Petitioner advised Dr. Wu that she had a history of low back pain for 1 ½ years prior, following an event in which she picked up large metal pieces (this would appear to be a reference to the event of May 7, 2012, the subject of associated case number 14 WC 26579). She similarly advised Dr. Sokolowski on the occasion of her first visit with him, that of August 12, 2014. As the Arbitrator found in the decision on 14 WC 26579 regarding the incident of May 7, 2012, that low back injury had resolved sometime prior to July 24, 2013.

Thus, the question becomes whether Petitioner has presented evidence sufficient to sustain her burden of proof in establishing an ongoing and repetitive injury to her low back caused by her employment with Respondent, culminating in her being taken off-work by Dr. Wu on July 12, 2014. The Arbitrator finds that Petitioner has not sustained her burden in this regard. The medical records of her treating physicians all purport to

relate her low back condition to the specific events of 5/7/12 and 11/21/13 rather than to a repetitive or cumulative process, and do not contain findings by either Dr. Wu or Dr. Sokolowski that her low back condition of ill-being could have been caused simply through her normal work duties.

Dr. Neal, in his report (see RX 3), was adamant that Petitioner's low back condition was degenerative in nature and had not been aggravated or accelerated by her ongoing work activities. Dr. Sokolowski provided no testimony on the subject of the repetitive nature of Petitioner's work duties, nor of any opinion regarding whether she had sustained a repetitive or cumulative trauma to her low back.

Petitioner testified as to the repetitive nature of her work, but there was no testimony regarding this having an increasing effect on her symptoms, and the fact that she worked full duty for more than two years following her initial report of low back symptoms indicates that the work was not in fact causing her condition to accelerate or worsen. Petitioner testified that by July 12, 2014 she could no longer tolerate working, but this does not in and of itself establish that it was repetitive work that was responsible for this change in her tolerance. It certainly does not, by itself, establish by a preponderance of the evidence that a repetitive or cumulative injury has occurred, and the Arbitrator therefore finds that Petitioner has not sustained her burden of proof in showing that an injury either occurred or manifested on July 12, 2014.

Having failed to establish that an injury of any kind occurred on July 12, 2014, the Petitioner has therefore necessarily failed to establish any

causal connection between such an injury and her subsequent condition of ill-being.

J. Medical

As noted in Section C and F above, the Petitioner failed to prove that a compensable injury occurred or manifested on July 12, 2014, and failed to prove a causal connection between any such injury and her later condition of ill-being. Therefore, no medical benefits are awarded.

K. Prospective Medical

As noted in Section C and F above, the Petitioner failed to prove that a compensable injury occurred or manifested on July 12, 2014, and failed to prove a causal connection between any such injury and her later condition of ill-being. Therefore, no prospective medical benefits are awarded.

L. TTD

As noted in Section C and F above, the Petitioner failed to prove that a compensable injury occurred or manifested on July 12, 2014, and failed to prove a causal connection between any such injury and her later condition of ill-being. Therefore, no temporary total disability benefits are awarded.

N. Respondent Credit

Respondent claims payment of $8,663.75 in nonoccupational indemnity disability benefits and an additional $3,748.80 in medical benefits allegedly related to this claim through a group insurance policy. Petitioner testified that Respondent does pay all or a portion of the premium for her health insurance, and that she submitted some or all of her disputed medical bills through that policy. The Arbitrator notes that the visit to Dr. Wu taking place on June 12, 2014 took place before the date of injury alleged in this claim, and is addressed in the Decision for case number 14 WC 26578. The payment made by Respondent's group insurance carrier for that date of service was $159.62, and this amount is subtracted from the total amount paid (See RX 6), to reach a total paid on this claim of $3,589.18.

Respondent is therefore entitled to $12,252.93 in credit under Section 8(j) of the Workers' Compensation Act, representing $8,663.75 in nonoccupational indemnity disability benefits and $3,589.18 in medical payments made by the group carrier.

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

Nakia Jackson,

Petitioner,

16IWCC0721

vs.

NO: 14 WC 26578

Ford Motor Company,

Respondent.

DECISION AND OPINION ON REVIEW

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

As indicated above, this matter was arbitrated under §19(b) of the Act. The Arbitrator found that Petitioner failed to meet her burden of proving a causal connection between this injury and the current condition of ill-being. The Commission affirms that finding. However, in the "ORDER" section of the decision, the Arbitrator included the language that "in no instance shall this award be a bar to subsequent hearing and determination of any additional amount of medical benefits or compensation for a temporary or permanent disability, if any." Because the Arbitrator denied subsequent benefits, the matter will not be remanded for determination of any additional benefits and therefore the decision does bar subsequent awards. Therefore, the Commission strikes the above quoted language from the "ORDER" section of the Decision of the Arbitrator.

16IWCC0721

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 13, 2016, is hereby affirmed and adopted with the changes noted above.

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

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

DATED: NOV 4 - 2016
o10/26/16
RWW/rm
46

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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

16IWCC0721

JACKSON, NAKIA
Employee/Petitioner

Case# **14WC026578**

FORD MOTOR COMPANY
Employer/Respondent

On 1/13/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4788 HETHERINGTON KARPEL ET AL
ANDREW PIPPEN
120 N LASALLE ST SUITE 2810
CHICAGO, IL 60602

0075 POWER & CRONIN LTD
ADAM F RETTBERG
900 COMMERCE DR SUITE 300
OAK BROOK, IL 60523

16IWCC0721

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)

NAKIA JACKSON
Employee/Petitioner

v.

FORD MOTOR COMPANY
Employer/Respondent

Case # **14** WC **26578**

An *Application for Adjustment 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 **11/16/15 and 12/15/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **11/21/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was*** given to Respondent with respect to the right shoulder, and ***was not*** given to Respondent with respect to the low back.

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

In the year preceding the injury, Petitioner earned **$43,583.27**; the average weekly wage was **$876.60**.

On the date of accident, Petitioner was **37** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$159.62** for other benefits, for a total credit of **$159.62**.

Respondent is entitled to a credit of **$159.62** under Section 8(j) of the Act.

ORDER

Respondent shall pay medical charges for visits to the Ford Medical Clinic, if applicable, on 11/21/13, 11/26/13, 11/27/13, and January 29, 2014 pursuant to the Medical Fee Schedule, and shall hold Petitioner harmless for same. As no causal connection between this injury and Petitioner's current condition of ill-being was found thereafter, no subsequent benefits are awarded.

Respondent shall be given a credit of $159.62 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.

As no causal connection for the right shoulder was found beyond 1/29/14, and no causal connection for the low back was found at any point, no further benefits are awarded.

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

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

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

David A. Kane
Signature of Arbitrator

JAN 13 2016

January 11, 2016
Date

ICArbDec19(b)

NAKIA JACKSON v. FORD

16IWCC0721

14 WC 26578

STATEMENT OF FACTS

Petitioner's testimony:

As of May 7, 2012, Petitioner Nakia Jackson was employed by Respondent Ford Motor Company. (TX, p. 8) Her job title was "body assembler." (Id.) This position involved work with the bare metal pieces of cars prior to assembly, and Petitioner performed work at various stations around the plant as part of this job. (Id.)

On May 7, 2012, Petitioner was working at the "floor pan" job." (TX, p. 9) This was not part of her prior usual rotation, and she had started at this position two days prior. (Id.) Floor pans are sheets of metal approximately 4 feet high by two feet wide. (Id.) They arrived at the work station stored horizontally in a rack, with about two or three hundred pieces per rack. (Id.) Petitioner would take five to seven pieces at a time out of the rack, lifting them vertically, then take two and place them onto a robot arm for further robotic assembly. (Id.) Petitioner estimated that each piece weighed between five and seven pounds. (TX, p. 10)

Petitioner typically worked ten-hour shifts for Respondent, and when assigned to a position, she would work it for the entire shift. (Id.) She estimated that over the course of a day working at the floor pan position she would lift "about 1200" floor pans. (Id.)

Petitioner testified that on May 7, 2012, she was lifting between five and seven floor pans out of the rack, and she "pulled" her back when standing up with the pans in her hands. (Id.) This occurred approximately six hours into her shift that day. (TX, p. 11) She contacted her supervisor, Lou Townsend, and told him what had happened. (TX, p. 11-12) Townsend sent her home and advised her that he would send her to the medical clinic if she still had pain the following morning on her return to work. (TX, p. 12)

The following morning, her back was hurting more than it had the previous day. (Id.) She informed Townsend, and he sent her to the Ford Medical Clinic. (Id.) They provided her with ibuprofen and a heating pad. (Id.) Petitioner testified that she did not see a doctor at the clinic, but did see a nurse. (TX, p. 13) She testified that she was not allowed to schedule a visit with a doctor. (Id.) The ibuprofen and heating pad did not help her lower back pain. (Id.)

For the next several months, into September 2012, she was reassigned to the "cowl top" job. (Id.) This involved installing dashboards in the vehicles. (TX, p. 14) There were two pieces for the cowl top – a larger one that was maneuvered with the aid of a mechanical hoist, and a smaller one that was maneuvered manually. (Id.) Petitioner testified that between May and September 2012 she felt her back would get "jerked" when using the mechanical hoist, but when installing the smaller pieces manually her back pain was unaffected either way. (TX, p. 14-15) She primarily worked without the hoist on the small cowl top pieces. (TX, p. 15) These pieces weighed about 15 pounds. (Id.) She typically installed 300 pieces per day. (TX, p. 15-16)

On September 1, 2012, Petitioner returned to seek treatment from the Ford Medical Clinic for lower back pain. (TX, p. 16) She was again provided with ibuprofen and a heating pad. (Id.) These were unhelpful. (Id.)

Petitioner testified that she continued to have low back pain from September 1, 2012 through November 21, 2013. (TX, p. 16-17) This pain increased over that period, and she started feeling pain in her left buttock. (TX, p. 17) During this period, she was seen again at the Ford Medical Clinic on July 24, 2013, and received ibuprofen and a heating pad, which were again not helpful regarding her lower back pain. (Id.)

On November 21, 2013, Petitioner was working at the cowl top position, installing the larger cowl tops. (Id.) She was performing this job that day because her partner who ran the mechanical hoist was out. (TX, p. 18) While using the hoist to lift the larger cowl top off the rack, Petitioner testified that the entire hoist fell from the ceiling, pulling her right shoulder and back down. (Id.) She experienced right shoulder pain and testified that she had increased pain in her lower back. (Id.) She contacted her supervisor, "Theresa." (TX, p. 19) She was sent to the plant medical clinic. (Id.)

Petitioner testified that upon arrival at the clinic, she specifically advised them that she was having pain in her right shoulder and lower back. (Id.) She did not receive treatment that day for her lower back. (Id.)

Petitioner sought treatment at Ford Medical Clinic again on several occasions over the following months: January 29, February 18, and May 29, 2014. (Id.) These visits were because her low back pain was getting

worse, and the pain in her left buttock was "shooting" down her left leg. (TX, p. 19-20) On these occasions, she again received ibuprofen and heating pads for her low back, which again did not help. (TX, p. 20) During this time, she continued to work at the cowl top position. (Id.)

During the period from May 8, 2012 through May 29, 2014, Petitioner also sought medical care from the Ford clinic for unrelated conditions, including stomach cramps and migraines. (TX, p. 21) She did not discuss her lower back, the pain in which she alleged continued to worsen, at these visits because she felt the clinic's provision of ibuprofen and heating pads wouldn't help. (TX, p. 21-22) Petitioner "just went for the matters at hand." (TX, p. 22)

On July 12, 2014, Petitioner consulted with Dr. John Wu, a primary care physician. (Id.) She did not have a primary care physician prior to that date. (Id.) She was referred by a co-worker to Dr. Wu. (Id.) Dr. Wu prescribed pain medication, x-rays, and an MRI of the lower back. (Id.) He also recommended that Petitioner be taken off-work. (Id.) Petitioner testified that she communicated this work status to Respondent by faxing the doctor's written statement to Unicare, which she then understood would inform Respondent. (TX, p. 24)

Petitioner obtained the x-rays that Dr. Wu had prescribed at Advocate Trinity Hospital. (TX, p. 22-23) The MRI was obtained on July 15, 2014, at Preferred Open MRI. (TX, p. 23) She returned to see Dr. Wu on July 22, 2014. (Id.) She felt pain in her lower back that was continuing to worsen, with pain in the left buttock and leg that was radiating to her right buttock. (Id.) Dr. Wu referred her to Dr. Mark Sokolowski, a back specialist. (Id.)

Petitioner told Dr. Wu that she wanted to return to work, so he provided restrictions that were accommodated by Ford. (TX, p. 23-24)

Petitioner was seen by Dr. Sokolowski on August 12, 2014. (TX, p. 24) At that visit, in addition to her prior symptoms she noted numbness in her toes. (TX, p. 25) Dr. Sokolowski recommended physical therapy and light duty work restrictions. (Id.) She remained on light duty at work, and attended physical therapy at ATI from August 20 through October 23, 2014. (Id.) This therapy helped her by 50%. (Id.)

She returned to Dr. Sokolowski on October 27, 2014. (TX, p. 25-26) She again reported worsening low back pain, pain in both buttocks, pain in the left leg, and numbness in her toes. (TX, p. 26) Dr. Sokolowski recommended injections. (Id.) She continued to follow up with Dr. Sokolowski through May 14, 2015, but did not receive the injections because they were not authorized by workers' compensation. (Id.)

On May 14, 2015, she returned to Dr. Sokolowski. (Id.) She had continued to work during this interval up until May 11, 2015. (TX, p. 27) She stopped working after May 11, 2015 because it had become difficult to stand, sit, or be at work that long. (Id.) Dr. Sokolowski took her off-work. (Id.) She scheduled an injection and planned to pay for it via her group insurance. (Id.) The first injection was administered on May 22, 2015, and followed up afterward with Dr. Sokolowski on June 25, 2015. (Id.) On that occasion she felt the injection hadn't worked. (TX, p. 28) Dr. Sokolowski kept her off-work, and recommended surgery. (Id.) Thereafter she continued to follow up with Dr. Sokolowski through the most recent visit prior to trial, on October 12, 2015. (Id.) As of that date, Dr. Sokolowski continued to keep

her off-work and recommend surgery to address her symptoms. (Id.) He additionally recommended that she begin seeing a chiropractor. (TX, p. 29)

Petitioner was seen at Southland Chiropractic & Rehabilitation on October 26 and 27, 2015. (Id.) She obtained stretching and massage as treatment. (Id.) These did help her pain while being administered, but the relief was not lasting. (Id.)

At the time of trial, Petitioner testified that she still felt worsening pain in her lower back, both buttocks, the left leg, and had numbness in her toes. (TX, p. 30) She did wish to undergo the surgery proposed by Dr. Sokolowski, because she still felt it was hard to sit or stand too long, and to get in and out of bed, and she just wanted relief. (Id.) She had never experienced low back pain prior to May 7, 2012, and had never sought professional medical consultation regarding such symptoms prior to that date. (Id.) Prior to the November 21, 2013 incident, she had never experienced leg or buttock pain similar to that currently reported, and had never sought professional medical treatment regarding such symptoms. (TX, p. 31)

Petitioner testified that she had been off-work from May 11, 2015 through the date of trial, and that she had received short-term disability benefits from Unicare amounting to 65% of her income during that period. (Id.)

On cross-examination, Petitioner testified that she had begun working for Respondent on or about February 6, 2012. (TX, p. 32) Following the floor pan incident of May 7, 2012, she reported to the Ford Medical Clinic and confirmed that she had filled out a Report of Injury form there. (TX, p. 33) Petitioner agreed that between May and September of 2012 she had not

sought any medical treatment for her lower back. (TX, p. 34) She agreed that when she returned to Ford Medical Clinic in September 2012, it was not due to any specific incident causing a resurgence of low back pain. (Id.) She confirmed that for approximately nine months after that visit she had not sought any medical treatment for her lower back. (TX, p. 34-35)

Petitioner additionally testified under cross-examination that her alleged injury of November 21, 2013 had involved an increase in low back pain as well as an onset of pain in the right shoulder. (TX, p. 36) She immediately reported to Ford Medical Clinic, and confirmed that she had filled out a Report of Injury on that occasion. (Id.) The Report of Injury contained an area marked "Nature and location of injury," and in that area, Petitioner wrote "pulled shoulder right side." (TX, p. 37; see also Respondent's Exhibit 2) There was no mention of any back injury on that date. (Id.) Petitioner agreed that she did not immediately seek any treatment for her back following this alleged injury. (TX, p. 38)

Petitioner confirmed under cross-examination that she had returned to Ford Medical Clinic a few days later, complaining of right shoulder pain. (TX, p. 38-39). Petitioner testified that she reported her low back pain on each of these occasions. (TX, p. 39) She returned to the clinic in January of 2014, and testified that she had complained then of right shoulder and low back pain. (Id.) She confirmed and agreed that there had been no specific injury to her low back on July 12, 2014, and that she had not filled out any Report of Injury for any incident occurring on or about that date. (TX, p. 41) She testified that she had been referred to Dr. Wu by a friend, and then by Dr. Wu to Dr. Sokolowski. (TX, p. 41-42)

Petitioner also confirmed having been examined by Dr. Bryan Neal at Respondent's request. (TX, p. 42) She testified that she had been truthful in her reporting to Dr. Neal, and that she had told Dr. Neal there had been two injuries to her back at work, one on May 7, 2012, and another on November 21, 2013. (Id.)

Petitioner testified, still under cross-examination, that she had experienced continual low back pain between May 7, 2012 and November 21, 2013, that she had seen Ford Medical Clinic on several occasions during this period, and that on each of those occasions she had complained of low back pain. (TX, p. 42-43)

She confirmed that in early 2013 she had been referred by Ford Medical Clinic to a physical therapy provider called "PTSIR" regarding an unrelated wrist issue. (TX, p. 43) On February 5, 2013, she completed a "Patient History Questionnaire" while at PTSIR. (TX, p. 44; see also Respondent's Exhibit 5) On this document she wrote that her main complaints were her right wrist and ring finger. (Id.) On the second page of this form there was a section marked "General Health," and in this section was an option for "chronic back pain." (TX, p. 44-45; see also Respondent's Exhibit 5) She did not check this option. (TX, p. 45; see also Respondent's Exhibit 5) Another option presented was for "Back Injury"; Petitioner confirmed that she had not checked that option either. (Id.) Below these options was another box that stated "I currently do not have any of the above health conditions", and this box was checked. (Respondent's Exhibit 5) Petitioner confirmed that she had signed this document having read the accompanying statement noting "To the best of my knowledge, the above

information is complete and factual." (TX, p. 6; see also Respondent's Exhibit 5)

Petitioner agreed that she had submitted some portion of her medical bills through a group insurance policy partially paid for by her employer. (TX, p. 46-47) Petitioner agreed that while she had testified she had difficulty sitting or standing for a long period of time, she had provided the entirety of her testimony under both direct and cross-examination while sitting. (TX, p. 47-48)

Under redirect examination, Petitioner testified that when visiting PTSIR on February 5, 2013, she had done so due solely to a wrist problem, and that she had not been there for treatment to her lower back. (TX, p. 49) Under re-cross examination, Petitioner admitted that she had not noted any other health conditions on the questionnaire despite the questionnaire specifically asking her to note any other health conditions. (TX, p. 51)

RECORDS

On May 8, 2012, Petitioner completed a form titled "Injury/Accident Investigation" provided by Respondent. (RX 1) On this form, Petitioner wrote that on May 7, "I was working on front floor panels. I may have picked up too many. I felt a little pain but none too major. I continued work, got up this morning, now the pain is a little intense."

Petitioner was seen at Ford Medical Clinic on May 8, 2012. (RX 4) Her history of injury provided is identical to that stated on the Injury/Accident Investigation form. She was assessed as having sustained a strain to the

lower back. No swelling, bruising, or edema was noted. The report indicates that heat and cold packs, and pain medications were presented, and that Petitioner reported upon discharge that her pain level had been reduced. Petitioner also noted that she could transfer from sitting to standing with less pain than on arrival.

Petitioner was subsequently seen at Ford Medical Clinic on July 24, 2012, for an unrelated nauseous condition. No mention is made of any low back complaints. She then returned to the clinic on September 1, 2012, stating "my back has been hurting every (sic) since I first came here for it. They took me off the job where I first hurt it, but it still hurts. I feel pulling in my back." She displayed limited range of motion from side to side. A hot compress was provided, as well as Tylenol, and she was advised to return to the clinic if needed.

She did not return to the clinic until November 28, 2012. On this occasion, she complained of right thumb and wrist pain following lifting a cowl top from a rack. No mention is made of any low back symptoms. Another "Injury/Accident Investigation" form is present on this date, and indicates complaints limited to the right wrist and thumb without mention of any low back complaints or symptoms.

Petitioner next presented to the Ford Medical Clinic on January 9, 2013. Her complaints were limited to the right wrist and thumb, and ring finger, and no mention is made of any low back complaints or symptoms. She returned on the following day with unchanged complaints.

Petitioner then was seen at Physical Therapy & Sports Injury Rehabilitation ("PTSIR") on February 5, 2013. Her "Patient History Questionnaire" indicates complaints are limited to the right wrist and ring finger, and any acute, ongoing, or chronic low back complaints or symptoms are specifically denied. (RX 5) She was also seen at the Ford Medical Clinic on February 5, 2013, and was found fit to work. (RX 4)

Petitioner returned to the Ford Clinic on May 14 and June 4, 2013 for unrelated maladies, and no mention is made of low back complaints or symptoms on either occasion.

Petitioner later completed another Injury/Accident Investigation form on July 23, 2013, on which she alleged a low back injury in May 2012 while picking up floor panels. (RX 4) She was seen in the Ford Clinic, and indicated that since May 2012 she had problems "once in a while" with her low back. She stated that her back began hurting on this date when picking up a floor pan.

Petitioner then returned to the Ford Clinic on August 7, August 20, September 26, and September 30, 2013, for unrelated conditions. On each of these occasions, no mention of low back complaints or symptoms is seen.

Petitioner then returned to Ford Clinic on November 21, 2013. On this occasion, she noted an injury on that date when a hoist fell from its post onto the floor, pulling on her right shoulder and arm. No mention is made of any complaints or symptoms other than to the right shoulder. An associated Injury/Accident Investigation form of the same date also

indicates "pulled shoulder right side" as the only complaint of injury, with no mention of any low back involvement. (RX 3) She returned to the Ford Clinic on November 26 and 27, again with complaints limited solely to the right shoulder.

She returned to the Ford Clinic on January 29, 2014, with complaints of pain in the right shoulder and low back. (RX 4) She stated the low back pain is constant and "never goes away", and that the right shoulder pain began that day. The low back pain is rated in intensity at 10/10. She denied any recent trauma. She returned to the Ford Clinic again with identical low back complaints on February 18, 2014, and did not relate any onset date or history, but did deny any recent falls or trauma.

Petitioner was seen at the Ford Clinic on April 9 and May 14, 2014, for unrelated complaints. No low back pain or symptoms are noted.

She then returned to the Ford Clinic on May 29, 2014, this time with low back complaints of pain. She denied any radiating pain. An appointment was made to be seen by the plant physician on June 2, but the visit does not appear to have taken place. She was observed to have a slow gait, and to be able to bend and twist at the waist with pain. She returned to the Ford Clinic on June 21, 2014, with complaints of low back pain, but was observed to have a normal gait and ability to bend and extend at the waist. Another appointment with the plant physician was set for June 27, 2014, but a later note from Dr. Patricia Lewis indicates that Petitioner would continue to see her primary doctor due to the denial of the associated workers' compensation claim. Petitioner returned to the clinic on July 12,

indicating that she had seen her primary physician and that an MRI had been ordered.

Petitioner saw a primary care physician, Dr. Henry Wu, on July 12, 2014. (PX 2) She noted a history of low back pain for 1 ½ years after picking up large metal pieces. On July 15, 2014, Dr. Wu recommended an MRI of the low back. On a return visit on July 22, 2014, Dr. Wu provided a referral to a spine surgeon. Dr. Wu's note indicates the MRI revealed a lumbar disc bulge. Dr. Wu provided work restrictions.

The MRI report, dated July 15, 2014, indicates a finding of L4-5 spondylosis with disc dehydration, bulging, and a small posterior central annular tear, with mild right and borderline left foraminal stenosis. (PX 3)

She then returned to the Ford Clinic on July 16, 2014. (RX 4) She noted a history of "recurrent low back pain for several years," and that "this time pain has lasted for weeks." A straight leg raise test was specifically noted to be normal. Several subsequent notes through March 30, 2015, indicate several returns to the Ford Clinic for paperwork processing regarding her then-ongoing treatment with outside physicians for low back pain.

Dr. Mark Sokolowski saw Petitioner on August 12, 2014. (PX 7) She complained of lumbar pain with radiation to the buttocks and lower extremities. She related this to an acute onset of low back pain on May 7, 2012 while at work when she was lifting floor pans from a rack. She noted that she required "regular Naprosyn to keep symptoms sufficiently manageable to allow her to continue at work." She advised that she had then been moved to a different position, and on September 21, 2013 had

aggravated her low back when a hoist jerked, pulling her shoulder. Her symptoms progressed and became intolerable by June of 2014, and she was placed on modified duty by Dr. Wu. Dr. Sokolowski prescribed a Medrol dosepak, Naprosyn, and physical therapy. He applied work restrictions of 5 pounds maximum lifting, no bending or squatting, and no prolonged standing or walking. He issued Petitioner a "semi-rigid lumbosacral orthosis."

Petitioner thereafter underwent a course of several physical therapy visits at ATI Physical Therapy. (PX 4) It was noted by ATI on October 24, 2014 that she had missed 6 visits, but had otherwise demonstrated improved lumbar range of motion and body mechanics.

Petitioner returned to Dr. Sokolowski on October 27, 2014. Her complaints from the prior visit remained. She reported no significant benefit to her symptoms from her ongoing treatment, and an epidural injection was recommended, with surgery to follow if the injection proved unhelpful.

She was seen again several times by Dr. Sokolowski, including visits on December 8, 2014, January 8, and February 10, 2015. Dr. Sokolowski noted positive straight leg raise tests on these occasions.

Petitioner was examined by Dr. Bryan Neal at Respondent's request on February 11, 2015. (RX 3) Dr. Neal reviewed the medical records to that point. Petitioner advised Dr. Neal that her average low back pain during the prior four to six weeks had been 7/10, and as high as 8-9/10. She needed to keep adjusting her position frequently to go from sitting to standing, and complained of pain radiating into the left hamstring. Her

bilateral toes had episodes of numbness. She reported an incident several weeks prior where she had become unable to walk or put any pressure on her right leg.

Dr. Neal performed an examination of Petitioner, finding her gait reciprocal but stiff. Her spinal range of motion was "tremendously limited", with minimal extension or lateral bending. Dr. Neal found straight leg raise tests positive for low back pain only, and found no "true" radicular pain. His diagnosis was nonradicular low back pain secondary to lumbar spondylosis.

Dr. Neal opined that this condition was not related to any injuries while working on either May 7, 2012, November 21, 2013, or July 12, 2014, and also not related to Petitioner's work activities in general. He noted that the diagnosis was based on Petitioner's reports of pain dead center in the midline of the low back, and lack of true radicular or sciatic pain. He found no evidence of neurologic involvement. He reviewed the MRI of 7/15/14, and opined that the L4-5 degenerative disc findings were chronic, long-standing imaging findings. He also noted that this opinion was based on review of the medical records to that point and the history provided by the Petitioner. Dr. Neal ruled out the incident of November 21, 2013 as having any relation to a low back condition, given the relevant medical records at that time contained complaints only regarding the right arm and shoulder.

Dr. Neal then concluded that therefore the only potential date of injury involving work was the initial claim of injury on May 7, 2012. He felt that the concurrent complaints at that time could be plausibly consistent with a low back strain, or with a pre-existing condition of lumbar spondylosis

becoming symptomatic with normal activities of daily life. He noted no apparent medical treatment for more than three months thereafter, indicating that the symptoms were well-tolerated or even resolved. He noted an additional three-month absence of medical treatment after the next visit of September 1, 2012, and that several instances of medical treatment after that time were unrelated to the low back. He noted the PTSIR questionnaire of 2/5/13 that noted no low back complaints whatsoever, supporting a history of resolution of any prior back problem. He continued to review the remainder of the treatment history to the time of his examination, noting multiple lengthy gaps in treatment and finding these to be consistent with a resolution of symptoms subsequent to the event of May 7, 2012, and consistent with degenerative processes.

Taking the totality of the history, records, and examination, Dr. Neal opined that Petitioner had an intrinsic ongoing condition without significant injury on May 7, 2012, and that the medical records did not support any low back injury on November 21, 2013 or July 12, 2014. Dr. Neal opined that no specific work incident or work activity in general had caused, permanently worsened, or accelerated Petitioner's pre-existing degenerative lumbar spondylosis. He felt that the treatment she had received had been reasonable and necessary given her complaints and findings, but was not related to any work incident or activity. He felt that prospective treatment for her symptoms could be considered, but would not be related to any work incident or activity. No current work restrictions were necessary based upon any safety issue or prevention of injury, but could be considered based upon subjective complaints of pain. Potential work restrictions would not be related to any work incident or activity.

Petitioner returned to Dr. Sokolowski on March 25, 2015. (PX 7) Dr. Sokolowski disagreed with Dr. Neal, finding the subsequent symptoms and conditions in Petitioner's low back related to the incident of May 7, 2012. He continued to recommend an epidural injection and work restrictions.

An epidural steroid injection was administered on May 22, 2015. Following this, Petitioner returned to Dr. Sokolowski on June 25, 2015. She reported no lasting benefits from the injection, and continued symptoms as before. He recommended proceeding with lumbar decompression surgery at L4-5, but noted that this was unlikely to provide any relief to the low back symptoms. It would only address the radicular symptoms. He recommended an updated MRI prior to surgery.

The MRI was performed, and Petitioner returned to Dr. Sokolowski on July 21, 2015. Dr. Sokolowski noted "clear disc desiccatory changes at L4-5 with an associated annular tear and left greater than right lateral recess stenosis and foraminal stenosis." Dr. Sokolowski opined that an x-ray of the lumbar spine found no spondylolisthesis or hip pathology.

The surgery was scheduled for August 5, 2015, but Petitioner was apparently found to be severely anemic, and it was postponed. She returned to Dr. Sokolowski on August 19, 2015, and the plan to proceed with surgery was unchanged, pending rebound of Petitioner's hemoglobin levels. She returned again to Dr. Sokolowski on October 12, 2015, and her hemoglobin level was improved. Surgery was re-scheduled for December 15, 2015. Chiropractic therapy for incremental pain relief was prescribed.

TESTIMONY OF DR. MARK SOKOLOWSKI

Dr. Mark Sokolowski testified at deposition on September 9, 2015. (PX 6) He testified as to the medical records he had reviewed prior to Petitioner coming under his care, and then to his own impressions. He noted that his surgical recommendation was one of two approaches, and was the more conservative of the two. He testified that his diagnoses of Petitioner were lumbar pain and radiculopathy secondary to an annular tear at L4-5. This opinion was based on objective examination findings as well as MRI imagery. He opined that this diagnosis was related to work accidents on May 7, 2012 and November 21, 2013. This opinion was based upon the reported temporal correlation of symptoms and events by Petitioner. He could not determine which event was the primary cause. He agreed with Dr. Neal that there were degenerative symptoms to an extent, based on the MRI findings, but felt that these were asymptomatic prior to May 7, 2012 and the work injury reported by Petitioner. Thereafter, he felt that her reports of ongoing pain were consistent with a previously-asymptomatic condition having been accelerated into a symptomatic state.

On cross-examination, Dr. Sokolowski noted that his impressions regarding the history of Petitioner's symptoms was based in part on the history provided to him by Petitioner. He noted that he had not reviewed the records of the Ford Medical Clinic. His opinion was unchanged by the fact that Petitioner had initially presented for low back pain on only two occasions in the first year following the May 7, 2012 event, based on the statements by Petitioner that her back had been hurting "ever since she was first seen." He agreed that a sprain or strain of the lower back would

likely have resolved within the three-month period that had elapsed between May 7 and September 1, 2012, but his opinion was unchanged because of Petitioner's subjective report on September 1, 2012 that her low back pain had continued throughout that period. He felt this refuted the possibility of a low back sprain or strain. His opinion was unchanged by the subsequent periods of time during which no treatment was sought and where low back complaints were only sporadically voiced by Petitioner, based in part upon an impression that Petitioner had complained of back pain to the Ford Medical Clinic approximately ten times between 2012 and 2014.

The Arbitrator incorporates and adopts the Conclusions of Law in the associated cases numbered 14 WC 26577 and 14 WC 26579.

CONCLUSIONS OF LAW

Issues:

C. Accident and

F. Causal Connection

This case involves the allegation of an injury to Petitioner arising out of and in the course of her employment with Respondent on November 21, 2013. Petitioner testified that she had ongoing low back pain relating to a prior work injury on May 7, 2012, through the time of this alleged injury, but the Arbitrator has found in regard to that prior injury that the Petitioner's

condition of ill-being had resolved by July 24, 2012 at the latest. Therefore, the Arbitrator will consider whether Petitioner sustained a new compensable injury on November 21, 2013.

As alleged by the Petitioner on her Application for Adjustment of Claim, the injury on November 21, 2013 is alleged to have involved the low back and right upper extremity. Petitioner testified that on November 21, 2013, she reported to her employer an injury involving her right shoulder and low back. However, the accident report completed by Petitioner on that date indicates only a complaint of injury to the right shoulder (see Respondent's Exhibit 2). There is no mention of a low back injury on this form, with Petitioner's statement being provided as:

> "I was working the hoist picking up a 502 out of the rack. When I pulled up on the hoist to lift the 502 it jerked out of the rack really hard and the hoist fell completely off the post, hit the floor and pulled my arm and shoulder on the right side. The bolt and clamps fell down on my head and down to the floor."

The associated medical visit to the Ford Medical Clinic contains this history as well. There is no mention of any low back involvement in this event, nor of any low back symptom or complaint. The assessment of the examiner is that Petitioner sustained a right shoulder/arm strain only. Petitioner testified that she did advise the clinic on this occasion that she had low back pain, but this is not reflected in the record.

The Arbitrator has considered whether the clinic could have left this complaint out, but notes that on other occasions where the Petitioner

alleges she advised the clinic she was having low back pain, that condition is reflected in those records. The Arbitrator does not find it plausible that the clinic would have left out this complaint on one specific occasion, whether purposefully or inadvertently, when it was correctly noted on all other apparent occasions where such a complaint was made. In fact, the Arbitrator notes that Petitioner returned to the clinic twice more on November 26 and 27, 2013, and again complained only of right shoulder pain.

The Arbitrator notes that the first example of a documented complaint of low back pain in alleged relation to the event of November 21, 2013 is in the Ford Medical Clinic note of January 29, 2014, some two months later. At this point, Petitioner states that her low back pain is constant, never goes away, and is at an intensity of 10/10. Petitioner again notes this back pain in a visit to the clinic on February 18, 2014, and then not again until May 29, 2014 despite two intervening visits at which one would expect such a severe complaint to have been made if it were present.

The Arbitrator does not find it plausible that Petitioner could have been in such intense pain for two months prior to the January 29, 2014 visit without seeking any medical treatment whatsoever, and thus finds the Petitioner's testimony (and the statement in this medical record) that her pain had continued in the interim to be without credibility. Similarly, the Arbitrator finds the Petitioner's testimony to the contrary regarding the gap in treatment between February 18 and May 29, 2014 (and then thereafter to July 12, 2014) to be lacking credibility.

The Arbitrator further notes that Dr. Sokolowski's opinion finding ongoing causal connection between Petitioner's low back condition and her work activity during this period is, by his own admission, based entirely upon Petitioner's representations to him at the time she came under his care. As the records of the Ford Medical Clinic clearly demonstrate Petitioner's later representations in this regard to be inaccurate, the credibility of Dr. Sokolowski's findings is negatively impacted, and the Arbitrator assigns these findings little weight. Dr. Neal's opinions did take into account these clinic records, and noted the inconsistency between Petitioner's allegations of continuous pain and her numerous lengthy gaps in seeking medical treatment. The Arbitrator assigns more weight to the opinion of Dr. Neal in this regard than to that of Dr. Sokolowski.

Based upon the evidence presented, the Arbitrator finds that Petitioner has sustained her burden of proof in showing that a compensable injury occurred on November 21, 2013, arising out of and in the course of her employment. The records and Petitioner's testimony are consistent that the event occurred as described. However, the Arbitrator finds that based on the totality of the evidence, this compensable injury involved only the right shoulder, and not the low back.

Petitioner's immediately-following medical records consistently reflect her complaints of right shoulder and arm pain, and it was not until more than two months later that any low back complaint is reflected. The Arbitrator therefore finds that Petitioner has sustained her burden of proof in establishing a causal connection between her subsequent right shoulder complaints and the injury of November 21, 2013, characterized in those

medical records as a shoulder sprain/strain. The Arbitrator further finds that this condition resolved on or before the clinic visit of February 18, 2014, as the last documented shoulder complaint of any kind was noted at the clinic visit of January 29, 2014.

The Arbitrator finds, based on the lack of mention of any low back involvement in this event in the immediate medical records, that Petitioner has not sustained her burden in establishing any causal connection between this event and her later low back complaints and symptoms.

E. Notice

The Arbitrator finds that Petitioner did provide notice of her injury to the Respondent as required by the Workers' Compensation Act, by reporting it on November 21, 2013. (See Respondent's Exhibit 2) However, the Arbitrator notes that this report only provided Respondent with notice that a right shoulder injury had occurred, with the first notice to Respondent of any claimed low back injury not occurring until January 29, 2014. The Arbitrator finds that Petitioner did not provide Respondent with any notice of, or information suggesting that, her low back had been injured or aggravated by the injury of November 21, 2013 within the 45-day period required by the Worker's Compensation Act. Thus, the Respondent's measure of liability stemming from this injury is limited to benefits related to the right shoulder only.

J. Medical

As the Arbitrator noted in Section E of this Decision, the Petitioner failed to provide notice of a low back injury to Respondent within 45 days as required by the Workers' Compensation Act, and failed to establish a causal connection between that event and her later low back complaints in any event, and therefore medical benefits relating to treatment for the low back are denied in relation to this claim.

As the Arbitrator found that both notice to the Respondent and causal connection to the subsequent right shoulder complaints have been proven by Petitioner, the Arbitrator awards the reasonable and necessary medical treatment for that condition. Based upon the evidence submitted, the only treatment for this condition took place at Respondent's medical clinic. No bills for right shoulder treatment from any other providers were submitted, and Petitioner did not testify that she ever obtained any treatment specific to the right shoulder. Therefore, there are no specific medical bills or amounts of payment awarded.

K. Prospective Medical

As noted in Sections C, E, F, and J above, the Arbitrator finds that prospective treatment in this matter could only be awarded relative to Petitioner's right shoulder, and not Petitioner's low back. As the only prospective treatment contemplated by Petitioner's physicians is directed at the low back, no prospective medical treatment is awarded relative to this claim.

L. TTD

Petitioner stipulated to no entitlement to temporary total disability benefits until July 12, 2014. (See Arb. Ex. 2) Petitioner's low back condition at that point is not causally connected to the injury of November 21, 2013, and her right shoulder condition, as noted above in Section C and F by the Arbitrator, had resolved by February 18, 2014, and therefore could not have been the cause of her work restrictions beginning on July 12, 2014. Accordingly, the Arbitrator awards no TTD benefits relative to this claim.

N. Respondent Credit

The only date of service prior to July 12, 2014, in the medical bills submitted into evidence by Petitioner is for a visit with Dr. Wu on June 12, 2014. (See Petitioner's Exhibit 2) Evidence submitted by Respondent indicates that the charge for this visit was paid through the group health insurance policy. (RX 6) The group carrier paid $159.62 for this visit, and thus the Respondent is entitled to credit under Section 8(j) in that amount in respect to this claim.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nakia Jackson,

Petitioner,

16IWCC0722

vs.

NO: 14 WC 26579

Ford Motor Company,

Respondent.

DECISION AND OPINION ON REVIEW

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

As indicated above, this matter was arbitrated under §19(b) of the Act. The Arbitrator found that Petitioner failed to meet her burden of proving a causal connection between this injury and the current condition of ill-being. The Commission affirms that finding. However, in the "ORDER" section of the decision, the Arbitrator included the language that "in no instance shall this award be a bar to subsequent hearing and determination of any additional amount of medical benefits or compensation for a temporary or permanent disability, if any." Because the Arbitrator denied subsequent benefits, the matter will not be remanded for determination of any additional benefits and therefore the decision does bar subsequent awards. Therefore, the Commission strikes the above quoted language from the "ORDER" section of the Decision of the Arbitrator.

16IWCC0722

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 13, 2016, is hereby affirmed and adopted with the changes noted above.

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

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

DATED: NOV 4 - 2016
o10/26/16
RWW/rm
46

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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

16IWCC0722

JACKSON, NAKIA
Employee/Petitioner

Case# **14WC026579**

FORD MOTOR COMPANY
Employer/Respondent

On 1/13/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4788 HETHERINGTON KARPEL ET AL
ANDREW PIPPEN
120 N LASALLE ST SUITE 2810
CHICAGO, IL 60602

0075 POWER & CRONIN LTD
ADAM F RETTBERG
900 COMMERCE DR SUITE 300
OAK BROOK, IL 60523

16IWCC0722

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)

NAKIA JACKSON
Employee/Petitioner
v.
FORD MOTOR COMPANY
Employer/Respondent

Case # **14** WC **26579**

An *Application for Adjustment 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 **11/16/15 and 12/15/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0722

FINDINGS

On the date of accident, **5/7/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**36,125.44**; the average weekly wage was $**694.72**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of $**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 medical charges for visits to the Ford Medical Clinic on 5/8/12 and 9/1/12 pursuant to the Medical Fee Schedule, and shall hold Petitioner harmless for same. As no causal connection between this injury and Petitioner's current condition of ill-being was found thereafter, no subsequent benefits are awarded.

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

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

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

David A. Kane
Signature of Arbitrator

January 11, 2016
Date

ICArbDec19(b)

JAN 13 2016

NAKIA JACKSON v. FORD

16IWCC0722

14 WC 26579 (injury date: 5/7/12)

``

STATEMENT OF FACTS

Petitioner's testimony:

As of May 7, 2012, Petitioner Nakia Jackson was employed by Respondent Ford Motor Company. (TX, p. 8) Her job title was "body assembler." (Id.) This position involved work with the bare metal pieces of cars prior to assembly, and Petitioner performed work at various stations around the plant as part of this job. (Id.)

On May 7, 2012, Petitioner was working at the "floor pan" job." (TX, p. 9) This was not part of her prior usual rotation, and she had started at this position two days prior. (Id.) Floor pans are sheets of metal approximately 4 feet high by two feet wide. (Id.) They arrived at the work station stored horizontally in a rack, with about two or three hundred pieces per rack. (Id.) Petitioner would take five to seven pieces at a time out of the rack, lifting them vertically, then take two and place them onto a robot arm for further robotic assembly. (Id.) Petitioner estimated that each piece weighed between five and seven pounds. (TX, p. 10)

Petitioner typically worked ten-hour shifts for Respondent, and when assigned to a position, she would work it for the entire shift. (Id.) She estimated that over the course of a day working at the floor pan position she would lift "about 1200" floor pans. (Id.)

Petitioner testified that on May 7, 2012, she was lifting between five and seven floor pans out of the rack, and she "pulled" her back when standing up with the pans in her hands. (Id.) This occurred approximately six hours into her shift that day. (TX, p. 11) She contacted her supervisor, Lou Townsend, and told him what had happened. (TX, p. 11-12) Townsend sent her home and advised her that he would send her to the medical clinic if she still had pain the following morning on her return to work. (TX, p. 12)

The following morning, her back was hurting more than it had the previous day. (Id.) She informed Townsend, and he sent her to the Ford Medical Clinic. (Id.) They provided her with ibuprofen and a heating pad. (Id.) Petitioner testified that she did not see a doctor at the clinic, but did see a nurse. (TX, p. 13) She testified that she was not allowed to schedule a visit with a doctor. (Id.) The ibuprofen and heating pad did not help her lower back pain. (Id.)

For the next several months, into September 2012, she was reassigned to the "cowl top" job. (Id.) This involved installing dashboards in the vehicles. (TX, p. 14) There were two pieces for the cowl top – a larger one that was maneuvered with the aid of a mechanical hoist, and a smaller one that was maneuvered manually. (Id.) Petitioner testified that between May and September 2012 she felt her back would get "jerked" when using the mechanical hoist, but when installing the smaller pieces manually her back pain was unaffected either way. (TX, p. 14-15) She primarily worked without the hoist on the small cowl top pieces. (TX, p. 15) These pieces weighed about 15 pounds. (Id.) She typically installed 300 pieces per day. (TX, p. 15-16)

On September 1, 2012, Petitioner returned to seek treatment from the Ford Medical Clinic for lower back pain. (TX, p. 16) She was again provided with ibuprofen and a heating pad. (Id.) These were unhelpful. (Id.)

Petitioner testified that she continued to have low back pain from September 1, 2012 through November 21, 2013. (TX, p. 16-17) This pain increased over that period, and she started feeling pain in her left buttock. (TX, p. 17) During this period, she was seen again at the Ford Medical Clinic on July 24, 2013, and received ibuprofen and a heating pad, which were again not helpful regarding her lower back pain. (Id.)

On November 21, 2013, Petitioner was working at the cowl top position, installing the larger cowl tops. (Id.) She was performing this job that day because her partner who ran the mechanical hoist was out. (TX, p. 18) While using the hoist to lift the larger cowl top off the rack, Petitioner testified that the entire hoist fell from the ceiling, pulling her right shoulder and back down. (Id.) She experienced right shoulder pain and testified that she had increased pain in her lower back. (Id.) She contacted her supervisor, "Theresa." (TX, p. 19) She was sent to the plant medical clinic. (Id.)

Petitioner testified that upon arrival at the clinic, she specifically advised them that she was having pain in her right shoulder and lower back. (Id.) She did not receive treatment that day for her lower back. (Id.)

Petitioner sought treatment at Ford Medical Clinic again on several occasions over the following months: January 29, February 18, and May 29, 2014. (Id.) These visits were because her low back pain was getting

worse, and the pain in her left buttock was "shooting" down her left leg. (TX, p. 19-20) On these occasions, she again received ibuprofen and heating pads for her low back, which again did not help. (TX, p. 20) During this time, she continued to work at the cowl top position. (Id.)

During the period from May 8, 2012 through May 29, 2014, Petitioner also sought medical care from the Ford clinic for unrelated conditions, including stomach cramps and migraines. (TX, p. 21) She did not discuss her lower back, the pain in which she alleged continued to worsen, at these visits because she felt the clinic's provision of ibuprofen and heating pads wouldn't help. (TX, p. 21-22) Petitioner "just went for the matters at hand." (TX, p. 22)

On July 12, 2014, Petitioner consulted with Dr. John Wu, a primary care physician. (Id.) She did not have a primary care physician prior to that date. (Id.) She was referred by a co-worker to Dr. Wu. (Id.) Dr. Wu prescribed pain medication, x-rays, and an MRI of the lower back. (Id.) He also recommended that Petitioner be taken off-work. (Id.) Petitioner testified that she communicated this work status to Respondent by faxing the doctor's written statement to Unicare, which she then understood would inform Respondent. (TX, p. 24)

Petitioner obtained the x-rays that Dr. Wu had prescribed at Advocate Trinity Hospital. (TX, p. 22-23) The MRI was obtained on July 15, 2014, at Preferred Open MRI. (TX, p. 23) She returned to see Dr. Wu on July 22, 2014. (Id.) She felt pain in her lower back that was continuing to worsen, with pain in the left buttock and leg that was radiating to her right buttock. (Id.) Dr. Wu referred her to Dr. Mark Sokolowski, a back specialist. (Id.)

Petitioner told Dr. Wu that she wanted to return to work, so he provided restrictions that were accommodated by Ford. (TX, p. 23-24)

Petitioner was seen by Dr. Sokolowski on August 12, 2014. (TX, p. 24) At that visit, in addition to her prior symptoms she noted numbness in her toes. (TX, p. 25) Dr. Sokolowski recommended physical therapy and light duty work restrictions. (Id.) She remained on light duty at work, and attended physical therapy at ATI from August 20 through October 23, 2014. (Id.) This therapy helped her by 50%. (Id.)

She returned to Dr. Sokolowski on October 27, 2014. (TX, p. 25-26) She again reported worsening low back pain, pain in both buttocks, pain in the left leg, and numbness in her toes. (TX, p. 26) Dr. Sokolowski recommended injections. (Id.) She continued to follow up with Dr. Sokolowski through May 14, 2015, but did not receive the injections because they were not authorized by workers' compensation. (Id.)

On May 14, 2015, she returned to Dr. Sokolowski. (Id.) She had continued to work during this interval up until May 11, 2015. (TX, p. 27) She stopped working after May 11, 2015 because it had become difficult to stand, sit, or be at work that long. (Id.) Dr. Sokolowski took her off-work. (Id.) She scheduled an injection and planned to pay for it via her group insurance. (Id.) The first injection was administered on May 22, 2015, and followed up afterward with Dr. Sokolowski on June 25, 2015. (Id.) On that occasion she felt the injection hadn't worked. (TX, p. 28) Dr. Sokolowski kept her off-work, and recommended surgery. (Id.) Thereafter she continued to follow up with Dr. Sokolowski through the most recent visit prior to trial, on October 12, 2015. (Id.) As of that date, Dr. Sokolowski continued to keep

her off-work and recommend surgery to address her symptoms. (Id.) He additionally recommended that she begin seeing a chiropractor. (TX, p. 29)

Petitioner was seen at Southland Chiropractic & Rehabilitation on October 26 and 27, 2015. (Id.) She obtained stretching and massage as treatment. (Id.) These did help her pain while being administered, but the relief was not lasting. (Id.)

At the time of trial, Petitioner testified that she still felt worsening pain in her lower back, both buttocks, the left leg, and had numbness in her toes. (TX, p. 30) She did wish to undergo the surgery proposed by Dr. Sokolowski, because she still felt it was hard to sit or stand too long, and to get in and out of bed, and she just wanted relief. (Id.) She had never experienced low back pain prior to May 7, 2012, and had never sought professional medical consultation regarding such symptoms prior to that date. (Id.) Prior to the November 21, 2013 incident, she had never experienced leg or buttock pain similar to that currently reported, and had never sought professional medical treatment regarding such symptoms. (TX, p. 31)

Petitioner testified that she had been off-work from May 11, 2015 through the date of trial, and that she had received short-term disability benefits from Unicare amounting to 65% of her income during that period. (Id.)

On cross-examination, Petitioner testified that she had begun working for Respondent on or about February 6, 2012. (TX, p. 32) Following the floor pan incident of May 7, 2012, she reported to the Ford Medical Clinic and confirmed that she had filled out a Report of Injury form there. (TX, p. 33) Petitioner agreed that between May and September of 2012 she had not

sought any medical treatment for her lower back. (TX, p. 34) She agreed that when she returned to Ford Medical Clinic in September 2012, it was not due to any specific incident causing a resurgence of low back pain. (Id.) She confirmed that for approximately nine months after that visit she had not sought any medical treatment for her lower back. (TX, p. 34-35)

Petitioner additionally testified under cross-examination that her alleged injury of November 21, 2013 had involved an increase in low back pain as well as an onset of pain in the right shoulder. (TX, p. 36) She immediately reported to Ford Medical Clinic, and confirmed that she had filled out a Report of Injury on that occasion. (Id.) The Report of Injury contained an area marked "Nature and location of injury," and in that area, Petitioner wrote "pulled shoulder right side." (TX, p. 37; see also Respondent's Exhibit 2) There was no mention of any back injury on that date. (Id.) Petitioner agreed that she did not immediately seek any treatment for her back following this alleged injury. (TX, p. 38)

Petitioner confirmed under cross-examination that she had returned to Ford Medical Clinic a few days later, complaining of right shoulder pain. (TX, p. 38-39). Petitioner testified that she reported her low back pain on each of these occasions. (TX, p. 39) She returned to the clinic in January of 2014, and testified that she had complained then of right shoulder and low back pain. (Id.) She confirmed and agreed that there had been no specific injury to her low back on July 12, 2014, and that she had not filled out any Report of Injury for any incident occurring on or about that date. (TX, p. 41) She testified that she had been referred to Dr. Wu by a friend, and then by Dr. Wu to Dr. Sokolowski. (TX, p. 41-42)

Petitioner also confirmed having been examined by Dr. Bryan Neal at Respondent's request. (TX, p. 42) She testified that she had been truthful in her reporting to Dr. Neal, and that she had told Dr. Neal there had been two injuries to her back at work, one on May 7, 2012, and another on November 21, 2013. (Id.)

Petitioner testified, still under cross-examination, that she had experienced continual low back pain between May 7, 2012 and November 21, 2013, that she had seen Ford Medical Clinic on several occasions during this period, and that on each of those occasions she had complained of low back pain. (TX, p. 42-43)

She confirmed that in early 2013 she had been referred by Ford Medical Clinic to a physical therapy provider called "PTSIR" regarding an unrelated wrist issue. (TX, p. 43) On February 5, 2013, she completed a "Patient History Questionnaire" while at PTSIR. (TX, p. 44; see also Respondent's Exhibit 5) On this document she wrote that her main complaints were her right wrist and ring finger. (Id.) On the second page of this form there was a section marked "General Health," and in this section was an option for "chronic back pain." (TX, p. 44-45; see also Respondent's Exhibit 5) She did not check this option. (TX, p. 45; see also Respondent's Exhibit 5) Another option presented was for "Back Injury"; Petitioner confirmed that she had not checked that option either. (Id.) Below these options was another box that stated "I currently do not have any of the above health conditions", and this box was checked. (Respondent's Exhibit 5) Petitioner confirmed that she had signed this document having read the accompanying statement noting "To the best of my knowledge, the above

information is complete and factual." (TX, p. 6; see also Respondent's Exhibit 5)

Petitioner agreed that she had submitted some portion of her medical bills through a group insurance policy partially paid for by her employer. (TX, p. 46-47) Petitioner agreed that while she had testified she had difficulty sitting or standing for a long period of time, she had provided the entirety of her testimony under both direct and cross-examination while sitting. (TX, p. 47-48)

Under redirect examination, Petitioner testified that when visiting PTSIR on February 5, 2013, she had done so due solely to a wrist problem, and that she had not been there for treatment to her lower back. (TX, p. 49) Under re-cross examination, Petitioner admitted that she had not noted any other health conditions on the questionnaire despite the questionnaire specifically asking her to note any other health conditions. (TX, p. 51)

RECORDS

On May 8, 2012, Petitioner completed a form titled "Injury/Accident Investigation" provided by Respondent. (RX 1) On this form, Petitioner wrote that on May 7, "I was working on front floor panels. I may have picked up too many. I felt a little pain but none too major. I continued work, got up this morning, now the pain is a little intense."

Petitioner was seen at Ford Medical Clinic on May 8, 2012. (RX 4) Her history of injury provided is identical to that stated on the Injury/Accident Investigation form. She was assessed as having sustained a strain to the

lower back. No swelling, bruising, or edema was noted. The report indicates that heat and cold packs, and pain medications were presented, and that Petitioner reported upon discharge that her pain level had been reduced. Petitioner also noted that she could transfer from sitting to standing with less pain than on arrival.

Petitioner was subsequently seen at Ford Medical Clinic on July 24, 2012, for an unrelated nauseous condition. No mention is made of any low back complaints. She then returned to the clinic on September 1, 2012, stating "my back has been hurting every (sic) since I first came here for it. They took me off the job where I first hurt it, but it still hurts. I feel pulling in my back." She displayed limited range of motion from side to side. A hot compress was provided, as well as Tylenol, and she was advised to return to the clinic if needed.

She did not return to the clinic until November 28, 2012. On this occasion, she complained of right thumb and wrist pain following lifting a cowl top from a rack. No mention is made of any low back symptoms. Another "Injury/Accident Investigation" form is present on this date, and indicates complaints limited to the right wrist and thumb without mention of any low back complaints or symptoms.

Petitioner next presented to the Ford Medical Clinic on January 9, 2013. Her complaints were limited to the right wrist and thumb, and ring finger, and no mention is made of any low back complaints or symptoms. She returned on the following day with unchanged complaints.

Petitioner then was seen at Physical Therapy & Sports Injury Rehabilitation ("PTSIR") on February 5, 2013. Her "Patient History Questionnaire" indicates complaints are limited to the right wrist and ring finger, and any acute, ongoing, or chronic low back complaints or symptoms are specifically denied. (RX 5) She was also seen at the Ford Medical Clinic on February 5, 2013, and was found fit to work. (RX 4)

Petitioner returned to the Ford Clinic on May 14 and June 4, 2013 for unrelated maladies, and no mention is made of low back complaints or symptoms on either occasion.

Petitioner later completed another Injury/Accident Investigation form on July 23, 2013, on which she alleged a low back injury in May 2012 while picking up floor panels. (RX 4) She was seen in the Ford Clinic, and indicated that since May 2012 she had problems "once in a while" with her low back. She stated that her back began hurting on this date when picking up a floor pan.

Petitioner then returned to the Ford Clinic on August 7, August 20, September 26, and September 30, 2013, for unrelated conditions. On each of these occasions, no mention of low back complaints or symptoms is seen.

Petitioner then returned to Ford Clinic on November 21, 2013. On this occasion, she noted an injury on that date when a hoist fell from its post onto the floor, pulling on her right shoulder and arm. No mention is made of any complaints or symptoms other than to the right shoulder. An associated Injury/Accident Investigation form of the same date also

indicates "pulled shoulder right side" as the only complaint of injury, with no mention of any low back involvement. (RX 3) She returned to the Ford Clinic on November 26 and 27, again with complaints limited solely to the right shoulder.

She returned to the Ford Clinic on January 29, 2014, with complaints of pain in the right shoulder and low back. (RX 4) She stated the low back pain is constant and "never goes away", and that the right shoulder pain began that day. The low back pain is rated in intensity at 10/10. She denied any recent trauma. She returned to the Ford Clinic again with identical low back complaints on February 18, 2014, and did not relate any onset date or history, but did deny any recent falls or trauma.

Petitioner was seen at the Ford Clinic on April 9 and May 14, 2014, for unrelated complaints. No low back pain or symptoms are noted.

She then returned to the Ford Clinic on May 29, 2014, this time with low back complaints of pain. She denied any radiating pain. An appointment was made to be seen by the plant physician on June 2, but the visit does not appear to have taken place. She was observed to have a slow gait, and to be able to bend and twist at the waist with pain. She returned to the Ford Clinic on June 21, 2014, with complaints of low back pain, but was observed to have a normal gait and ability to bend and extend at the waist. Another appointment with the plant physician was set for June 27, 2014, but a later note from Dr. Patricia Lewis indicates that Petitioner would continue to see her primary doctor due to the denial of the associated workers' compensation claim. Petitioner returned to the clinic on July 12,

indicating that she had seen her primary physician and that an MRI had been ordered.

Petitioner saw a primary care physician, Dr. Henry Wu, on July 12, 2014. (PX 2) She noted a history of low back pain for 1 ½ years after picking up large metal pieces. On July 15, 2014, Dr. Wu recommended an MRI of the low back. On a return visit on July 22, 2014, Dr. Wu provided a referral to a spine surgeon. Dr. Wu's note indicates the MRI revealed a lumbar disc bulge. Dr. Wu provided work restrictions.

The MRI report, dated July 15, 2014, indicates a finding of L4-5 spondylosis with disc dehydration, bulging, and a small posterior central annular tear, with mild right and borderline left foraminal stenosis. (PX 3)

She then returned to the Ford Clinic on July 16, 2014. (RX 4) She noted a history of "recurrent low back pain for several years," and that "this time pain has lasted for weeks." A straight leg raise test was specifically noted to be normal. Several subsequent notes through March 30, 2015, indicate several returns to the Ford Clinic for paperwork processing regarding her then-ongoing treatment with outside physicians for low back pain.

Dr. Mark Sokolowski saw Petitioner on August 12, 2014. (PX 7) She complained of lumbar pain with radiation to the buttocks and lower extremities. She related this to an acute onset of low back pain on May 7, 2012 while at work when she was lifting floor pans from a rack. She noted that she required "regular Naprosyn to keep symptoms sufficiently manageable to allow her to continue at work." She advised that she had then been moved to a different position, and on September 21, 2013 had

aggravated her low back when a hoist jerked, pulling her shoulder. Her symptoms progressed and became intolerable by June of 2014, and she was placed on modified duty by Dr. Wu. Dr. Sokolowski prescribed a Medrol dosepak, Naprosyn, and physical therapy. He applied work restrictions of 5 pounds maximum lifting, no bending or squatting, and no prolonged standing or walking. He issued Petitioner a "semi-rigid lumbosacral orthosis."

Petitioner thereafter underwent a course of several physical therapy visits at ATI Physical Therapy. (PX 4) It was noted by ATI on October 24, 2014 that she had missed 6 visits, but had otherwise demonstrated improved lumbar range of motion and body mechanics.

Petitioner returned to Dr. Sokolowski on October 27, 2014. Her complaints from the prior visit remained. She reported no significant benefit to her symptoms from her ongoing treatment, and an epidural injection was recommended, with surgery to follow if the injection proved unhelpful.

She was seen again several times by Dr. Sokolowski, including visits on December 8, 2014, January 8, and February 10, 2015. Dr. Sokolowski noted positive straight leg raise tests on these occasions.

Petitioner was examined by Dr. Bryan Neal at Respondent's request on February 11, 2015. (RX 3) Dr. Neal reviewed the medical records to that point. Petitioner advised Dr. Neal that her average low back pain during the prior four to six weeks had been 7/10, and as high as 8-9/10. She needed to keep adjusting her position frequently to go from sitting to standing, and complained of pain radiating into the left hamstring. Her

bilateral toes had episodes of numbness. She reported an incident several weeks prior where she had become unable to walk or put any pressure on her right leg.

Dr. Neal performed an examination of Petitioner, finding her gait reciprocal but stiff. Her spinal range of motion was "tremendously limited", with minimal extension or lateral bending. Dr. Neal found straight leg raise tests positive for low back pain only, and found no "true" radicular pain. His diagnosis was nonradicular low back pain secondary to lumbar spondylosis.

Dr. Neal opined that this condition was not related to any injuries while working on either May 7, 2012, November 21, 2013, or July 12, 2014, and also not related to Petitioner's work activities in general. He noted that the diagnosis was based on Petitioner's reports of pain dead center in the midline of the low back, and lack of true radicular or sciatic pain. He found no evidence of neurologic involvement. He reviewed the MRI of 7/15/14, and opined that the L4-5 degenerative disc findings were chronic, long-standing imaging findings. He also noted that this opinion was based on review of the medical records to that point and the history provided by the Petitioner. Dr. Neal ruled out the incident of November 21, 2013 as having any relation to a low back condition, given the relevant medical records at that time contained complaints only regarding the right arm and shoulder.

Dr. Neal then concluded that therefore the only potential date of injury involving work was the initial claim of injury on May 7, 2012. He felt that the concurrent complaints at that time could be plausibly consistent with a low back strain, or with a pre-existing condition of lumbar spondylosis

becoming symptomatic with normal activities of daily life. He noted no apparent medical treatment for more than three months thereafter, indicating that the symptoms were well-tolerated or even resolved. He noted an additional three-month absence of medical treatment after the next visit of September 1, 2012, and that several instances of medical treatment after that time were unrelated to the low back. He noted the PTSIR questionnaire of 2/5/13 that noted no low back complaints whatsoever, supporting a history of resolution of any prior back problem. He continued to review the remainder of the treatment history to the time of his examination, noting multiple lengthy gaps in treatment and finding these to be consistent with a resolution of symptoms subsequent to the event of May 7, 2012, and consistent with degenerative processes.

Taking the totality of the history, records, and examination, Dr. Neal opined that Petitioner had an intrinsic ongoing condition without significant injury on May 7, 2012, and that the medical records did not support any low back injury on November 21, 2013 or July 12, 2014. Dr. Neal opined that no specific work incident or work activity in general had caused, permanently worsened, or accelerated Petitioner's pre-existing degenerative lumbar spondylosis. He felt that the treatment she had received had been reasonable and necessary given her complaints and findings, but was not related to any work incident or activity. He felt that prospective treatment for her symptoms could be considered, but would not be related to any work incident or activity. No current work restrictions were necessary based upon any safety issue or prevention of injury, but could be considered based upon subjective complaints of pain. Potential work restrictions would not be related to any work incident or activity.

Petitioner returned to Dr. Sokolowski on March 25, 2015. (PX 7) Dr. Sokolowski disagreed with Dr. Neal, finding the subsequent symptoms and conditions in Petitioner's low back related to the incident of May 7, 2012. He continued to recommend an epidural injection and work restrictions.

An epidural steroid injection was administered on May 22, 2015. Following this, Petitioner returned to Dr. Sokolowski on June 25, 2015. She reported no lasting benefits from the injection, and continued symptoms as before. He recommended proceeding with lumbar decompression surgery at L4-5, but noted that this was unlikely to provide any relief to the low back symptoms. It would only address the radicular symptoms. He recommended an updated MRI prior to surgery.

The MRI was performed, and Petitioner returned to Dr. Sokolowski on July 21, 2015. Dr. Sokolowski noted "clear disc desiccatory changes at L4-5 with an associated annular tear and left greater than right lateral recess stenosis and foraminal stenosis." Dr. Sokolowski opined that an x-ray of the lumbar spine found no spondylolisthesis or hip pathology.

The surgery was scheduled for August 5, 2015, but Petitioner was apparently found to be severely anemic, and it was postponed. She returned to Dr. Sokolowski on August 19, 2015, and the plan to proceed with surgery was unchanged, pending rebound of Petitioner's hemoglobin levels. She returned again to Dr. Sokolowski on October 12, 2015, and her hemoglobin level was improved. Surgery was re-scheduled for December 15, 2015. Chiropractic therapy for incremental pain relief was prescribed.

TESTIMONY OF DR. MARK SOKOLOWSKI

Dr. Mark Sokolowski testified at deposition on September 9, 2015. (PX 6) He testified as to the medical records he had reviewed prior to Petitioner coming under his care, and then to his own impressions. He noted that his surgical recommendation was one of two approaches, and was the more conservative of the two. He testified that his diagnoses of Petitioner were lumbar pain and radiculopathy secondary to an annular tear at L4-5. This opinion was based on objective examination findings as well as MRI imagery. He opined that this diagnosis was related to work accidents on May 7, 2012 and November 21, 2013. This opinion was based upon the reported temporal correlation of symptoms and events by Petitioner. He could not determine which event was the primary cause. He agreed with Dr. Neal that there were degenerative symptoms to an extent, based on the MRI findings, but felt that these were asymptomatic prior to May 7, 2012 and the work injury reported by Petitioner. Thereafter, he felt that her reports of ongoing pain were consistent with a previously-asymptomatic condition having been accelerated into a symptomatic state.

On cross-examination, Dr. Sokolowski noted that his impressions regarding the history of Petitioner's symptoms was based in part on the history provided to him by Petitioner. He noted that he had not reviewed the records of the Ford Medical Clinic. His opinion was unchanged by the fact that Petitioner had initially presented for low back pain on only two occasions in the first year following the May 7, 2012 event, based on the statements by Petitioner that her back had been hurting "ever since she was first seen." He agreed that a sprain or strain of the lower back would

likely have resolved within the three-month period that had elapsed between May 7 and September 1, 2012, but his opinion was unchanged because of Petitioner's subjective report on September 1, 2012 that her low back pain had continued throughout that period. He felt this refuted the possibility of a low back sprain or strain. His opinion was unchanged by the subsequent periods of time during which no treatment was sought and where low back complaints were only sporadically voiced by Petitioner, based in part upon an impression that Petitioner had complained of back pain to the Ford Medical Clinic approximately ten times between 2012 and 2014.

The Arbitrator incorporates and adopts the Conclusions of Law in the associated cases numbered 14 WC 26577 and 14 WC 26578.

CONCLUSIONS OF LAW

Issues:

F. Causal Connection

Petitioner's testimony and the sparse medical records immediately following the alleged lifting incident on May 7, 2012 are consistent, and there does not appear to be any serious dispute that the events described by the Petitioner when she lifted a floor pan on that day occurred. Respondent stipulated as to the occurrence of an accidental injury arising

out of and in the course of Petitioner's employment on that date. The question becomes what that injury was.

The Petitioner reported immediate low back pain commencing on May 7, 2012, and there are no medical records or indications anywhere within the record that there were any symptoms present prior to that date. However, the Petitioner continued to work without restrictions thereafter, and did not seek additional treatment for nearly four months. While Petitioner testified that her low back pain continued throughout, and she also stated this to the Ford Medical Clinic on September 1, 2012, this claim is not consistent with the total absence of any documented complaint or request for medical attention during the interim period. Since after the September 1, 2012 visit the Petitioner then went another ten months (until the 7/24/13 visit) without complaint or medical treatment, the Arbitrator finds Petitioner's claims that her pain continued throughout this lengthy period to be less than fully credible.

This absence of full credibility in turn impacts the credibility of Dr. Sokolowski's opinions relating subsequent complaints to the event of May 7, 2012. Dr. Sokolowski noted that his opinion was, necessarily, based in part upon the history provided to him by Petitioner, as he was apparently not privy to the Ford Medical Clinic records. Dr. Sokolowski testified that he was quite certain that Petitioner's complaints and symptoms had continued throughout the period after May 7, 2012 until she came into his care two years later, but the records are very clear that these complaints were, at the very most, sporadic.

Dr. Neal's opinion did take this medical history into full account, and he specifically noted the multiple and lengthy periods during which Petitioner did not seek medical treatment for low back pain following the May 7, 2012 event. Dr. Neal felt that given this documented history, the May 7 event could be consistent with a lumbar sprain or strain that later resolved, and Dr. Sokolowski agreed that a sprain or strain would likely have resolved by September 1, 2012. Dr. Sokolowski's conclusion that Petitioner's complaints had continued is not supported by the Petitioner's behavior during that period, and relies entirely on Petitioner's subjective reports. As such, the Arbitrator assigns more weight on this issue to the opinion of Dr. Neal than that of Dr. Sokolowski.

Accordingly, the Arbitrator finds that the Petitioner sustained a lumbar sprain/strain only on May 7, 2012, that had likely resolved by the next medical visit she made on September 1, 2012, and had certainly resolved by the next visit thereafter at which any back symptoms were noted, made on July 24, 2013. The Arbitrator therefore finds that Petitioner has not sustained her burden of proof in establishing a causal connection between her work injury on May 7, 2012, and her condition of ill-being as of trial on November 16, 2015.

J. Medical

Having found that Petitioner did sustain a compensable injury on May 7, 2012, the Arbitrator awards payment of medical bills related to that lumbar sprain/strain accordingly. However, the records show that the only

treatment of any kind sought prior to Petitioner's recovery from that injury (by July 24, 2013 at the latest) would have been the visits of May 8 and September 1, 2012 at Respondent's own medical clinic, and the Arbitrator awards payment of any charges generated by these visits if such is required. Petitioner did not submit into evidence any bills for other treatment during this period of time, and therefore none are awarded.

K. Prospective Medical

Having found that Petitioner sustained a compensable injury on May 7, 2012, but that this injury resolved by July 24, 2013 at the latest, any future treatment contemplated is therefore not related to the May 7, 2012 work injury. The Arbitrator declines to award any additional specific treatment in relation to this claim.

L. TTD

Having found that Petitioner sustained a compensable injury on May 7, 2012, but that this injury resolved by July 24, 2013 at the latest, Petitioner is entitled to temporary total disability benefits for any lost time from work that may have occurred within that period. However, Petitioner testified that she did not lose any time from work within this period, and in fact stipulated at trial that the only time lost was in 2014 and 2015. The Arbitrator therefore declines to award any additional TTD benefits in relation to this claim.

N. Respondent Credit

No evidence was submitted by either party indicating related medical treatment paid for through Respondent's group policy for the injury of May

7, 2012, and the Arbitrator therefore awards no credit to Respondent under Section 8(j) with respect to this claim. Credit for treatment paid for through Respondent's group policy in relation to the associated claims will be noted in the Arbitrator's decisions on associated cases numbered 14 WC 26577 and 14 WC 26578.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Piper,

Petitioner,

16IWCC0723

vs.

NO: 13 WC 33612

Oshkosh Specialty Vehicles,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of the injury 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 a Decision dated April 14, 2016, the Arbitrator found that Petitioner sustained a 35% loss of use of his left leg following Petitioner's October 15, 2010 accident. On review, Respondent argued that the Arbitrator's award was not supported by a preponderance of the evidence. The Commission agrees and reduces Petitioner's permanent partial disability award to 27.5% loss of use of the left leg. The Commission acknowledges Petitioner's testimony regarding his self-limitation of recreational activities because of his left knee. However, we note that Dr. Thometz released Petitioner to return to full duty work in August of 2013. However, Petitioner subsequently sustained an unrelated left shoulder injury approximately three months later for which he was off of work and underwent surgery. On July 6, 2015, Petitioner's last examination by Dr. Thometz prior to arbitration, Petitioner was noted to have full extension of the left knee, flexion to 120 degrees, and mild patellofemoral crepitus. Other than home exercise, Dr. Thometz did not recommend any additional treatment for Petitioner's left knee chondromalacia.

All else is affirmed and adopted.

16IWCC0723

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $669.64 per week for a period of 59.125 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent partial disability to Petitioner to the extent of 27.5% loss of use of his left leg.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $39,600.00. 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: NOV 7 - 2016
RWW/plv
o-10/5/16
46

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0723

PIPER, JOHN
Employee/Petitioner

Case# 13WC033612

OSHKOSH SPECIALTY VEHICLES
Employer/Respondent

On 4/14/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.35% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0000 BRISKMAN BRISKMAN & GREENBERG
SUSAN E FRANSEN
175 N CHICAGO ST
JOLIET, IL 60432

2389 GILDEA & COGHLAN
EDWARD A COGHLAN
901 W BURLINGTON AVE SUITE 500
WESTERN SPRINGS, IL 60558

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

JOHN PIPER
Employee/Petitioner

Case #13 WC 33612

V.

OSHKOSH SPECIALTY VEHICLES
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on March 31, 2016. After reviewing all of the issues, the stipulations of the parties and the evidence, it is hereby found and ordered as follows:

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

K. ☐ What temporary benefits are due: ☐ TPD ☐ Maintenance ☐ TTD?

L. ☒ What is the nature and extent of injury?

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

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On October 15, 2010, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $59,050.16; the average weekly wage was $1,135.58.
- At the time of injury, the petitioner was 53 years of age, single with no children under 18.
- The petitioner agreed that the respondent is not liable for any medical services provided to the petitioner.
- The petitioner agreed that the respondent paid $6,813.45 in temporary total disability benefits.
- The respondent agreed that the petitioner is entitled to temporary total disability benefits for nine weeks and that only his left knee was injured on October 15, 2010.

ORDER:

- The respondent shall pay the petitioner the sum of $669.64/week for a further period of 75.25 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 35% loss of use of his left leg.

- The respondent shall pay the petitioner compensation that has accrued from October 15, 2010, through March 31, 2016, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Robert E. Williams

Signature of Arbitrator

April 14, 2016

Date

APR 14 2016

FINDINGS OF FACTS:

The petitioner, a field service technician, sustained a work injury on October 15, 2010. X-rays of his left knee on November 18, 2010, were normal. A left knee MRI on December 17, 2010, revealed a large, mildly complex Baker's cyst. He received medical care for his left knee on January 3, 2011, at Ingalls Occupational and reported a left knee injury on October 15, 2010, after catching his left leg in the rungs of a ladder. The doctor noted that an MRI revealed a large, mildly complex Baker's cyst. Physical therapy was started for the diagnosis of a left knee strain. The petitioner followed up on January 10th and 24th. On July 7, 2011, Dr. Thometz performed a left arthroscopic partial medial meniscectomy, excision of medial plica and an aspiration of popliteal cyst. The petitioner reported continuing knee symptoms at post-op follow-ups through March 25, 2013, at which time he received his first Orthovisc injection in his left knee. He received additional Orthovisc injections on April 1st and 8th and reported overall improvement on May 20th. On November 25, 2013, Dr. Thometz noted that the petitioner's knee was about the same – largely anterior discomfort, discomfort most days increased with stairs or prolonged walking. On July 6, 2015, Dr. Thometz noted that the petitioner's knee was mild and sore and that his symptoms were increased with standing, squatting and climbing stairs.

The petitioner started care for his right shoulder in August 2011. A right shoulder MRI on August 10th revealed tendinosis. The petitioner started care with Dr. Thometz for his left shoulder on February 17, 2014, which he reported was due to lifting a 50-pound door on November 16, 2013. A left shoulder MRI on March 10, 2014, revealed a partial-thickness tear of the articular surface, tendinopathy of the subscapularis tendon and a

degenerative tear of the superior anterior labrum. On May 15, 2014, the petitioner had a left shoulder arthroscopic debridement, manipulation, subacromial decompression, debridement of type I labral tear and rotator cuff repair.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner complains of the inability to rollerblade or ice skate due to fear of injury. He has limited his biking and hiking. He has pain six days a week that increases with ascending stairs and physical activities. The respondent shall pay the petitioner the sum of $669.64/week for a further period of 75.25 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 35% loss of use of his left leg.

STATE OF ILLINOIS)
) SS.
COUNTY OF WINNEBAGO)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tina Tabron,
Petitioner,

16IWCC0724

vs.

NO: 13 WC 1537

General Mills, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 10, 2015, is hereby affirmed and adopted.

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

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

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

DATED: NOV 7 - 2016
o10/26/16
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0724

TABRON, TINA
Employee/Petitioner

Case# **13WC001537**

GENERAL MILLS INC
Employer/Respondent

On 12/10/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

2986 PAUL A COGHLAN & ASSOC
15 SPINNING WHEEL RD
SUITE 100
HINSDALE, IL 60521

16IWCC0724

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Tina Tabron
Employee/Petitioner

v.

General Mills, Inc.
Employer/Respondent

Case # **13** WC **01537**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Rockford**, on **October 13, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 4, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$34,281.00**; the average weekly wage was **$759.20**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **1** dependent child.

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

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance. Respondent paid **$34,835.88** for other benefits.

Respondent paid benefits of **$37,223.38** for which credit would be given under Section 8(j) of the Act.

ORDER

BECAUSE PETITIONER HAS FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT HER CONDITION OF ILL BEING IS CAUSALLY CONNECTION TO THE ACCIDENTAL INJURY SUSTAINED ON JANUARY 4, 2011, THE CLAIM FOR COMPENSATION IS DENIED.

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

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

Signature of Arbitrator

December 9, 2015
Date

DEC 10 2015

Statement of Facts

Petitioner Tina Tabron testified that she was employed by Respondent General Mills on January 4, 2011 in general utility. She had been employed for 7 years. Her job duties included filling in for employees who were not there. She testified that on January 4, 2011, she worked in the frozen packaging department. Product passes through a deep freezer. Every 30 minutes Petitioner would go into the freezer for a quality check. To go into the freezer she would ascend three stairs to a deck. The surface of the decking was plastic with holes in it. She would do her quality inspection and then descend stairs on the opposite side of the machine.

Petitioner testified that, on January 4, 2011, as she came down the three stairs, her foot caught between the step and the doorjamb at the bottom of the stairs. Her right boot tore off of her foot. She testified that she fell forward and twisted. She testified that she felt pain in her right leg on the inside of her calf. She hurt her big toe, and into the arch of her right foot. Petitioner testified that she found her shoe, put it on and reported the fall to her manager.

Petitioner testified she completed her shift through 6:00 AM and then went to Physicians Immediate Care. She testified that she complained of her big toe to the arch of her right foot, her right calf and her right elbow. The records of Physician's Immediate Care were admitted as Petitioner's Exhibit 1. On January 5, 2011, Petitioner presented with right great toe pain, right calf pain, and right elbow pain. Her history was that she fell. She was coming out of a freezer and foot got stuck in the step down area of the freezer. Petitioner reported that she fell forward and her shoe fell off and she had some scraping along the back of her foot. Dr. Gander noted bruising along the lateral aspect of the right calf and great right toe. The right ankle was non tender with normal stable eversion and inversion. There was mild tenderness of the right elbow with full range of motion. X-rays taken did not reveal any fractures. Petitioner was diagnosed with a contusion to the right great toe and calf. Dr. Gander continued petitioner on full duty work but adviser her to ice the area and take Tylenol and Naproxen.

Petitioner returned to Physicians Immediate Care on January 12, 2011. Petitioner reported significant improvement but noted bruising was still present on the calf. Petitioner indicated that she was experiencing stiffness in the right great toe and 2nd toe. Dr. Gander noted mild swelling over the dorsum of the great toe and tenderness. The right ankle was non tender with normal stable eversion and inversion, full range of motion and no weakness. There was no tenderness in the right foot or toes. Petitioner was advised to continue full duty work and ice the area. She was to discontinue her medications. She was released from further care. She was expected to be at maximum medical improvement in two weeks with no impairment (PX 1 p 9).

Petitioner testified that she understood from the doctor at Physicians Immediate Care that the pain would go away. She continued to work full duty. She testified that she continued to take Ibuprofen for symptoms. Petitioner testified that her symptoms were getting worse and she sought treatment with Dr. Heath Hoffman, a podiatrist. Dr. Hoffman's records were admitted as Petitioner's Exhibit 2 and Respondent's Exhibit 4. Petitioner first saw Dr. Hoffman on July 28, 2011. Petitioner provided a history of right heel and arch pain for several months. She relates only one incident of accident to the right foot many months ago where she caught her foot in a door, pinching her foot. Petitioner advised that she wears steel toed boots at work and works long hours while standing. The notes of PA Krista Wenger record a referral from Dr. Gorham and complaints of ankle and arch pain for a couple of months (RX 4). Upon examination, Dr. Hoffman noted tenderness along the insertion of the plantar fascia and posterior tibial tendon as well as hammer toe with 2-5 bilateral moderate bunion deformity. X-rays of the right foot showed plantar and posterior calcaneal heel spur with mild degenerative changes. Petitioner's weight at that time was noted as 329 pounds. The records note Petitioner suffered from

diabetes, hypertension and morbid obesity. The diagnoses were pain in limb, Achilles tendinitis, plantar fascia fibromatosis, tibialis tendinitis, and hammer toe (PX 2 p 68). She was referred to physical therapy and was told to use arch supports. Petitioner was advised to follow up in six weeks and to check benefits for custom insoles and for diabetic shoes.

On August 8, 2011, Petitioner reported no improvement. Dr. Hoffman ordered an MRI. The MRI of the right ankle performed on August 9, 2011 was interpreted by the radiologist as showing moderate tenosynovial fluid about the distal tibialis posterior tendon compatible with tenosynovitis, edema within the anterior calcaneus which may be related to the contusion, subcutaneous edema, and mild bright signal about the posterior plantar fascia medial fascicle most compatible with mild plantar Fasciitis with moderate plantar heel spur (PX 3 p 108).

On August 29, 2011, Dr. Hoffman's diagnosis was tibial tendinitis and plantar fascia fibromatosis. Dr. Hoffman took Petitioner off work and told her to use the cam boot (PX 2 p 58-59). She was to begin physical therapy and continued off work following her appointments on September 12, 2011, October 3, 2011 and November 1, 2011. On December 6, 2011, Petitioner presented with a new symptom of burning on the inside of her ankle (PX 2 p 40). She was having difficulty with walking. The doctor indicated her remaining options for treatment would be to do nothing, cast the foot and be non-weight bearing, or do surgery including talonavicular fusion and possible PT repair. Petitioner was placed in a hard short leg cast and given a knee scooter (PX 2 p 41). On December 21, 2011, Petitioner had cracked the cast on the bottom of the foot. Petitioner denied putting weight on her foot and stated that the cast had gotten wet and her husband pushed it on, causing it to break. Petitioner was again casted and advised to follow up in six weeks (PX 2 p 31). On January 20, 2012, Petitioner was put back in a cam boot and told to begin physical therapy (PX 2 p 26). On February 22, 2012, she had moderate swelling to the forefoot and pain along with the burning pain on the side of her right medial ankle. A new MRI of the foot and ankle was ordered to look for lis franc dislocation and tarsal tunnel syndrome (PX 2 p 21-22).

On February 28, 2012, Petitioner presented to Swedish American for repeat x-rays and MRI of her right foot and ankle. The x-rays of the right ankle showed soft tissue swelling with mild osteoarthritic changes at the first metatarsophalangeal joint and first interphalangeal joint, a small vessel calcification compatible with known history of diabetes and a moderate plantar heel spur. The MRI of the right foot states that the indication is diabetic foot pain and swelling after injury and showed marked subcutaneous tissue edema with mild intramuscular edema which may be related to cellulitis or a contusion, and mild osteoarthritic changes to the first metatarsophalangeal joint. The MRI of the right ankle showed persistent tenosynovial fluid about the tibialis posterior and flexor digitorum longus compatible with tenosynovitis and interval increase compatible with a type 1 partial thickness tear to the tibialis posterior; diffuse non specific subcutaneous edema: resolution of prior trabecular edema compatible with resolution of a prior bone bruise; and thickening of the posterior plantar fascia likely related to mild plantar fasciitis.

On February 29, 2012 Petitioner returned to Dr. Hoffman for review of the MRI's and x-rays. Petitioner reported that her pain had increased since her last appointment. Dr. Hoffman diagnosed petitioner with worsening tibialis tendinitis. Dr. Hoffman opined that Petitioner could elect to continue conservative treatment, apply bracing, get a second opinion or undergo surgery. Dr. Hoffman strongly recommended surgery due to Petitioner's continued deterioration of the PT tendon and lack of overall improvement. Petitioner indicated that she would need to discuss her options with her husband and would call with her decision. Petitioner did not return to Dr. Hoffman after this date.

On March 12, 2012, Petitioner sought a second opinion from Dr. David Yeager. Dr. Yeager's records were admitted as Petitioner's Exhibit 4 and Respondent's Exhibit 3. Petitioner reported pain in the arch and swelling across the top of her right foot. Petitioner provided a history of getting her foot jammed while coming out of a freezer at work. Petitioner's medical history was positive for diabetes. Petitioner reported that she had been treating with Dr. Hoffman and Dr. Hoffman recommending surgical intervention consisting of talonavicular joint fusion with repair to the posterior tibial tendon. Dr. Yeager reviewed the MRIs and x-rays and diagnosed posterior tibial tendonitis with hypertrophy of the posterior tibial tendon, mild talonavicular joint arthritis and equinus deformity of the right extremity. Dr. Yeager agreed with Dr. Hoffman's surgical recommendation of talonavicular joint fusion and repair of the posterior tibial tendon. Dr. Yeager further added that Achilles tendon lengthening would assist with Petitioner's limited motion of the foot. Petitioner returned to Dr. Yeager on April 10, 2012 for surgical consultation. Dr. Yeager noted that Petitioner had decreased ankle range of motion and that she was unable to perform single toe raises and also that her foot was externally rotated with deviated hallux of the dorsal medial prominence. Dr. Yeager recommended surgery consisting of right tendon - Achilles lengthening, Evan's calcaneal osteotomy with graft and talonavicular joint fusion and possible bunionectomy.

Petitioner presented for pre-operative evaluation with Dr. Yeager on June 20, 2012. Dr. Yeager discussed weight loss and dietary changes with Petitioner. On July 13, 2012, Petitioner presented to the family medicine department of KSB for further pre-operative evaluation. Petitioner had a positive history of hypertension and type 2 diabetes that is not well controlled. Petitioner provided family history of ankle problems with her mother. Dr. Juan Hernandez indicated that petitioner should follow up regarding her weight; petitioner was noted to be 5'8" tall and 342 pounds. Petitioner was cleared for surgery.

Petitioner underwent surgery on July 18, 2012 at KSB Hospital with Dr. Yeager. The surgery consisted of talonavicular joint fusion with plate and screw fixation, percutaneous tendo Achilles lengthening, Evans calcaneal osteotomy with graft augmentation, bunionectomy and repair of the posterior tibial tendon. The surgery was performed without complication. Post-operative x-rays showed the hardware in place.

Petitioner was seen postoperatively for her flat foot reconstruction on July 25, 2012, August 1, 2012, August 31, 2012, and September 28, 2012 doing well. The office notes of Dr. Hoffman indicate that the visits are not workers comp. related. Petitioner provided a history that she "slammed her foot down last Saturday causing pain," which appears to have happened after a fall. Further petitioner reported that she could not have x-rays due to the fact that she may be pregnant. Petitioner was advised to increase her weight bearing on her foot and follow up in one month (PX 4 p 125-131).

On October 15, 2012, Petitioner reported she "slammed her foot down on a bleacher and felt something pop in my calf." Dr. Yeager assessed petitioner and diagnosed her with a partial tear of the right Achilles tendon. She was taken off of physical therapy and advised to remain in the CAM boot (PX 4 p 123-124). By November 5, 2012, the pain had improved but there was still swelling. On November 26, 2012, Petitioner resumed therapy and was using a cam walker boot. On December 19, 2012, she reported that she was using regular shoes and felt like she was getting stronger. On January 21, 2013, Petitioner complained of minimal discomfort, and lower leg edema. She was to continue regular shoes and physical therapy. On March 12, 2013, Dr. Yeager noted there was still swelling in her right lower extremity. He recommended use of compression stockings. Petitioner's weight is noted at 342 pounds Petitioner was to follow up in one month for possible discharge and maximum medical improvement (PX 4 p 113-121). Petitioner testified that she continued off work during all this time.

On April 22, 2013, Petitioner reported mild pain on the lateral aspect of her right foot. She was continuing with physical therapy. On May 20, 2013, she reported the compression stockings helped with her swelling. The doctor noted that she was healing well, however it was slow. He recommended she continue physical therapy. Petitioner continued with monthly follow up visits through She continued to have mild pain on the lateral aspect August 13, 2013 (PX 4 p 173-184). She was discharged from physical therapy on July 24, 2013 to a home exercise program at that time (PX 5 p 280). On October 8, 2013, she received new orthotics (PX 4 p 170). On November 5, 2013, Petitioner reports she has good days and bad days. She has occasional pain in the right Achilles, but otherwise feels pretty good.

December 3, 2013, Petitioner is still having mild discomfort on the dorsal lateral aspect of the right foot. She had more pain with ambulation. She relates that ever since she fell in March of this year and slammed her foot down, it has been bothering her. X-rays were taken and show incomplete fusion with fracture of the hardware. He indicated that she should continue use of the compression stockings and consider use of cam walker boot. The alternative option would be to remove the hardware from the prior surgery. He also offered her an Arizona brace (PX 4 p 166-167, 185). On February 26, 2014, Petitioner was having cramping of the back of the legs and occasionally in the front of the. Petitioner related that she would like to have the hardware removed. The doctor discussed surgery to remove the hardware and refuse the talonavicular joint. On March 26, 2014, the doctor indicated that she may need to apply for social security disability (PX 4 p 163).

On May 21, 2014, Dr. Yeager's notes Petitioner related minimal discomfort and relates she can see her feet again. He then records Petitioner's statement that this all began when she initially injured her foot at work when she fell and twisted her right foot. Petitioner then summarized her care including stating the "workmen's compensation doctor" told her it was okay and it would get better (PX 4 p 160). Dr. Yeager's assessment is post right foot reconstruction due to fall at work, teno Achilles lengthening, Workers' Compensation Case (PX 4 p 161).

Petitioner testified she continues to see Dr. Yeager. She was casted for orthotics on August 19, 2014. On October 21, 2014, she continued to have pain on the lateral aspect of her right foot area worse with ambulation. The doctor performed an injection over the third metatarsal cuneiform joint. Dr. Yeager added a diagnosis of mid-foot arthritis (PX 4 p 191-192). On February 4, 2015, Dr. Yeager again discussed removal of the hardware. He notes that Petitioner is treating with Dr. Hoffman for a left Achilles rupture. He notes that her treatment for that condition, will determine treatment for the right foot (PX 4 p 189).

Dr. Yeager prepared a narrative report on August 23, 2013 (PX 8). He states he reviewed the records of Physicians Immediate Care and Dr. Hoffman. He provides Petitioner's accident history, his diagnosis of Petitioner's condition, and details the surgery performed on July 18, 2012. He opines that the mechanism of injury could cause the problem with the posterior tibial tendon. He notes that the progression in deterioration caused the loss of the arch. He opined a causal connection between the accident and the surgery performed. He felt Petitioner was close to MMI and felt that Petitioner returning to regular work would be up to her and her limitations. He stated Petitioner would need a 15-20 minute break every 4 hours on her feet.

Yeager testified by evidence deposition on May 28, 2014 (PX 7). He testified that the treatment she had was reasonable and necessary and that she had pretty much reached MMI at this point. He did indicate that the hardware was fractured. He testified that she may need to have it removed at some point in the future. At present, Petitioner was advancing no symptoms in the area of the fractured hardware. If the area is fused and the hardware is asymptomatic, he would leave it there. Dr. Yeager opined that the diagnoses and need for

treatment were causally related to the work injury that occurred on January 4, 2011. He stated that, depending on the height and depending on how her foot was when she landed, because of her increased weight, the force can cause a tendon to become painful and possibly rupture. He testified the MRI findings were consistent with the mechanism of injury. The changed MRI findings on the second MRI were consistent with the passage of time following the injury. Dr. Yeager testified that diabetics are more susceptible to foot problems, as are obese individuals. There are studies of spontaneous rupture of the tendon in diabetics. When asked whether he reviewed the records to determine if Petitioner's complaints were consistent, Dr. Yeager stated he "went by what she told me."

Dr. George B. Holmes, Jr. performed a Section 12 examination for Respondent on November 13, 2013 (RX 1). Dr. Holmes took a history, reviewed medical records of Physician's Immediate Care, Dr. Hoffman and Dr. Yeager through May 25, 2013, and performed a physical examination of Petitioner. His x-ray exam noted that the joint is not completely fused. His diagnosis is that Petitioner is status post attempted talonavicular fusion as well as bunionectomy. He finds little atrophy and no swelling. He opines that Petitioner is not in need of further medical treatment with respect to the accident on January 4, 2011. He finds no causal relationship between the accident and the treatment since July 28, 2011, including the surgery performed. He finds the treatment on January 5 and January 12, 2011 related and that Petitioner reached maximum medical improvement as of that date. He states that the treatment thereafter is for symptoms not reported and unrelated to the accident. He opines that the Petitioners foot problems are consistent with her underlying medical conditions of obesity, diabetes and high blood pressure. He opined that, based upon his examination, Petitioner could return to her employment as a utility worker for Respondent.

Dr. Holmes testified by evidence deposition taken on January 5, 2015 (RX 2). Dr. Holmes testified he reviewed the records through Dr. Yeager's August 25, 2013 report. He testified that the difference between his credentials and a podiatrist is that a podiatrist does not go to medical school. He opined that Petitioner's conditions of ill being for which the surgery with Dr. Yeager was performed were unrelated to the work accident on January 4, 2011. He testified that the injuries sustained in the accident were limited to the right great toe and her right calf. The examination was negative for any injuries to the foot or ankle. He testified that the examination at the Physician's Immediate Care was fairly thorough. Petitioner was discharged a week later with anticipated MMI of two weeks and did well until July when she presented with a different constellation of symptoms in different areas of her foot. His impression was that the findings and subsequent treatment were related to other factors, not the accident. Diabetes can and does impact the condition. Dr. Holmes agreed with the diagnosis by Dr. Hoffman and Dr. Yeager The care and treatment she received were appropriate for the diagnoses. He testified that the mechanism of injury as recorded in the medical records could not cause Achilles tendonitis, plantar facial fibromatosis, edema within the anterior aspect of the distal tibialis tendon, tenosynovitis of the distal tibialis tendon, or pain at the insertion of the Achilles tendon. It could cause subcutaneous edema.

Petitioner testified that she continues to follow up with Dr. Yeager on a regular basis. She is taking over-the-counter pain medication along with prescribed muscle relaxers. Dr. Yeager is still contemplating the additional surgery to remove the hardware from her foot. She has continued to be off of work and has not returned to any type of occupation.

Conclusions of Law

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

Petitioner must prove by a preponderance of the evidence that there is a causal connection between the accidental injuries sustained on January 4, 2011 and the condition of ill being alleged. To establish causation under the Act, a Petitioner must prove that some act or phase of her employment was a causative factor in her ensuing injury. Based upon the record as a whole, the Arbitrator finds that Petitioner has failed to sustain her burden of proving that the condition of ill being in her left foot is causally connected to the accidental injuries sustained.

Petitioner sustained an undisputed injury on January 4, 2011 when her foot caught between the step and the doorjamb at the bottom of the stairs and she fell. Petitioner's testimony at trial that there was a twisting is not supported by the medical records. Her testimony and history to Dr. Yeager of immediate pain in the arch of her foot is also contradicted by the records of Physicians Immediate Care. Petitioner presented with right great toe pain, right calf pain, and right elbow pain. Her history was that she fell. She was coming out of a freezer and foot got stuck in the step down area of the freezer. Petitioner was diagnosed with a contusion to the right great toe and calf. The Arbitrator finds significant that Dr. Gander recorded a detailed physical examination of the foot and ankle, as commented upon by Dr. Holmes, and noted no findings consistent with Petitioner's allegations. On January 12, 2011, the records state that Petitioner reported significant improvement but noted bruising was still present on the calf. Petitioner indicated that she was experiencing stiffness in the right great toe and 2nd toe. A detailed physical examination of the foot and ankle was again recorded noting that the right ankle was non tender with normal stable eversion and inversion, full range of motion and no weakness. There was no tenderness in the right foot or toes.

The Arbitrator also finds significant that, after Petitioner's release from care by Physician's Immediate Care, she worked full duty and sought no medical treatment for six months. The Arbitrator finds Petitioner's testimony that this gap was because she had been told the pain would go away unpersuasive. The Arbitrator notes that no evidence was presented of any attempt to seek treatment was delayed or denied by Respondent.

Dr. Hoffman's records also challenge her statements. The initial history taken by PA Wenger records complaints in the arch and heel for "a couple of months." Dr. Hoffman notes that the complaints developed "several months" ago and that the accident was "many months" ago. The February 28, 2012 MRI of the right foot states that the indication is diabetic foot pain and swelling after injury.

Petitioner presented the causal connection opinion of Dr. Yeager. Respondent presented the causation opinion of Dr. Holmes. The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts. In weighing the expert medical opinions, the Arbitrator finds the opinion of Dr. Holmes more persuasive.

Dr. Yeager did not see Petitioner until over a year after the accident. His history includes Petitioner's claim that her symptoms in the foot and heel initiated with the accident date, which is specifically contradicted by the initial medical records. Although he reviewed the records of Physician's Immediate Care and Dr. Hoffman in preparing his August 23, 2013 report, he testified at his deposition that he "went by what she told me." He also conceded that Petitioner's obesity and diabetes made her more susceptible to foot injuries. The Arbitrator also notes that the records of Dr. Hoffman and Dr. Yeager document Petitioner's long pre-existing history of poorly controlled diabetes, morbid obesity and hypertension. The records through Dr. Yeager's August, 2013 report also indicate that this is not a Workers' Compensation visit.

Dr. Holmes opines that the Petitioners foot problems not causally connected to the accident. He testified that the injuries sustained in the accident were limited to the right great toe and her right calf. The examination at Physician's Immediate Care was quite thorough and was negative for any injuries to the foot or ankle. When Petitioner sought further treatment in July, she presented with a different constellation of symptoms in different areas of her foot. Dr. Holmes opines that the Petitioners foot problems are consistent with her underlying medical conditions of obesity, diabetes and high blood pressure. With respect to the weight to be given to this opinion, the Arbitrator takes into consideration the testimony as to the difference in training and credentials between a board certified orthopedic surgeon with a fellowship in foot and ankle surgery and a podiatrist, particularly with respect to medical training on medical conditions unrelated to the foot. The Arbitrator considers that Dr. Yeager's records document that Petitioner has recently developed a rupture to the left Achilles tendon unrelated to any recorded episode of trauma.

Based upon the record as a whole, including the medical records admitted and the persuasive opinions of Dr. Holmes, the Arbitrator finds that, as a result of the accidental injuries sustained on January 4, 2011, the Petitioner suffered a contusion to the right great toe and calf. This condition reached maximum medical improvement within two weeks after the January 12, 2011 discharge from Physician's Immediate Care. Petitioner's subsequent condition of ill being in the right foot and treatment for said condition is not causally connected to the accidental injuries sustained on January 4, 2011.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Causal Connection above, the Arbitrator finds that any and all medical treatment after January 12, 2011 is not causally connected to the accidental injury sustained on January 4, 2011. Petitioner's claim for medical bills is therefore denied.

In support of the Arbitrator's decision with respect to (K) Temporary Compensation, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Causal Connection above, the Arbitrator finds that any and all lost time after January 12, 2011 is not causally connected to the accidental injury sustained on January 4, 2011. Petitioner's claim for temporary compensation is therefore denied.

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

Based upon the Arbitrator's finding with respect to Causal Connection above, the Arbitrator finds that, as a result of the accidental injuries sustained on January 4, 2011, the Petitioner suffered a contusion to the right great toe and calf. Petitioner did not testify to any ongoing complaints for these conditions of ill being. No treatment was received for these conditions after January 12, 2011. On January 12, 2012, the discharge note from Physician's Immediate Care states was expected to be at maximum medical improvement in two weeks with no impairment. Dr. Holmes did not find any permanent disability causally connected to the accident.

Based upon the record as a whole and Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that she sustained any permanent disability as a result of the accidental injury on January 4, 2011.

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michelle Watts,

Petitioner,

16IWCC0725

vs.

NO: 14 WC 7161

Global Brass & Copper,

Respondent.

DECISION AND OPINION ON REVIEW

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

The parties stipulated that Petitioner was temporarily totally disabled following the February 4, 2014 accident from February 7, 2014 through February 26, 2014. At issue at arbitration was Respondent's denial of TTD during several subsequent time periods, where it claims that Petitioner did not meet her burden of proving not only that she did not work but that she could not work. The parties stipulated that Petitioner was entitled to TTD benefits for Petitioner's surgery and post-operative period from December 5, 2015 through September 6, 2015. On review, we find that the Arbitrator correctly denied TTD benefits from February 27, 2014 until Petitioner began treating with Dr. Thomas Lee on April 1, 2014. The record contains no documentation of medical treatment or authorizations for her absence from work during this

time period. Petitioner's surgeon, Dr. Lee, testified that he had no opinion regarding Petitioner's ability to work prior to the first time he saw her on April 1, 2014.

The Arbitrator further found that Petitioner was not entitled to TTD benefits from April 1, 2014 through December 4, 2014. After reviewing all of the evidence, we modify the Arbitrator's Decision and award TTD benefits for this period. On April 1, 2014, Petitioner presented to Dr. Lee. She reported that her medications included 8 Norco per day. Dr. Lee diagnosed a right lumbar disc herniation at L3-4 and prescribed Lidoderm patches and physical therapy. Although the office note states that Dr. Lee recommended Petitioner remain off of work, a separate restriction slip for light duty modifications was issued. The records show that on April 10, 2014, Dr. Lee updated Petitioner's status to "off work until next follow up."

We note that Dr. Lee's office records and work status slips during the first few months of treatment show that he authorized periods of restrictions as well as temporary total disability from all employment. During his deposition, Dr. Lee testified that he relied on Petitioner's subjective history and statements. He testified that Petitioner told him she tried working light duty for two weeks after the injury but was unable to tolerate it, and that Respondent could not accommodate any restrictions he issued. Therefore, he testified that it was in Petitioner's best interest to remain off of work pending surgery. Petitioner testified that her symptoms were so severe that she could not tolerate even walking from Respondent's parking lot into the facility - a distance of approximately 100 to 150 yards. Respondent's safety coordinator testified that Respondent was able to accommodate injured employees according to their specific restrictions. However, we note that Petitioner was also taking significant dosages of narcotic medications during this time period. Relying on the medical records of Dr. Lee and his October 9, 2014 deposition testimony, we find that Petitioner proved she was temporarily totally disabled from April 1, 2014 through December 4, 2014. We do not find that Respondent's denial of TTD was unreasonable or vexatious in this case.

Petitioner underwent a lumbar decompression and fusion on December 5, 2015, and the parties stipulated that Petitioner was temporarily totally disabled from the date of surgery through September 6, 2015. The Arbitrator found that Petitioner failed to prove she was entitled to TTD benefits after September 6, 2015. We affirm this and all remaining findings of the Arbitrator and hereby remand this case pursuant to §19(b) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $736.81 per week for a period of 77 5/7 weeks representing February 7, 2014 through February 26, 2014 (2 6/7), April 1, 2014 through December 4, 2014 (35 3/7), and December 5, 2014 through September 6, 2015 (39 3/7), that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

16IWCC0725

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. Respondent is entitled to a credit for all amounts paid under its group health plan, pursuant §8(j) of the Act.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $31,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 7 - 2016
RWW/plv
o-10/5/16
46

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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

16IWCC0725

WATTS, MICHELLE
Employee/Petitioner

Case# **14WC007161**

GLOBAL BRASS & COPPER
Employer/Respondent

On 12/10/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

5434 ONDER SHELTON O'LEARY ET AL
KARI S PETERSON
110 E LOCKWOOD AVE
ST LOUIS, MO 63119

0299 KEEFE & DePAULI PC
MICHAEL F KEEFE
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

16IWCC0725

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)

Michelle Watts
Employee/Petitioner

v.

Global Brass & Copper
Employer/Respondent

Case # **14** WC **7161**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **October 22, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **February 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 **$62,326.59**; the average weekly wage was **$1,105.21**.

On the date of accident, Petitioner was **51** years of age, ***single*** with **0** dependent children.

The parties stipulated at the time of hearing that Petitioner was temporarily totally disabled for the timeframes of February 7, 2014 through February 26, 2014 and December 5, 2014 through September 6, 2015.

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

Respondent shall be given a credit of **$30,556.92** for TTD, **$0** for TPD, **$0** for maintenance, **$12,015.43** in non-occupational indemnity disability benefits, and **$5,781.04** for other benefits (consisting of a permanency advancement), for a total credit of **$48,353.39**.

Respondent is entitled to a credit for **all amounts paid under group health plan** under Section 8(j) of the Act.

ORDER

Petitioner is ***not*** entitled to temporary total disability benefits under Section 8(b) of the Act for the timeframe of February 27, 2014 through December 4, 2014. Furthermore, Petitioner is ***not*** entitled to temporary total disability benefits under Section 8(b) of the Act for the timeframe of September 7, 2015 through October 22, 2015.

Respondent shall pay the sum of **$14.18/week for a total of 42 2/7 weeks** (addressing the timeframes of February 7, 2014 through February 26, 2014 and December 5, 2014 through September 6, 2015), representing temporary total disability benefits underpayment under Section 8(b) of the Act given the parties' stipulation at the time of hearing to Petitioner's entitlement to temporary total disability benefits for said timeframes.

Petitioner's request for the award of penalties and attorney's fees under Sections 19(k) and Section 16 is denied.

Respondent shall be given a credit of **$30,556.92** for TTD, **$0** for TPD, **$0** for maintenance, **$12,015.43** in non-occupational indemnity disability benefits, and **$5,781.04** for other benefits (consisting of a permanency advancement), for a total credit of **$48,353.39**.

Respondent is entitled to a credit for **all amounts paid under group health plan** under 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

12/7/15
Date

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DEC 10 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
19(b) ARBITRATION DECISION

Michelle Watts
Employee/Petitioner

Case # 14 WC 7161

v.

Consolidated cases: N/A

Global Brass & Copper
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified at the time of arbitration that she is 52 years old and lives in Alton, Illinois. Petitioner testified that she is currently employed by Global Brass & Copper, where she has worked for 21 years. Petitioner testified that she is an Operator A, and that her job duties include calculating the dimensions of various alloys to get them from one process to the next, that she has to carry 20- and 30-pound steel work rolls consistently throughout the shift approximately 30-40 feet, that she has to push 610-pound cylinders into a buggy, and that she has to pry or feed material into the machine using a 10-pound crowbar which she sometimes has to lift overhead.

Petitioner testified that she was injured on February 4, 2014 when she was pushing a 610-pound cylinder onto a buggy. Petitioner testified that she reported the injury. Petitioner testified that she felt a sharp pain going down the right side of her leg, and that her pain initially started in her back. Petitioner testified that when she reported the accident to her employer, she was asked if she wanted to go the hospital. Petitioner testified that after she was treated at the hospital, she went to see Dr. Robinson who sent her for an MRI. Petitioner testified that she then began seeing Dr. Lee on April 1, 2014 and has been under his care since that time.

Petitioner testified that in February of 2014 she saw Dr. Randolph at the request of her employer, and it was her understanding that Dr. Randolph gave an opinion on what her work restrictions should be that was somewhat different from her treating physician. Petitioner testified that it was her understanding that she was to go back light duty, and she admitted that Respondent offered her light duty work. Petitioner testified that she attempted to work light duty, which consisted of walking throughout the plant and having the operators read and sign a document, as well as doing filing.

Petitioner testified that the plant consists of two buildings, and that she would have to walk through both buildings. Petitioner testified that each building was the size of a football field, and that the plant floor was concrete and usually had oily spots on it which would make the floor slippery. Petitioner testified that she had to wear a specific type of boots that had rubber soles, which she estimated weighed ten pounds.

Petitioner testified that the filing was to be done in the office located in the plant, and that it was in the furthest building from the parking lot. Petitioner testified that she had to walk through two buildings, down a flight of steps and up two flights of steps in order to get to the office. Petitioner testified that there were several parking lots at Respondent's facility, and she admitted that she could have parked in a lot closer to the office, but indicated that none of the lots were close. Petitioner testified that there was no entrance to the office building that would allow her not to have to walk through the two plant buildings. Petitioner testified that the parking lot was gravel.

Petitioner testified that she stopped working light duty because she was in excruciating pain and was getting shooting pains down her leg. Petitioner testified that if she stood up she hurt, and that if she sat down she hurt as well. Petitioner testified that she was asked to do a lot of filing, which required her to get up and take a lot of the old files out of the old cabinets and either throw them away or file them into a new cabinet. Petitioner testified that filing required her to bend and twist.

Petitioner testified that she spoke with Dr. Lee about her returning to work, and she agreed that in June of 2014 Dr. Lee provided her with restrictions, that she took the work slip to the company nurse, and that Respondent did not accommodate the restrictions. Petitioner testified that Dr. Lee then completely took her off work.

Petitioner testified that on December 5th she had her first surgery with Dr. Lee, after which there were complications. Petitioner testified that following surgery she had to be hospitalized for two months. Petitioner testified that her understanding of the complications was that she had cracks on her spine, that her heart rate dropped, that her blood pressure dropped, and that her spine was unstable. Petitioner testified that other surgeries were performed as a result of the complications, and that while in the hospital for two months she underwent rehabilitation. Petitioner testified that after she left the hospital she had a wheelchair, and her bedroom needed to be rearranged so that she could access the room. Petitioner testified that her family members cooked for her, did her laundry, and helped her get in and out of bed.

Petitioner testified that she has continued to remain under the care of Dr. Lee, and that he has directed her to see pain specialists Dr. Dharma and Dr. Gu. Petitioner testified that Dr. Lee sent her for therapy, which included land therapy at SSM and aquatic therapy at Alton Physical Therapy.

Petitioner testified that in August she went to Dr. Bernardi at the request of her employer, and it was her understanding that Dr. Bernardi gave an opinion on her ability to work. Petitioner testified that it was her understanding that she was supposed to return light duty, which she discussed with Dr. Lee. Petitioner testified that it was her understanding that Dr. Lee did not want her to return to work. Petitioner subsequently modified her testimony and indicated that it was her understanding that Dr. Lee did not want her to lift more than ten pounds, not to walk on uneven surfaces, not to walk more than 20 minutes without a ten minute break, and not to drive.

Petitioner testified that she asked an unnamed representative of Respondent to provide transportation, but it had not been provided. Petitioner testified that family members drove her where she needed to go, and that they were not always available. Petitioner testified that this has caused her to miss physical therapy appointments, and that she has paid family members for gas for driving her to and from appointments.

Petitioner testified that she still has lower back pain, pain in her hips, numbness down her leg, pain going down her thigh and numbness in the bottom of her foot. Petitioner testified that she gets lightheaded and dizzy, and that she has a tendency to fall off balance because of weakness on her right side. Petitioner testified that if she stands for long periods of time her symptoms get worse, and that laying down and taking her medications helps. Petitioner testified that she now has to have someone do yard work and things around the house for her, and that she used to teach dance.

Petitioner testified that she has not returned to work since April 1, 2014, and that she began receiving checks from her employer on December 3, 2014. Petitioner testified that the checks stopped on September 6, 2015 and has not received any TTD since that point in time.

Petitioner testified on cross-examination that she saw Dr. Lee on the Monday prior to the arbitration hearing, at which time he provided Petitioner with a return to work slip. Petitioner testified on cross-examination that Dr. Dharma prescribed her medications, and that she recently underwent a CT scan of her back as well as electrical studies by Dr. Peeples.

Petitioner testified on cross-examination that on September 2nd she went on a trip with her family to Seattle, Washington to take care of family business. Petitioner testified on cross-examination that she flew to Seattle.

Petitioner testified on cross-examination that at the time of the September 15, 2015 visit with Dr. Lee, she spoke to him about there being oil on the floor at work and that it was slippery. Petitioner agreed on cross-examination that she had not been to the plant, however, for more than a year. Petitioner testified on cross-examination that when she last saw Dr. Lee, he restricted her from driving. Petitioner testified on cross-examination that she lives approximately five miles from the plant.

On redirect examination, Petitioner testified that in the 21 years that she has worked at the plant, the floors have been consistently in the same condition.

Joseph Wickenhauser testified on behalf of Respondent at the time of hearing. Mr. Wickenhauser testified that he is employed by GBC Metal in East Alton, and has been with the company for 26 years. Mr. Wickenhauser testified that he is the Safety Excellence Coordinator and has held the position for approximately four years. Mr. Wickenhauser testified that part of his responsibilities in this position is to place recovering workers into light duty positions.

Mr. Wickenhauser testified that several weeks prior to the arbitration hearing he was contacted by Respondent's counsel about the availability of a temporary position for Petitioner, and he indicated that he was familiar with Petitioner and her injuries. Mr. Wickenhauser testified that there was work available within the restrictions set forth by Dr. Bernardi. Mr. Wickenhauser testified that Petitioner would have been placed in an office setting and would not have been placed in operations, and that such a light duty position was still available.

On cross-examination, Mr. Wickenhauser testified that he did not have a medical background but did have an ergonomic background which consisted of training through the National Safety Council as well as training and certification through Humatek, which was provided through their insurance carrier. Mr. Wickenhauser testified that certification is provided after a week-long training course with professionals from Humatek, and that a test is taken at the end of the course which consists of an exercise

evaluating both jobs and the different functions of a machine. Mr. Wickenhauser testified that he was doing a recertification through another company, and he was of the understanding that the certification was valid for three years.

On cross-examination, Mr. Wickenhauser testified that he worked with Petitioner when she worked for Respondent, and that they had previously been coworkers. Mr. Wickenhauser testified that he did not, however, supervise Petitioner. Mr. Wickenhauser testified that he had knowledge of Petitioner's medical condition and had seen the report of Dr. Bernardi as well as the reports from Dr. Lee, but that he had not seen Petitioner's hospital records. Mr. Wickenhauser testified that he did not recall having seen the records from Dr. Dharma, but he was of the understanding that PT records were sent directly to the insurance carrier. Mr. Wickenhauser testified that he had not seen the most recent CT scan nor the EMG/nerve conduction studies that had recently been performed.

On cross-examination, Mr. Wickenhauser testified that he did not recall what restrictions were issued by Dr. Lee as of the Monday prior to arbitration. Mr. Wickenhauser testified that transportation has not been offered to Petitioner to get her to and from work. Mr. Wickenhauser testified that the office setting position that was available consisted of performing clerical work, which would consist of sorting and filing mill tickets. Mr. Wickenhauser testified that the office that Petitioner would be working at was located in the brass mill office which was "right up front." When asked if Petitioner would have to walk up stairs to get there, Mr. Wickenhauser testified that one location was upstairs for light duty, but Petitioner could be located downstairs if that was what her restrictions called for. Mr. Wickenhauser testified that the same position could be offered either upstairs or downstairs in the same building. Mr. Wickenhauser testified that Petitioner would have a desk in the office where she would be working, and that a number of offices downstairs in the brass mill building were available for Petitioner.

On cross-examination, Mr. Wickenhauser testified that the position offered to Petitioner was not a set position, but consisted of filing work for which they sometimes secured temporary personnel. Mr. Wickenhauser testified that file boxes could be brought in and placed next to Petitioner's desk, and that someone else could pick them up and put them where they belonged. Mr. Wickenhauser testified that the position that was available involved filing but was mostly sedentary work. Mr. Wickenhauser testified that the office was not carpeted. Mr. Wickenhauser testified that to get to the stairs that led to the office upstairs, one did not have to walk through the plant but instead would use an outside door. Mr. Wickenhauser testified that the outside door was located on the south side of the building, and that the parking lot was approximately 150 yards away, was paved and was not gravel. Mr. Wickenhauser testified, however, that the pavement was old so sometimes there was loose gravel within the parking lot.

On cross-examination, Mr. Wickenhauser testified that the position that was offered was within the restrictions placed on Petitioner by Dr. Bernardi but did not, to his knowledge, take into account any of her treating physician's restrictions.

On redirect examination, Mr. Wickenhauser testified that Respondent has the ability to modify temporary positions depending on the restrictions that the physician imposes, and that they go by what the doctor's orders are. On re-cross examination, Mr. Wickenhauser testified that in this case they were going by the restrictions recommended by Dr. Bernardi.

The Application for Adjustment of Claim was signed by Petitioner on February 17, 2014 for the alleged date of accident of February 4, 2014. (Arb. Ex. 2). According to the Application for Adjustment of Claim, Petitioner alleges that she sustained injury while tugging and pulling on a cylinder that weighed approximately 610 pounds, and that her lumbar spine was injured as a result thereof. (Arb. Ex. 2).

The deposition of Dr. Thomas Lee was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Dr. Lee testified that he is a board-certified orthopedic surgeon who specializes in spine surgery. He initially saw Petitioner on April 1st, at which time Petitioner gave a chief complaint of low back pain. Dr. Lee testified that Petitioner stated that on February 2, 2014, she was moving a 600-pound cylinder and adjusting it back and forth after which she developed symptoms which included low back pain and right leg pain going down to the thigh and sometimes into the outside of her right calf. Petitioner described increased pain with increased abdominal pressure such as sneezing and pain while sitting, but she had relief from lying down. Petitioner denied any prior problems with her back. (PX1).

Dr. Lee testified that Petitioner gave a job description at that office visit, which included standing a lot, climbing off and on the forklift, and using a pry bar at times that would involve a great deal of force. Petitioner also reported that she had been on light duty in the middle of March for two weeks, but at the time she was seen she was off work. Petitioner reported that she could not tolerate the walking and sitting at work. (PX1).

Dr. Lee testified that the physical examination performed on that date revealed weakness in Petitioner's right iliopsoas muscle, her right hip flexor muscle that brings the knee up towards the chest, and that the left showed some decrease as well. Petitioner had pain with testing, but he thought that was perhaps her being inhibited by pain. Petitioner's quadriceps strength was also reduced on the right, though she did have some pain with testing. Dr. Lee testified that the weakness that Petitioner was exhibiting corresponded with the L3 nerve root and perhaps the L4 nerve root as well, and that this would be involved with an L3-4 disc problem which was what he was seeing on the MRI scan and x-rays. His impression of the x-rays as provided by Petitioner revealed right L3-4 foraminal disk herniation with spondylolisthesis. He wrote a script for physical therapy, gave Petitioner a pain patch and planned to keep her off work until therapy started. He also wrote a work slip keeping her off work until April 8th as well as another slip taking her off work on April 10th. (PX1).

Dr. Lee testified that he next saw Petitioner on May 13, at which time she complained that her back was still hurting, that it was shifting some to the left and alternating sides, and that it would go to the buttock region and outside lateral hips. Petitioner reported that she felt a little improvement with physical therapy, and she again noted the increase in her back pain with coughing and sneezing. Dr. Lee testified that Petitioner also went into a little bit more of her job history, which included that she had been working at her current place of employment for 20 years, that she was an operator which involved a lot of heavy work including pushing 100-300 pounds of coil off the machines with a mechanical loader and used a pry bar to feed the machine, and that sometimes she stood for eight hours straight. The physical examination performed revealed weakness in her right iliopsoas and diminished right versus left quadriceps response. He recommended epidural steroid injections and continued physical therapy, which Petitioner had at the Work Center. (PX1).

Dr. Lee testified that he next saw Petitioner on June 10, 2014, at which time Petitioner's pain level seemed to be increasing and would come and go in intensity. Petitioner reported that she had

difficulty standing more than 10 minutes, and she localized the pain in a band distribution in the area about 4 cm below the top of the iliac crest and into the right gluteal muscle area and out towards the lateral hip bone. The physical examination performed revealed that Petitioner was tender in an area associated with her sacroiliac joint on the left, but also in the midline just below the iliac crest which was roughly the L4 region. The test for sacroiliac joint pain was mildly positive during that test. He wrote a light duty slip at that time, restricting Petitioner to four-hour workdays, light duty, and no prolonged standing more than 10 minutes. He also recommended that Petitioner continue physical therapy and pursue coverage for the epidural injections. (PX1).

Dr. Lee testified that when he next saw Petitioner on July 10, 2014, Petitioner complained of low back pain and band distribution around the L4 level that was going out to both of the sacroiliac joints on both sides, hip pain and right groin pain. Petitioner reported that her activities of daily living were severely limited. The physical examination performed revealed some increased muscle tone in the right low back muscles along the spine, which looked like there was muscle spasm that was centered around the L3-4 level that he suggested was a protective mechanism in that the body was trying to protect the disk or injury of the spine itself. Dr. Lee testified that the test with stepping up on a step on one leg independently showed confirmation of some weakness in the right quadriceps and/or hip flexor muscle complex, and that Petitioner showed diminished psoas strength and quadriceps strength on more direct testing. Petitioner showed a halting rhythm to her range of motion, which was often interpreted as a sign of instability of the disk. Petitioner also had decrease in the muscle mass or asymmetry, such that the left side was less than the right. Dr. Lee testified that the significance of the findings was that they were objective confirmation of radiculopathy, and he believed the L3-4 disk was affected. He also reviewed the diagnostic studies, which he suggested showed an L3-4 disk protrusion with herniation at L3-4 spondylolisthesis, for which he recommended surgery to consist of L3-4 reconstruction with fusion and involving a cage between the bones and then rods that were semi-rigid in the back part of the spine. (PX1).

Dr. Lee testified that it was his opinion that Petitioner's work injury caused or contributed to the condition for which he was seeing her and recommending treatment. He took Petitioner off work as Petitioner indicated there was no light duty available, and it was his understanding that Respondent did not accommodate the light duty restrictions that he had previously issued at the last office visit. (PX1).

Dr. Lee testified that he next saw Petitioner on August 21, at which time Petitioner complained of right-sided back pain that would go into the hip on the outside and would go into the thigh about halfway down; that there was a pins and needles sensation that went across the low back if she was standing too long; that by the end of the day she could barely walk because of hip pain; and that walking was very day to day because of the hip pain. The physical examination performed revealed some reduction of the iliopsoas muscle strength at the L3 innervated muscle and pain in the SI joint region on testing. A sacroiliac joint injection and physical therapy were recommended at that time. (PX1).

Dr. Lee testified that he saw Petitioner the day prior to the deposition (which was taken on October 9, 2014), at which time Petitioner was still having ongoing symptoms at a high level. Petitioner reported that her pain was going into the hips and in the low back and buttocks, and she would occasionally get throbbing in the right calf. He noted that surgery was approved. The physical examination performed revealed confirmation that Petitioner had pain with loading the spine just below

the iliac crest level, which this time was a little bit lower which caused him to wonder if the adjacent disk was involved, which he opined would also be something that was caused by or contributed to the work injury as well. Dr. Lee testified that the films performed gave him information for surgical planning purposes, and that he also recommended a discography and CT due to the suspicion about the adjacent level. After the discography, he would then make his final determination about the surgical site. He continued to keep Petitioner off work and wrote a work slip. (PX1).

On cross-examination, Dr. Lee testified that he takes major medical insurance plans. He testified that the purpose of discography would be the symptoms from the L4-5 disk and L5 nerve root, although he conceded that the majority of Petitioner's symptoms seemed like it was higher at the L3-4 disk. He testified that the MRI showed a small bulge at L4-5, and that there was no foraminal stenosis of any kind. He testified that when you do discography you are looking for annular tears, but the MRI showed no nerve root involvement at all. (PX1).

On cross-examination, Dr. Lee testified that at his July 10, 2014 exam he noted atrophy in Petitioner's left thigh, but that Petitioner's radiculopathy was bilateral although she had not articulated to him radiculopathy in any portion of the thigh. He testified that it was uncommon for a person to have one centimeter of a smaller circumference in one thigh versus the other, and that anything more than about ½ centimeter was unusual. (PX1).

On cross-examination, Dr. Lee testified that he would not have any opinion about Petitioner's ability to work in any particular capacity before April 1, 2014, which was the time at which he first saw her. He testified that he could make a determination but he did not actually do any physical examination before that date. He testified that he was aware that Dr. Randoph was a physiatrist, and that he had a physiatrist on staff as well. He testified that he was familiar enough with physiatry to know that they are trained to evaluate an individual's ability to work with or without restrictions. (PX1).

On cross-examination, Dr. Lee testified that as of April 8, 2014, he recommended that Petitioner return to work with no lifting more than 10 pounds, no bending and no stooping, as well as alternate sitting, standing and walking every 10-15 minutes. He testified that Dr. Randolph in his February 26, 2014 note recommended no lifting greater than 10-15 pounds occasionally, limit pushing/pulling to no more than 30 pounds, avoiding activities that involve bending and twisting, that continued standing should be avoided, and that ideally work activities which allowed change of position were recommended. He agreed that both sets of restrictions were similar. He also agreed that both he and Dr. Randolph had recommended physical therapy. (PX1).

On cross-examination, Dr. Lee agreed that he would permit Petitioner to return to light duty April 8, 2014 because her physical therapy started, but he held her off after that date because the physical therapy had not started. (35-36). On cross-examination, Dr. Lee agreed that physical therapy started on April 15th, and that he would have permitted Petitioner to return to work with his April 1st restrictions as of the time that she started therapy on April 15, 2014. (36).

On cross-examination, Dr. Lee agreed that as of April 1, 2014 he became Petitioner's treating physician, and that at no point between April 1, 2014 and the time of the deposition had he had a telephone conference with Dr. Robinson about the direction of care for Petitioner. He agreed that as of

April 4, 2014, Dr. Robinson had taken Petitioner off work. He agreed that as of the first office visit on April 1, 2014, he had never ordered epidurals. (PX1).

With respect to the May 13, 2014 note, on cross-examination Dr. Lee agreed that his notes did not contain reference to any conversations he had with Petitioner about what light duty options were made available to her by her employer, but rather that Petitioner reported that the light duty he had prescribed was not accommodated. He agreed that the first light duty restrictions that he wrote on April 1, 2014 made no reference to working four hours per day, and that his subsequent restrictions did include working no more than four hours per day. He testified that the medical necessity behind only working four hours per day was that Petitioner showed a progression between the April 1st and June 10th dates showing increasing compensatory problems for which he was trying to protect her from progression. When asked if there were any objective changes between April 1st and June 10th, Dr. Lee testified that he was getting concerned that there was significant radiculopathy at that point, and that Petitioner's clinical reports were not good thereby making surgery necessary. He testified that even with activities of daily living Petitioner seemed to be getting worse, and he was more convinced that there was an underlying radiculopathy. He testified that he thought that after four hours Petitioner's muscles were going to fatigue, and she was not going to be able to protect her back. He testified that when Petitioner was working light duty, she reported that she could not tolerate the walking and sitting. He testified that he took Petitioner completely off work as of July 10th. (PX1).

On cross-examination, Dr. Lee testified that he sometimes takes patients headed for a one-level fusion completely off work depending on the circumstances, and that Petitioner's circumstances included that she continued to be surgical and had a new component of sacroiliac symptoms that were susceptible to weightbearing activities on firm surfaces. He agreed that in the prior 3-4 months, Petitioner's symptoms and her condition had worsened despite the fact that she had not set foot on her employer's premises to work in several months. (PX1).

On cross-examination, Dr. Lee testified that his typical protocol for a one-level fusion involved allowing patients to return to an office setting for half days at about 4 weeks, and assuming the fusion is healing at 8-12 weeks the patient's activity level is increased, and that in 3-5 months the individual is returned to full duty. He testified that if a two-level fusion were performed the timetable did not change in every case, but there was a greater chance of the fusion being delayed. He agreed that Petitioner was not a smoker, and that pseudoarthrosis was less of a concern for her. (PX1).

On redirect, Dr. Lee testified that the increase in sacroiliac pain was a response of the evolving radiculopathy. He testified that on May 13th, he felt that Petitioner's physical examination and complaints required her to be completely off work at that juncture. He testified that an annular tear is a tear in the outer lining of the disk that is a very painful condition that can be hard to see sometimes on MRI scans, and that annular tears on some occasions require surgical intervention. (PX1).

The medical records of Tesson Heights Orthopedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was given a work slip on October 19, 2015 indicating that Petitioner was allowed to return to work with restrictions of no walking on uneven surfaces or surfaces with poor traction, no lifting more than 10 pounds, no standing or walking more than 20 minutes without a 10 minute break, and no driving. (PX2).

The medical records of Tesson Heights Orthopedics reflect that Petitioner was seen on September 15, 2015, at which time Petitioner reported that she felt the same, that she had low back pain, and that she described right lateral leg numbness/tingling to the fourth and fifth toes. It was noted that Petitioner could walk a half block, and some days she had to sit before she turned around and went back home. The records reflect that she had in the interim gone to a neurology IME and that restrictions were discussed. It was noted that Petitioner was not driving and that she did not really go out except with her sister who would help with grocery shopping, but it was noted that she did do some housework. Petitioner was working on her home exercise program. Petitioner reported that with regard to her work environment, it was an oily environment and that there was a mist of oil in the air. Petitioner further indicated that she felt a little off balance sometimes and reported that she was slipping in the plant and wore steel-toed "metatarsal" boots. The physical examination performed revealed that Petitioner was holding her lumbosacral junction stiffly. The x-rays showed what appeared to be at L3-4 a fused left facet joint and possible early bridging of the left cage chamber adjacent to the center divider in the cage, that in the right posterolateral region there was not a fusion, that Petitioner had a gap at the pars consistent with the pars defect site that was subsequently grafted but had not bridged, and that L4-5 showed a probable bridge but there was still some osteocartilaginous density in the left facet region. Dr. Lee indicated that overall Petitioner appeared to be healing the fusion, though it appeared to be delayed in terms of maturation. Dr. Lee wrote a script for an external bone growth stimulator for a diagnosis of delayed union at L3-5. (PX2).

The medical records of Tesson Heights Orthopedics reflect that Petitioner was seen on July 23, 2015, at which time Petitioner reported bilateral hip pain. Petitioner reported that her right leg throbbed, and her bilateral heels were numb. Petitioner reported that she noticed after the aquatic therapy that she felt like she was getting increased pain and leg weakness as the day progressed, and she noticed some weakness as she tried to get out of the pool. Dr. Lee noted on exam that Petitioner demonstrated the sacroiliac region again and some towards the midline at or just above the iliac crest, and that Petitioner showed a half grade decrease quadriceps, tibialis anterior and gastroc on the right compared to the left. The records reflect that Dr. Lee recommended a CT scan to assess for a delayed union at L3-4. (PX2).

The medical records of Tesson Heights Orthopedics reflect that Petitioner was seen on June 25, 2015, at which time Petitioner reported a chief complaint of pain in the low back and right sacroiliac pain. Petitioner reported that she did get a little numbness still in the right lateral distal calf and malleolar region and perhaps a little bit towards the hindfoot. The physical examination performed revealed that Petitioner was tender over the right posterior superior iliac spine, and her gastroc symptoms had recovered nicely. Dr. Lee reviewed the x-rays which showed the implant was in good position, that there was no arthrosis change of the SI joint, and there was some bone graft shadow seen where it appeared to be bridging. The records reflect that Dr. Lee intended to switch Petitioner to a soft back brace as needed, speak to Dr. Dharma and Dr. Gu regarding her prescriptions, and that he wrote a script for continuing land therapy once a week and adding in aquatic therapy twice a week. Dr. Lee continued to keep Petitioner off work until they could get the medication decreased to an acceptable level. (PX2).

The medical records of Tesson Heights Orthopedics reflect that Petitioner was seen on May 26, 2015, at which time it was noted that it had been 3½ months since her two level lumbar fusion. Petitioner reported that she was still bothered by pain in her lower back that radiated from the paraspinal area as well as the sacroiliac area, pain over to the right hip and numbness that radiated down the lateral leg and

involved the entire foot. Petitioner reported that her back pain was constant, and that without medications it was 9/10. Petitioner reported that the numbness was constant, and that she continued to experience swelling in her right foot if she had been up for more than 15 minutes. It was noted that Petitioner had been doing physical therapy and that it was going well for her. Dr. Yazdi indicated that Petitioner was making a very slow recovery and that given her medications, she was not able to drive or go to work. Petitioner was instructed to follow up with Dr. Lee in one month with AP and lateral films of the lumbar spine, and she was also recommended to continue therapy. (PX2).

The medical records of Tesson Heights Orthopedics reflect that Petitioner was seen on April 13, 2015, at which time it was noted that it had been two months since her last surgery which was L3-4 posterior wedge osteotomy and instrumentation, and that Petitioner had had multiple surgeries in order to fuse L3-4 and L4-5 since they both were found to have pars defects as well as disc herniation. Petitioner reported that after the first surgery she had some leg weakness bilaterally which had improved, and she was currently experiencing numbness and tingling in the right leg and a little bit in the left leg. Petitioner reported that she did not believe that her symptoms had changed much in the last two weeks. Petitioner reported that she continued to get swelling in the right leg especially in the foot when it was dependent, and that she had numbness in the right lateral leg as well as the left heel. Petitioner reported she had throbbing pain at the waistline on the right side, and that her pain got worse with increased walking as did her numbness. The records reflect that flexion and extension view of the lumbar spine showed proper placement of all instrumentation. Dr. Yazdi believed that Petitioner had some neurological deficits that may take some time to recover, and that her nerve recovery could take up to 18 months or two years before it was complete. Dr. Yazdi gave Petitioner a prescription to continue physical therapy, and she was noted to remain off work. (PX2).

The medical records of Tesson Heights Orthopedics reflect that Petitioner was seen on March 12, 2015, at which time Petitioner reported bilateral hip pain, some numbness in the foot and complaints of constipation. Petitioner reported that the left gluteal tendon area cramped with ambulation and she had tried some over-the-counter potassium supplements that did not seem to help. Petitioner reported that she was following with a hematologist, and she was taking multiple medications. The examination performed revealed that Petitioner was using a quad cane, that she was wearing the brace appropriately, that her gait was a little unsteady, and that she ambulated slowly but effectively. Dr. Lee reviewed Petitioner's activities at home, and he did not see that she could return to work given her description of her work environment. Dr. Lee instructed that Petitioner switch from home therapy to outpatient therapy. Dr. Lee opined that the cardiac condition although uncovered during the surgery was not related to the work injury, but that the treatment for the deep vein thrombosis (*i.e.*, DVT) would be related as it resulted from the prolonged downtime related to the surgery and weakness that was work-related. (PX2).

The medical records of Tesson Heights Orthopedics reflect that Petitioner called on February 27, 2015, requesting medication refills and a script for a wheelchair with a basket. (PX2).

The medical records of Tesson Heights Orthopedics reflect that Petitioner was seen on February 9, 2015 for an incision check which was noted to be fully healed. Petitioner still complained about bilateral numbness and tingling in her legs and feet mainly at night, and she also mentioned that she had shortness of breath and that her heart would race as well. Petitioner was advised to call her primary care physician about the shortness of breath and heart racing. The records also reflect that Petitioner was

admitted to St. Anthony's Medical Center on January 7, 2015 for L3-4, L4-5 anterior lumbar interbody fusion via direct lateral retroperitoneal approach, placement of fusion cages, L3-4 rod removal with bilateral screw placement, and placement of cellular allograft. The records further reflect that Petitioner was admitted to St. Anthony's Medical Center on January 12, 2015 for L3-4, L4-5 posterior closing wedge osteotomy with posterior spinal fusion, placement of rods at L3-4, L4-5 and use of local autogenous bone graft. (PX2).

The medical records of Tesson Heights Orthopedics reflect that Petitioner was seen on December 1, 2014 with a report of right groin pain along the inguinal ligament with a burning component. Petitioner was noted to be tender below the iliac crest, and review of the discography showed a positive concordant response at L3-4 and L4-5, negative at L2-3. Dr. Lee's impression was that of (1) L3-4 spondylolisthesis with protrusion; (2) L4-5 annular tear. The records reflect that an open approach to surgery was discussed, and that Petitioner wished to proceed with the proposed treatment. (PX2).

The medical records of Tesson Heights Orthopedics reflect that Petitioner was admitted to St. Anthony's Medical Center on December 6, 2014 for L3-4 microlaminectomy with discectomy, L3-4, L4-5 posterior spinal fusion, placement of posterior instrumentation, use of local autogenous bone graft with osteocel cellular allograft. (PX2).

Included within the medical records of Tesson Heights Orthopedics were those pertaining to the lumbar discography performed on November 24, 2014, which was interpreted as being markedly positive discography at L3-4 and L4-5; that the L2-3 disc was completely negative; and that Petitioner was recommended to see Dr. Lee for reevaluation. Also included within the medical records of Tesson Heights Orthopedics were those pertaining to the CT lumbar spine post-discogram also performed on November 24, 2014, which was interpreted as revealing (1) 2 mm grade I L3-4 anterolisthesis with facet arthropathy, annular disc bulge, and right foraminal herniation, that a right foraminal-far lateral full thickness annular defect was observed with contrast extravasation into the outermost annular fibers and the right L4 perineural space, and that there was moderate central canal stenosis and severe right greater than left foraminal stenosis at that level; (2) L2-3 and L4-5 contain contrast, predominantly in the right sided annular fibers; there was minimal contrast in the nuclear cavity at L4-5, and that there was circumferential disc bulges seen at both these levels, resulting in mild foraminal stenosis but no central canal stenosis. (PX 2). Furthermore, Petitioner underwent pre-operative x-rays of the complete spine which were interpreted as a negative study; the noted diagnosis was that of congenital spondylolisthesis. (PX2).

The medical records of Dr. David Peeples were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on September 10, 2015, at which time Petitioner was seen for electrodiagnostic evaluation of low back and right leg pain, numbness and question of radiculopathy. Petitioner reported sustaining a back injury at work in February 2014, that she subsequently had three lumbar surgeries the most recent of which was in January 2015 and that she had an L3-5 fusion. Petitioner described right leg pain extending to the onset of her right foot, and that her low back pain was increased with prolonged standing and sitting. Petitioner reported that she felt her right leg was fatigable and weak, but that she had no left leg or sphincteric symptoms. The records reflect that the study revealed no electrodiagnostic findings for multiple chronic right lumbar radiculopathies

with no associated acute denervation, and that there was evidence for chronic right L3, L4, L5 and S1 radiculopathies; the left side was normal with no associated acute denervation. (PX3).

The medical records of Cedar Imaging were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner underwent a CT of the lumbar spine on September 10, 2015, which was interpreted as follows: (1) Anterior interbody and posterior fusion of L3-L5 without significant spinal canal stenosis in the fusion site; no evidence of hardware loosening or displacement; solid osseous fusion in the L4-5 disc space and partial solid osseous fusion in the L3-4 disc space; (2) annular disc bulge and facet arthropathy at L2-3 and L5-S1 with mild lateral spinal canal and bilateral foraminal stenosis at L2-3. (PX4).

The medical records of St. Anthony's Medical Center (including records for Dr. Dharmavarapu/"Dharma") were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on April 23, 2015, at which time she complained of shooting pain in the right leg, that certain exercises increased her sciatic pain and that she was unable to sleep secondary to pain. Petitioner was assessed with lumbago, lumbar radiculopathy, lumbar spinal fusion, and myofascial pain, and was given a script for Oxycodone. Petitioner was next seen on May 26, 2015, at which time it was noted that Petitioner complained of increasing back pain and numbness in the leg that was still about the same, and that the Oxycodone was not helping her much. Petitioner reported that she was taking more Gabapentin which was helping her more with the numbness. Petitioner was assessed with lumbago, lumbar radiculopathy, lumbar spinal fusion, and myofascial pain, and was given a script for Dilaudid. (PX5).

The records reflect that Petitioner was next seen on June 25, 2015, at which time it was noted that Petitioner complained of low back pain, that the Dilaudid was not working at all and that she was getting shooting pain going to the right leg. Petitioner was assessed with lumbago, lumbar radiculopathy, lumbar spinal fusion, and myofascial pain, and was again given a script for Dilaudid. (PX5)

The records reflect that Petitioner was next seen on July 23, 2015, at which time it was noted that Petitioner complained of pain in the lower back and along the waist line. Petitioner stated that the pain medications were helping her much, and that she went to see Dr. Lee who asked that she have an SI joint injection. Petitioner was assessed with lumbago, lumbar radiculopathy, lumbar spinal fusion, myofascial pain and sacroiliitis, and she was scheduled to undergo the bilateral SI joint steroid injection the following week as well as having been given a prescription for "MS IR." (PX5)

The records reflect that Petitioner was next seen on August 20, 2015, at which time it was noted that Petitioner presented with right lower extremity DVT s/p IVC filter placement in January 2015. It was noted that Petitioner's DVT had since resolved, and that Petitioner presented for IVC filter removal. Petitioner was next seen on August 25, 2015, at which time it was noted that Petitioner complained of low back pain and pain going to the right leg. It was noted that Petitioner had seen a neurologist who was running some tests including an EMG/NCS. Petitioner was told that she should not get any injections in the back at that time. Petitioner was assessed with lumbago, lumbar radiculopathy, lumbar spinal fusion, myofascial pain and sacroiliitis, and she was given a prescription for MS IR. (PX5).

The medical records of SSM Physical Therapy were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. Petitioner underwent an initial evaluation on March 16, 2015 with a

noted diagnosis of lumbago. Petitioner reported that she had a live-in that was doing a lot of her house work, that she was able to do all self-care independently with pain, and that she was ambulating with a quad cane due to complaints of numbness in the legs and feet. Petitioner rated her pain as 3/10, and it was noted that she reported numbness in the right lower leg/foot and left heel. Petitioner was assessed as presenting with bilateral lower extremity symptoms that were consistent with nerve root irritation and injury. The records reflect that Petitioner underwent therapy for the timeframe of March 16, 2015 through August 18, 2015. (PX6).

The records reflect that at the time of the April 7, 2015 visit, it was noted that Petitioner had increased swelling with activity in the left lower extremity on that date, that the swelling was unchanged despite intervention performed in the clinic, that the plan was to reassess the swelling at the next visit and if no change, to contact the physician regarding increased swelling and pain at the lateral thigh, upper leg and foot. When Petitioner returned on April 8, 2015, the swelling in the lower extremities was still present and Petitioner was advised to elevate her lower extremities higher. When Petitioner returned on April 10, 2015, Petitioner was tolerating 15-20 minutes of standing prior to increased complaints and visualization of increased swelling in the right lower extremity. Petitioner was questioned about her heart condition and she reported that she had not followed up with her physician regarding A-fib. (PX6).

The records reflect that at the time of the April 16, 2015 visit, it was noted that Petitioner reported that the swelling was decreasing in her bilateral legs. At the time of the April 30, 2015 visit, Petitioner continued to present with increased irritability, that with more activity she would have flare-ups but the flare-ups seemed to be shorter in duration, that her numbness was improving and that she was making progress with standing tolerance, core stabilization and lower extremity strengthening. At the time of the May 5, 2015 visit, Petitioner was noted to be continuing to put forth effort during her sessions, and she had progressed to lifting and pushing light loads (*i.e.*, less than 10 pounds in clinic) without flare up. At the time of the May 6, 2015 visit, Petitioner reported that she was still having groin, lateral thigh and foot pain/burning. The Re-Evaluation performed on May 28, 2015 noted that Petitioner had last been seen in physical therapy on May 7, 2015; that she had made minimal progress objectively since her last visit but stated that she had been attempting to ambulate more without her quad cane per tolerance and walking in her home without her brace as tolerated in order to regain core strength; and that she was still having complaints of increased burning of the right lower extremity and swelling of the bilateral lower extremities with prolonged standing. (PX6).

The records reflect that at the time of the May 29, 2015 visit, Petitioner reported that her pain level had been up and down since she was last seen, that she was still having burning in the right lower extremity and constant swelling of her bilateral extremities, that she was trying to walk around the house more without her brace as instructed by her physician but noticed her low back pain increased with longer walks, that she was having 6/10 low back pain currently and burning down the entire right lower extremity, and that she ambulated into the clinic without any assistive device. At the time of her June 8, 2015 visit, Petitioner reported that she was having 8/10 pain, that she was having more complaints of numbness and tingling in the right foot, that she was having a burning sensation, that she denied doing anything to cause increased pain other than walking around the house without her brace, that after two hours of walking without her brace she was in pain, and that her pain medication did not "touch her pain." Petitioner had variable complaints in the lower back and right lower extremity at the time of the June 9, 2015 visit. Petitioner cancelled her appointment on June 19, 2015. (PX6).

The records reflect that at the time of the July 2, 2015 re-evaluation, it was noted that new orders had been received for right SIJ dysfunction and Petitioner was instructed to continue physical therapy once per week for the next six weeks. At the time of the August 17, 2015 visit, it was noted that Petitioner reported 6-7/10 low back pain and right leg pain and numbness, that she walked one block the day prior and her right leg had swelled, and that she was still swollen. At the time of the August 18, 2015 visit, it was noted that since her last evaluation Petitioner demonstrated decreased functional disability as measured by the Oswestry Back Disability Index as well as decreased resting level pain, that she presented with impairments of decreased right lower extremity strength and light touch sensation, decreased trunk stabilization, impaired standing balance, numbness in the right leg, and pain with prolonged standing or walking. (PX6).

The medical records of St. Anthony's Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner was scheduled originally for the stage 2 anterior part of her stabilization but she went into atrial fibrillation with rapid ventricular response. The records reflect that because of her significant medical issues, surgery, spinal precautions and significant functional decline, Acute Rehab was consulted. With regard to the operative note, the records reflect that on December 5, 2014 Petitioner's post-operative diagnoses included: (1) L3-4 spondylolisthesis with bilateral pars fractures and right L4 superior articular process fracture; (2) L3-4 disk protrusion/stenosis; (3) L4-5 annular tear; (4) scoliosis. (PX7).

The medical records of St. Anthony's Medical Center also reflect that Petitioner was in the Inpatient Physical Medicine and Rehab unit for the timeframe of December 11, 2014 through January 7, 2015. The Discharge Summary for the admission indicated that Petitioner during surgery had numbness and weakness of the lower extremities, after which surgery was aborted. Additionally, the records reflect that Petitioner underwent an inferior vena cavogram with inferior vena cava filter placement and ultrasound access on January 2, 2015 for a history of left lower extremity DVT and a notation was made regarding undergoing spinal surgery in the near future. The Operative Report dated January 7, 2015 referenced the procedure performed by Dr. Lee on that date, which included (1) L3-4 and L4-5 posterior closing wedge osteotomy with posterior spinal fusion; (2) placement of Globus rods at L3-4 and L4-5; (3) local autogenous bone graft with Grafton demineralized bone matrix. The records reflect that Petitioner was admitted for additional inpatient rehabilitation for further physical/occupational therapy. (PX7).

The interpretive report of the MRI performed at St. Anthony's Medical Center was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner underwent an MRI of the lumbar spine on March 12, 2014, which was interpreted as revealing degenerative changes greatest at L3-4 with right subarticular narrowing and moderate to severe right foraminal narrowing; correlate for right L3 and/or L4 radiculopathy. (PX8).

The Notice of Motion and Order was entered into evidence at the time of arbitration as Petitioner's Exhibit 9, the Petition for an Immediate Hearing Under Section 19(b) of the Act was entered into evidence at the time of arbitration as Petitioner's Exhibit 10, and Petitioner's Motion for Penalties and Attorney's Fees was entered into evidence at the time of arbitration as Petitioner's Exhibit 11. With respect to Motion for Penalties and Attorney's Fees, Petitioner asserts that Respondent is liable for penalties and attorney's fees for (1) failing and refusing to pay TTD benefits pursuant to the Act; and (2)

Respondent has failed and refused to pay and authorize Petitioner's medical benefits as required under the Act. (PX11).

The wage statement was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Respondent stipulated at the time of hearing, however, that Petitioner's average weekly wage was $1,105.21.

The report of Dr. Bernardi was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The report reflects that Petitioner was seen by Dr. Bernardi on August 4, 2015 for a Section 12 examination. Petitioner reported that she injured her low back at work on February 4, 2014 while employed at Respondent in East Alton, that she was hired in May of 1994, that she had been off since April of 2014, that she had not had any other jobs, and that she had applied for Social Security Disability. (RX2).

The report reflects that Petitioner completely denied any prior history of significant or sustained low back pain predating her February 4, 2014 accident, and that before that date she had never seen a chiropractor or medical doctor with symptoms referable to her lumbar spine. Petitioner reported that she had undergone several surgical procedures to address her low back symptoms, that she continued to follow up, that she had seen a pain management physician, that she saw a pulmonologist about the DVT she developed following one of her procedures, and that she had retained an attorney regarding her pending claim. (RX2).

The report reflects that Petitioner reported that on February 4, 2014, she rolled a cylinder that weighed approximately 600 pounds onto a buggy, and that as she went from a flexed forward to an upright position she felt pain in her low back. Petitioner reported that she walked over to a control panel, and one or two minutes later she developed a very sharp pain in her right leg. Petitioner was ultimately referred to Dr. Lee by her attorney, who ordered x-rays and an MRI, recommended PT, recommended injections and ultimately offered surgery. Petitioner's first surgery was performed on December 5, 2014, and prior to the procedure Petitioner had low back pain which was almost exclusively lateralized to the right. The report further reflects that Petitioner had severe leg pain that involved the posterolateral aspect of her right thigh and calf which terminated in the dorsum of her foot, and that her symptoms were constant. (RX2).

The report reflects that Petitioner described low back pain that was situated at waist level, that both sides were affected, and that she had throbbing pain in her right leg which involved the posterolateral aspect of her thigh and calf. Petitioner described a numb sensation in the same distribution and indicated that her right foot swells, and that occasionally she noted a sense of numbness in her left heel. (RX2).

After outlining the medical records and diagnostic imaging reviewed as part of the examination performed, Dr. Bernardi opined that Petitioner's diagnoses as they pertained to her ongoing lumbar symptoms included (1) congenital lumbar stenosis; (2) L3-4 degenerative spondylolisthesis; (3) L3-4 and L4-5 degenerative/congenital stenosis; (4) status-post staged L3 to L5 decompression/instrumented fusions; (5) low back and right leg pain of uncertain etiology. Dr. Bernardi in performing the physical examination noted that other than the asymmetry in her lower extremity reflexes Petitioner's neurological examination was normal, and that the pattern of weakness noted on his examination did not have a neuropsychological basis. Dr. Bernardi indicated that despite the fact that her post-operative radiographs

looked good, Petitioner was still taking a sizeable amount of analgesics on a daily basis and he could not identify a physical reason why she required so much pain medication. Dr. Bernardi believed that Petitioner had developed a tolerance to narcotics which he believed was clouding her clinical presentation and perceived sense of disability, and he also believed it would adversely affect her response to any additional treatment. (RX2).

With respect to the issue of recommended medical treatment, the report reflects that Dr. Bernardi was of the opinion that even though the etiology was unclear Petitioner described persistent right leg pain for which he believed it was reasonable for her to continue taking Neurontin. Furthermore, Dr. Bernardi did not recommend that Petitioner undergo an SI joint injection as he could not imagine how it would change her treatment, and he thought Petitioner's chronic opioid use would make the interpretation of her response extremely problematic. As to the issue of atrial fibrillation with a rapid ventricular response, Dr. Bernardi conceded that the management of the condition fell outside his area of expertise and that Petitioner's internist/cardiologist could attest as to how long she might require the medication. With respect to the issue of DVT, Dr. Bernardi indicated that this was not a problem he typically managed, but he noted that Dr. Gu saw Petitioner on May 7, 2015 at which time Petitioner was instructed to return in three months, and if she was improving his plan was to remove her Greenfield filter and stop her anticoagulation. As to the issue of Petitioner's paralytic ileus following her surgery, Dr. Bernardi suggested that this was a very common complication following lumbar spine procedures, was transient and was not associated with any long term problems. (RX2).

With respect to the issue of returning to work, Dr. Bernardi noted that Petitioner stated that she had applied for Social Security Disability that he believed suggested that she did not feel capable of returning to gainful employment. Dr. Bernardi noted that Petitioner's disability and need for activity restrictions were driven by her subjectively perceived pain, and he suspected that her chronic opioid use was adversely affecting this. Dr. Bernardi noted that he believed that Petitioner could work with restrictions, and that he believed it would be in her best interest to do so. Dr. Bernardi opined that Petitioner should avoid activities that involve repetitive bending and twisting movements. Additionally, Dr. Bernardi opined that Petitioner should avoid lifting more than 15 pounds, and that depending on the results of the additional diagnostic testing recommended (including an EMG/NCS, non-contrast CT of the lumbar spine and an MRI so as to assess Petitioner's canal dimensions), the restrictions would most likely be modifiable. (RX2).

A letter dated August 31, 2015 from Michael Keefe to Kari Peterson confirming Ms. Peterson's agreement to the admission of Dr. Bernardi's report into evidence was entered into evidence at the time of arbitration as Respondent's Exhibit 3. Furthermore, the second page of the letter indicated that Mr. Keefe had received confirmation that Respondent could accommodate the restrictions recommended by Dr. Bernardi. (RX3). The letter reflects that Mr. Keefe asked Ms. Peterson to discuss the situation with Petitioner when she returned from her family business, and that it was his understanding that Petitioner would be gone the week of September 1st but returning the following week. (RX3).

A letter dated September 15, 2015 from Mr. Michael Keefe to Ms. Kari Peterson acknowledging receipt of the 19(b) was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The letter indicated that Petitioner worked the week of August 31, 2015 through September 4, 2015 in the Brass Mill office, and that Petitioner did not show back up to work September 7, 2015 through September

11, 2015. The letter further indicated that if Petitioner was willing to go back to work light duty with the restrictions suggested by Dr. Bernardi, the work was available. (RX4).

A letter dated September 22, 2015 from Mr. Michael Keefe to Ms. Kari Peterson was entered into evidence at the time of arbitration as Respondent's Exhibit 5. The letter indicated that Mr. Keefe had been informed that Petitioner had not, in fact, worked at the end of August/beginning of September, and that there was a miscommunication with the plant. The letter further indicated that Respondent had "carved out" an area within the office for Petitioner to work and therefore there would be no risk of her reinjuring herself because of the work activities being assigned. (RX5).

Respondent's Response to Penalties was entered into evidence at the time of arbitration as Respondent's Exhibit 6. In its Response, Respondent asserted that it had paid for recommended surgery as well as TTD benefits through September 6, 2015, and that Respondent submitted its report from Dr. Bernardi to Petitioner's attorney. Respondent further asserted that it had made Petitioner's attorney aware that work was available within the restrictions recommended by Dr. Bernardi, and that Petitioner had refused to work. (RX6).

CONCLUSIONS OF LAW

The parties stipulated at the time of hearing that on February 4, 2014, Petitioner sustained accidental injuries that arose out of and in the course of her employment, and that Petitioner's current condition of ill-being was causally connected to the injury. (AX1).

With respect to disputed issues (L) pertaining to temporary total disability benefits and (O) pertaining to the ability to work light duty, given the commonality of facts and evidence related to these issues, the Arbitrator addresses them jointly.

"[T]o prove temporary total disability, the employee must demonstrate not only that he did not work, but also that he was unable to work." *Ming Auto Body/Ming of Decatur, Inc. v. Industrial Comm'n*, 387 Ill. App. 3d 244, 256, 899 N.E.2d 365, 378, 326 Ill. Dec. 148 (2008). As the Arbitrator finds that Petitioner has failed to demonstrate that she did not work and was unable to work during the timeframes of February 27, 2014 through December 4, 2014 and September 7, 2015 through October 22, 2015, the Arbitrator finds that Petitioner is not entitled to temporary total disability benefits for either timeframe.

In so concluding, the Arbitrator notes that no off work slips covering the timeframe of February 27, 2014 through March 31, 2014 were entered into evidence at the time of arbitration, and as a result thereof the Arbitrator finds that Petitioner has failed to that she was temporarily and totally disabled for that particular period.

As to the subsequent timeframe of April 1, 2014 through December 4, 2014, the Arbitrator notes that while Dr. Lee in his office note of May 13, 2014 referenced that Petitioner was medically unable to work, no corresponding off work slip was entered into evidence at the time of arbitration. Similarly, while Dr. Lee in his office note of October 7, 2014 indicated that Petitioner had been off work for eight months, no corresponding off work slip was entered into evidence at the time of arbitration. In addition, while Petitioner was apparently seen by Dr. Lee on December 1, 2014, no reference was even made in the

office note as to Petitioner's work status on that date nor was there a corresponding off work slip entered into evidence at the time of arbitration.

The Arbitrator suggests that although the report of Dr. Randolph was not separately admitted into evidence at the time of hearing, the Arbitrator's understanding of Dr. Randolph's recommended restrictions is based not only on the deposition testimony of Dr. Lee but also on the testimony of Petitioner. The Arbitrator's understanding of the restrictions recommended by Dr. Randolph in his February 26, 2014 report were that of no lifting greater than 10-15 pounds occasionally, limit pushing/pulling to no more than 30 pounds, avoiding activities that involve bending and twisting, that continued standing should be avoided, and that ideally work activities which allowed change of position were recommended. The Arbitrator notes that such an understanding is based upon the cross-examination testimony of Petitioner's treating physician, Dr. Lee. (PX1). The Arbitrator further suggests that Dr. Lee agreed that his recommended restrictions were similar to those as recommended by Dr. Randolph, the physiatrist who had examined Petitioner prior to her presentation to Dr. Lee. (PX1).

Furthermore, the Arbitrator finds that Petitioner acknowledged at the time of arbitration her understanding of Dr. Randolph's work restriction recommendations. Petitioner testified that it was her understanding that she was to go back light duty, and she admitted that Respondent offered her such light duty work. Petitioner admitted that she attempted to work light duty, which consisted of walking throughout the plant and having the operators read and sign a document, as well as doing filing. Petitioner admitted that she stopped working light duty because she was in excruciating pain and was getting shooting pains down her leg. As such, the Arbitrator finds that Petitioner admitted that light duty work had, in fact, been offered to her by Respondent within the restrictions recommended by Dr. Randolph, and that Petitioner refused to continue to work. This, when coupled with the lack of evidence of off work slips covering the timeframe of February 27, 2014 through March 31, 2014, results in the Arbitrator's finding that Petitioner is not entitled to temporary total disability benefits for the timeframe of February 27, 2014 and December 4, 2014.

With respect to the request for temporary total disability benefits for the timeframe of September 7, 2015 through October 22, 2015, the Arbitrator notes that Mr. Wickenhauser testified that part of his work responsibilities as the Safety Excellence Coordinator with Respondent is to place recovering workers into light duty positions. As corroborated by the letter dated August 31, 2015 from Mr. Keefe to Ms. Peterson confirming that Respondent could accommodate the restrictions recommended by Dr. Bernardi (RX3), Mr. Wickenhauser testified that there was, in fact, work available for Petitioner at Respondent's facility within the restrictions recommended by Dr. Bernardi. Mr. Wickenhauser testified that Petitioner would have been placed in an office setting and would *not* have been placed in operations, and that the light duty position was still, in fact, available as of the time of the hearing.

The Arbitrator finds both Mr. Wickenhauser's testimony regarding the offer of light duty work within the restrictions recommended Dr. Bernardi and the letter from Mr. Keefe to Ms. Peterson to demonstrate that light duty work was, in fact, offered to Petitioner which she apparently refused to perform. As such, the Arbitrator finds that Petitioner is not entitled to the award of temporary total disability benefits for the timeframe of September 7, 2015 through October 22, 2015.

Given the parties' stipulation at the time of hearing as to the issue of Petitioner's average weekly wage, the Arbitrator awards the sum of $14.18/week for a total of 42 2/7 weeks (addressing the

timeframes of February 7, 2014 through February 26, 2014 and December 5, 2014 through September 6, 2015), which represents temporary total disability benefits under Section 8(b) which were underpaid up to the time of arbitration given the parties' stipulation at the time of hearing to Petitioner's entitlement to temporary total disability benefits for such timeframes.

With respect to disputed issue (M), the Arbitrator finds that Respondent reasonably relied upon the opinions of Dr. Randolph in disputing Petitioner's request for temporary total disability benefits for the timeframe of February 27, 2014 through December 4, 2014, and the Arbitrator further finds that Respondent reasonably relied upon the opinions of Dr. Bernardi in disputing Petitioner's request for temporary total disability benefits for the timeframe of September 7, 2015 through October 22, 2015. As a result thereof, the Arbitrator denies Petitioner's request for the award of penalties and attorney's fees under Sections 19(k) and Section 16.

"An employer's reasonable and good faith challenge to liability ordinarily will not subject it to penalties under the Act." *Matlock v. Industrial Comm'n,* 321 Ill. App. 3d 167, 173, 746 N.E.2d 751, 756, 253 Ill. Dec. 930 (2001). Generally, penalties are unwarranted when there are conflicting medical opinions, or when the employer acts in reliance upon responsible medical opinion. *Matlock,* 321 Ill. App. 3d at 173, 746 N.E.2d at 756. Here, the Arbitrator finds that Respondent acted in reliance on a qualified medical opinion to dispute Petitioner's entitlement to temporary total disability benefits in this case for both timeframes at issue at the time of arbitration. Furthermore, Petitioner herself admitted that light duty work had been offered to her by Respondent within the restrictions recommended by Dr. Randolph, which Petitioner admitted that she refused to continue to perform. Similarly, the evidence established at the time of hearing demonstrated that Petitioner was also offered work within the restrictions recommended by Dr. Bernardi in his August 4, 2015 report, which Petitioner also apparently refused to perform. These refusals, when coupled with the lack of off work slips and Petitioner's notably inconsistent actions in her traveling to Seattle, Washington for family-related issues, results in the Arbitrator's denial of the award of penalties and attorney's fees.

The Arbitrator notes that the Request for Hearing form submitted into evidence at the time of hearing as Arbitrator's Exhibit 1 reflected that the parties initially disputed the average weekly wage applicable to Petitioner's claim. The Arbitrator points out that it was not until after the case had begun to proceed on the record that Respondent admitted to a mathematical error and thereafter stipulated to the average weekly wage alleged by Petitioner. The effect of such a stipulation was that Petitioner was ultimately underpaid temporary total disability benefits in the amount of $14.18 per week for a total of 42 2/7 weeks for the timeframes of February 7, 2014 through February 26, 2014 and December 5, 2014 through September 6, 2015, respectively, in light of the parties' stipulation at the time of hearing to Petitioner's entitlement to temporary total disability benefits for said timeframes. As a result, the Arbitrator finds that the temporary total disability underpayment was not withheld in bad faith nor was the underpayment unreasonable, and therefore denies to award penalties under Section 19(l) and attorney's fees under Section 16 for such an underpayment.

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

GEORGE LEETH,

Petitioner,

vs. NO: 10 WC 14165

16IWCC0726

GORDON TRUCKING, INC.

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review under §19(b) having been filed by the parties herein and proper notice given, the Commission, after considering the issues of benefit rates, medical expenses, prospective medical care, temporary total disability, causal connection, and penalties and fees pursuant to Section 16, Section 19(k) and Section 19(l) of the Act, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission notes that Petitioner was employed by KRC Logistics/Stanley General from September 26, 2011 through May 18, 2012 and was awarded temporary total disability benefits throughout this period. During this time period Petitioner was able to work and did work as a forklift driver and then as a dispatcher before resigning that position on May 18, 2012. The Commission vacates the award of temporary total disability benefits for the period of time from September 26, 2011 through May 18, 2012.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $553.52 per week for a period of 77 and 6/7 weeks, commencing January 16, 2010 through September 25, 2011 and commencing May 19, 2012 through August

31, 2012, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical services, in the sum of $ 914.00 for services provided at Midwest Spine Care; $2,446.23 for medications provided by Injured Workers' Pharmacy; for medications and $13,316.28 for medications provided by Prescription Partners pursuant to §8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize the pain management program as recommended by Dr. Mark Chang of Midwest Spine Care pursuant to Sections 8(a) and 8.2 of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. 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: NOV 7 - 2016
o-9-8-16
SM/msb
44

Stephen Mathis

David L. Gore

Mario Basurto

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

LEETH, GEORGE
Employee/Petitioner

Case# **10WC014165**

16IWCC0726

GORDON TRUCKING
Employer/Respondent

On 9/8/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.27% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
JASON CARROLL
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0075 POWER & CRONIN LTD
ELENA CINCIONE
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

16IWCC0726

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)

GEORGE LEETH
Employee/Petitioner
v.
GORDON TRUCKING
Employer/Respondent

Case # **10** WC **14165**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **July 24 and August 25, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 15, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$43,174.56**; the average weekly wage was **$830.28**.

On the date of accident, Petitioner was **34** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit $48,868.67 for TTD benefits paid, $2,076.17 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $50,944.84 for benefits that were paid.

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 $553.52/week for 103 2/7 weeks, commencing January 16, 2010 through September 25, 2011 and May 19, 2012 through August 31, 2012, as provided in Section 8(b) of the Act..

Respondent shall pay Petitioner temporary partial disability benefits in the amount $223.58 per week for the 18 week period of September 26, 2011 through January 29, 2012 and in the amount $40.70 per week for the 15 5/7 week period of January 30, 2012 through May 18, 2012, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $914.00 for services provided at Midwest Spine Care; $2,446.23 for medications provided by Injured Workers' Pharmacy; and $13,316.28 for medications provided by Prescription Partners, as provided in Sections 8(a) and the medical fee schedule.

Respondent shall authorize the pain management program as recommended by Dr. Mark Chang of Midwest SpineCare 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.

David A. Kane
Signature of Arbitrator

September 4, 2015
Date

SEP 8 - 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GEORGE LEETH,	)	16IWCC0726
	)	
Petitioner,	)	
	)	
v.	)	10 WC 14165
	)	
GORDON TRUCKING,	)	
	)	
Respondent.	)	

FINDINGS OF FACT AND CONCLUSIONS OF LAW

PROCEDURAL HISTORY

This claim was previously tried pursuant to Section 19(b) of the Illinois Workers' Compensation Act on November 29, 2011 and December 21, 2011 before Arbitrator David Kane in Chicago, Illinois. (PX1). A decision by the Arbitrator was filed with the Commission on January 12, 2012. (PX2). Petitioner filed a Petition for Review and a Decision and Opinion on Review was filed on October 15, 2012. (Id.).

The Commission reversed the decision of the Arbitrator. (PX1). The Commission ordered Respondent to pay Petitioner temporary total disability benefits of $553.52 per week for a period of 88 2/7 weeks, from January 16, 2010, through September 25, 2011 and temporary partial disability benefits of $223.58 per week for a period of 9 2/7 weeks from September 26, 2011, through November 29, 2011. (Id.). The Commission further ordered Respondent to pay reasonable and necessary medical expenses in the amount of $14,922.67, pursuant to the medical fee schedule and to authorize and pay for prospective medical treatment as recommended by Dr. Mark Chang. (Id.).

Respondent filed a Review of the Commission's decision in the Circuit Court of Cook County, Illinois. (PX1). Judge Robert Lopez Cepero confirmed the Commission's decision. (Id.). Respondent filed an Appeal before the Appellate Court of Illinois, First Judicial District, Workers' Compensation Division, however, that appeal was dismissed by the Appellate Court on January 8, 2014 by motion of Respondent. (Id.). The claim was remanded back to the Illinois Workers' Compensation Commission for further proceedings.

FINDINGS OF FACT

Petitioner George Leeth testified for a second time at the subsequent 19(b) hearing on July 24, 2015. (T. p. 8). He testified that he was working for KRC Logisitics/Stanley General at the time of his first trial in November of 2011. (Id. at 12). Following his first trial, Petitioner testified he was working the same approximate number of hours as at the time of his first trial, which was sixty to seventy hours per week. (Id.). The parties stipulated at the first trial that Petitioner earned an average of $494.90 per week while working in this position. (PX1).

On cross examination, Petitioner testified he was promoted to the Dispatch Department of KRC Logistics/Stanley General on January 30, 2012. (T. p. 58). His earnings changed from $13.00 per hour to a salary position of $40,000 per year, which the Arbitrator notes equates to $769.23 per week. (T. p. 58-59, RX12). Petitioner testified he resigned from that position as of May 18, 2012. (T. p. 59). He testified he resigned because he was being asked to do things that would have been illegal under federal regulations. (Id. at 12).

Petitioner testified that the last time he treated with Dr. Mark Chang at Midwest Spine Care prior to his first trial was on September 15, 2011. (T. p.

10). Following his first trial, his next visit with Dr. Chang was on May 31, 2012. (Id. at 10-11). At that visit, Dr. Chang noted Petitioner was doing about the same. (PX2 p. 22). He noted that Petitioner tried doing a light duty job but it greatly aggravated his back and left leg. (Id.). Petitioner continued to complain of intermittent left leg weakness. (Id.). Dr. Chang recommended long-term pain management by a pain specialist. (Id.). Petitioner testified he wants to pursue the recommendations made by Dr, Chang at this visit. (T. p. 14).

Petitioner's Subsequent Employment as a CDL Truck Driver

Following his May 31, 2012 visit to Dr. Chang, Petitioner testified he began working for another employer, Fore Transportation, at the end of August or beginning of September, 2012. (T. p. 14-15). He testified he accepted the position of a CDL driver. (Id. at 15). He testified he drove a "day cab," which he explained is an eighteen-wheel truck, and made daily deliveries of goods. (Id. at 15-16). Petitioner drove this truck against the explicit instructions of Dr. Chang that it was unsafe for him to do so. (PX1 and PX2 p. 23).

Prior to starting his job with Fore Transportation, Petitioner applied for certification with the Department of Transportation in Indiana. (T. p. 16). On his paperwork, he listed his back injury as a low back strain, which he noted is what the doctors that Respondent sent him to said it was. (Id. at 17). He passed the CDL certification. (Id.).

When he began driving the truck for Fore Transportation, Petitioner testified he continued to have episodes of drop foot. (T. p. 18). He testified he felt "a lot of weakness" in his left leg while driving the truck and sometimes it would give out. (Id. at 20). He testified that in January of 2013, he was driving his truck and was stopped at a stop light. (Id. at 21). He

testified he had his left foot on the clutch and his left leg went numb. (Id.). He explained that his left foot "popped off the clutch and I tapped the rear bumper of the car in front of me." (Id.). Following this incident, which he reported to his employer, he continued to drive the truck. (Id. at 22).

Petitioner continued to treat with Dr. Chang after he began working for Fore Transportation. (PX2). At his January 10, 2013 visit, Dr. Chang noted he still had lower back pain and left leg pain and weakness. (PX2 p. 24). He further noted Petitioner's ongoing left leg weakness and dragging of his left foot. (Id.). Dr. Chang indicated Petitioner was trying to work at that time. (Id.). At his visit on April 11, 2013, Dr. Chang noted Petitioner was frustrated because he did not know when his left leg would give out. (Id. at 26).

Petitioner's Accident of April 25, 2013

Two weeks after his April 11 visit with Dr. Chang, Petitioner was injured in a work-related accident while working for Fore Transportation on April 25, 2013. (T. p. 24). Petitioner testified he was attempting to assist a drunk driver who had stopped his vehicle on Interstate 80-94 in the eastbound lanes in Indiana, approximately two miles outside of Michigan. (Id. at 24, 26). He testified he was getting back into his truck while on the phone with 911 regarding the drunk driver. (Id. at 24). As he was climbing into his truck, his truck was struck by another semi-truck, whose driver was killed instantly in the collision. (Id.).

Leeth testified that he was halfway into his truck when his vehicle was impacted by the second truck. (T. p. 25). He explained that the door of his truck slammed on his left hip, left leg, and left ankle. (Id.). When the door slammed on him, he testified his hand was stuck in a handle. (Id.). As the door recoiled, he testified he went out with the door and ended up falling to

the ground onto his left ankle. (Id. at 25-26). He testified this landing is what fractured his ankle and tore ligaments and tendons. (Id. at 25). Petitioner was transported from the scene of the accident by ambulance to St. Anthony Memorial Hospital in Michigan City, Indiana. (PX6 p. 21). Dr. Jerry Sosbe treated Petitioner at St. Anthony and noted he was "half in and half out of truck" when he was rear ended by another semi-truck. (Id. at 23). Petitioner complained of pain to his left shoulder, lower back, left hip, left wrist, left foot, and numbness and tingling radiating down his left leg. (Id. at 23, 25). X-rays of Petitioner's lumbar spine, left femur, left lower leg, left foot, left shoulder, and left wrist were completed. (Id. at 27-28). His X-rays were essentially all negative and he was discharged the same morning. (Id. at 27-30). Further diagnostic testing of a lumbar MRI was completed on May 1, 2013. (PX7 p. 75). The lumbar MRI revealed no significant findings. (Id.).

Petitioner began treating at Lakeshore Bone & Joint Institute in Chesterton, Indiana following this new accident on May 10, 2013. (PX7 p. 78). He treated with Dr. Thomas Kay at that visit who noted Petitioner's complaints that day were primarily left ankle pain and swelling, left hip pain, and lower extremity swelling. (Id.). Dr. Kay completed a physical examination. (Id. at 78-80). He diagnosed Petitioner with a significant medial and lateral left ankle sprain, contusions, and a "mild lumbar strain." (Id. at 80). Following that initial visit, he began a course of physical therapy at ATI Physical Therapy for his left ankle and low back. (Id. at 83).

Petitioner followed up with Dr. Kay on June 7, 2013. (PX7 p. 88). He continued to complain of lower back and left sided sacroiliac pain, and pain in his lateral left hip, left knee, and left ankle. (Id.). Dr. Kay noted he continued to get occasional radicular pain down his left leg. (Id.). He

referred Petitioner to a spine specialist for his complaints of radicular pain. (Id. at 90).

Petitioner's Treatment with Dr. Anton Thompkins

Pursuant to Dr. Kay's referral, Petitioner treated with Dr. Anton Thompkins, also at Lakeshore Bone & Joint Institute, for the first time on July 15, 2013. (PX7 p. 101). Dr. Thompkins noted that since his accident of April 25, 2013, Petitioner complained of pain in his gluteal area and his leg "wants to give out on occasion." (Id.). Dr. Thompkins suspected an injury to the neural plexus outside of the spinal canal and possibly a sacroiliac joint issue in his hip and pelvic area. (Id.). He recommended an MRI of Petitioner's pelvis and hip area. (Id.).

Petitioner also continued to treat with Dr. Chang for his injuries sustained in the accident of January 15, 2010. (PX2). At his July 18, 2013 visit, Dr. Chang noted Petitioner had been involved in the fatal motor vehicle accident on April 25, 2013. (Id. at 27). Petitioner complained of increased lower back and left leg pain. (Id.). Dr. Chang noted the weakness in his left leg, which was sporadic, had become more constant. (Id.). Dr. Chang suggested that Petitioner had sustained an acute worsening of chronic left S1 radiculopathy but that he found a similar amount of weakness with the left leg. (Id.).

The MRIs of his hip and pelvis recommended by Dr. Thompkins were completed on July 30, 2013. (PX7 p. 108). Following completion of these MRIs, Petitioner returned for his second and final visit to Dr. Thompkins on August 12, 2013. (Id. at 111). He reviewed the MRIs and stated there was "a finding suspicious of a fracture on the anterior superior aspect of the left acetabulum with some depression." (Id.). He continued, "There is also left SI joint bruising with some edema noted as well." (Id.). Dr. Thompkins

concluded, "From my perspective, the pain that he is having in his left hip area is most likely secondary to these particular findings and most likely not related to his spine...it is not from his spine." (Id.).

Petitioner's Ongoing Medical Care

Petitioner continued to treat with Dr. Chang. (PX2 p. 28). At his October 17, 2013 visit, Dr. Chang once again reiterated his recommendation that Petitioner consult a pain clinic for long term pain management. (Id.).

He also continued to treat with Dr. Kay at Lakeshore Bone & Joint Institute for the injuries he sustained in the April 25, 2013 accident. (PX7). At his August 19, 2013 visit, Dr. Kay noted he continued to complain of left hip pain that could be so severe it caused his leg to give out. (Id. at 115). He also complained of left knee pain and popping and lateral ankle pain. (Id.). Dr. Kay concurred with the findings of bone bruises in the area of the left SI joint and in the left hip. (Id. at 117). He opined he expected a full recovery with rest and subsequent rehabilitation. (Id.).

Petitioner continued to treat with Dr. Kay for his left hip, knee, and ankle pain. (PX7). He eventually underwent left ankle surgery performed by Dr. Kay on February 13, 2014. (Id. at 148). Dr. Kay released Petitioner at maximum medical improvement on August 29, 2014. (Id. at 175). However, Petitioner subsequently began treating with Dr. Johnny Lin at Midwest Orthopaedics at Rush due to his left ankle pain. (PX10 p. 5). Dr. Lin performed a second left ankle surgery on March 4, 2015. (Id. at 23-27).

At his most recent visit with Dr. Chang on May 8, 2014, he again advised Petitioner to begin a long term pain management program at a pain clinic. (PX2 p. 29). Petitioner testified he continues to experience left drop foot. (T. p. 38). He testified that on some days it can occur multiple

times but he sometimes can go a week without it happening. (Id.). He testified that his drop foot condition did not change after his April 25, 2013 accident. (Id. at 40). Petitioner admitted several times that he knowingly drove a semi-truck against the explicit instructions of Dr. Chang. (Id. at 18, 45, 46, 79). He testified that he decided to drive a truck because he was "broke." (Id. at 80). He continued:

> I was about to lose everything I owned. I had a family to support; and to be honest with you, other jobs didn't pay as much. I knew I was going to make about 60 to 80 thousand driving a truck for Fore. I had to take that chance. That's the only way I could stay afloat at that point.

II. CONCLUSIONS OF LAW

F. WHETHER PETITIONER'S PRESENT CONDITION OF ILL BEING IS CAUSALLY RELATED TO THE ACCIDENT?

The Arbitrator finds that Petitioner's current condition of ill-being as it relates to his lower back injury, namely a nerve contusion at L5-S1 causing uncontrolled left drop foot, is causally related to his work accident of January 15, 2010 while working for Respondent.

The law of the case doctrine instructs that this causal connection finding should be found. The law of the case doctrine is a rule of practice, based on sound policy that, where an issue is once litigated and decided, that should be the end of the matter and the un-reversed decision of a question of law or fact made during the course of litigation settles that question for all subsequent stages of the suit." *Irizarry v. Industrial Comm'n*, 337 Ill.App 3d 598, 606, 786 N.E.2d 218, 224 (2003); *McDonald's Corp. v. Vittorio Ricci Chicago, Inc.*, 125 Ill.App.3d 1083, 1086-87, 466 N.E.2d 1116, 1119 (1984).

In *Irizarry*, the Arbitrator determined at a Section 19(b) hearing that a causal connection existed between the claimant's work accident and the injuries to his left knee, neck, right shoulder, and back. 337 Ill.App 3d at 606. The causal connection determination became a final judgment from which Respondent did not appeal, thus, the determination became the law of the case. *Id.* Respondent was barred from raising the causation issue again during a later proceeding. *Id.* at 607.

The facts in the case at bar are analogous to *Irizarry*. The doctrine of the rule of the law of the case therefore applies. The decision of the Commission that Petitioner's nerve contusion at L5-S1 causing left drop foot was causally connected to his January 15, 2010 work accident became a final order when Respondent withdrew its Appellate Court appeal. This causation finding is therefore the law of the case and cannot be re-litigated.

Like the claimant in *Irizarry*, this Petitioner is alleging the same injuries as in his prior claim. Although Petitioner sustained a subsequent accident on April 25, 2013, the treating medical records are clear that his injuries sustained in that accident are different from the January 15, 2010 claim.

First, the lumbar MRI completed on May 1, 2013 revealed no significant findings. Petitioner also treated with Dr. Thompkins, a back specialist, twice following this accident. Dr. Thompkins concluded, "From my perspective, the pain that he is having in his left hip area is most likely secondary to these particular findings (in hip and pelvis MRIs) and most likely not related to his spine…it is not from his spine." (Id.). Following this visit, his treatment was solely focused on his left hip and left ankle at Lakeshore Bone & Joint Institute.

There is no medical opinion to support a finding that Petitioner injured his lumbar spine or worsened his prior condition in any way in the April 25, 2013 accident other than a temporary increase in symptoms. Dr. Chang's treatment recommendations made nearly two years before this accident on May 31, 2012 and over one year after it remained exactly the same: Referral to a pain clinic for long term pain management.

For the foregoing reasons, the Arbitrator finds that Petitioner's current condition of ill-being as it relates to his lower back injury, namely a nerve contusion at L5-S1 causing uncontrolled left drop foot, is causally related to his accident of January 15, 2010.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

The Arbitrator finds that medical services provided to Petitioner have been reasonable and necessary. Respondent has not paid all appropriate charges.

Petitioner has undergone a conservative treatment program consisting of medication management, bracing, and follow-up orthopedic treatments with Dr. Chang. These ongoing attempts at conservatively treating the injury were reasonably completed. The medical treatment that has been provided to Petitioner since his injury has been an attempt to conservatively treat his injuries until he can obtain the additional recommended treatments that have been denied by Respondent. It has been both reasonable and necessary to address his injuries.

For these reasons, Respondent shall pay reasonable and necessary medical services pursuant to the medical fee schedule, of $914.00 for treatment provided by Midwest SpineCare from May 31, 2012 through May 8, 2014; $2,446.23 for medications dispensed by Injured Workers' Pharmacy; and $13,316.28 for medications dispensed by Prescription Partners as provided in Sections 8(a) and 8.2 of the Act.

K. WHETHER PETITIONER IS ENTITLED TO TTD AND TPD BENEFTIS?

The Arbitrator finds Petitioner is owed an additional $8,302.04 in unpaid TTD benefits and an additional $2,587.84 in unpaid TPD benefits from Respondent as provided in Sections 8(a) and 8(b) of the Act.

Dr. Chang never released Petitioner to return to full duty work as a truck driver. There is no alternate medical evidence to contradict Dr. Chang's opinions. It is clear from the record that, although Petitioner did eventually return to work driving a truck, it was against the explicit instructions of Dr. Chang that it was dangerous for him to do so.

Respondent offered no basis to deny payment of ongoing TPD benefits once the prior Commission decision became final. Petitioner continued to work in the same light duty position that he was previously awarded benefits. He worked in that same position until he received a raise as of January 30, 2012. He continued to work in a light duty capacity and the only change was the amount of weekly TPD benefits that should have been paid to him.

The Arbitrator also finds Petitioner's testimony credible as to why he resigned from his position at KRC Logistics/Stanley General for legal reasons. He had not yet reached maximum medical improvement and

therefore became entitled to TTD benefits until he began working for Fore Transportation.

For the foregoing reasons, the Arbitrator finds Petitioner has proven by a preponderance of the evidence that he is owed TTD benefits in the amount of $553.52 from January 16, 2010 through September 25, 2011 (88 2/7 weeks) and from May 19, 2012 through August 31, 2012 (15 weeks), which is a total of 103 2/7 weeks, as provided in Section 8(b) of the Act. Petitioner has proven by a preponderance of the evidence that he is owed TTD benefits totaling $57,170.71. Respondent shall be given a credit $48,868.67 for TTD benefits previously paid. Therefore, Petitioner is owed an additional $8,302.04 in unpaid TTD benefits from Respondent as provided in Section 8(b) of the Act.

The Arbitrator also finds Petitioner has proven by a preponderance of the evidence that he is owed TPD benefits from September 26, 2011 through May 18, 2012, which is a period of 33 5/7 weeks. Respondent provided no reason to deny TPD benefits following receipt of the Commission decision once the Appellate appeal was dismissed. Nonetheless, they only issued TPD payments totaling $2,076.17 for the previously awarded period of September 26, 2011 through November 29, 2011.

Petitioner continued to work in the same position at KRC Logistics/Stanley General that he was working at the time of the original 19(b) arbitration until he received a promotion as of January 30, 2012 when his earnings changed from $13.00 per hour to a salaried position of $40,000 per year, which the Arbitrator previously found equates to $769.23 per week. Petitioner continued in that salaried position until he was essentially forced to resign as of May 18, 2012. For the 18 week period of

September 26, 2011 through January 29, 2012, Respondent shall pay to Petitioner temporary partial disability benefits in the amount of $4,024.44, which is $223.58 per week. For the 15 5/7 week period of January 30, 2012 through May 18, 2012, Respondent shall pay to Petitioner temporary partial disability benefits in the amount of $639.57, which is $40.70 ($830.28 - $769.23 X 2/3 = $40.70) per week.

Petitioner has proven by a preponderance of the evidence that he is owed TPD benefits totaling $4,664.01. Respondent shall be given a credit $2,076.17 for TPD benefits previously paid. Therefore, Petitioner is owed an additional $2,587.84 in unpaid TPD benefits from Respondent as provided in Section 8(a) of the Act.

M. SHOULD PENALTIES OR FEES BE IMPOSED UPON RESPONDENT?

The Arbitrator finds that a reasonable dispute existed as to ongoing causation and entitlement to further benefits. Therefore, the Arbitrator denies imposition of penalties and attorney's fees.

O. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

The Arbitrator finds that Respondent shall authorize the treatment that has been recommended by Dr. Mark Chang of Midwest SpineCare.

The Arbitrator has already found that the Petitioner's lower back injury of a nerve contusion at L5-S1 causing left drop foot is causally related to the injuries sustained on January 15, 2010. This condition of ill being is well documented within the treating medical records and was not changed following the April 25, 2013 accident. The recommendation for long term pain management at a pain clinic made by Dr. Chang is the only

treatment currently being recommended. This recommendation was also made on May 31, 2012, which is nearly one year before Petitioner's second accident. It has been made very clear that Petitioner is not a surgical candidate and this treatment is the only thing offered to potentially treat his condition. It is both reasonable and necessary in order to treat the Petitioner's lower back injury.

For these reasons, the Arbitrator finds that Respondent shall authorize the recommended treatment plan as outlined by Dr. Chang, including long term pain management at a pain clinic.

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

Constance Sarlo,

Petitioner,

vs.

NO: 13WC020497

ABM Industries Inc.,

Respondent,

16IWCC0727

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 24, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that 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.

16IWCC0727

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $20,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 9 - 2016
MJB/bm
o-11/1/16
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SARLO, CONSTANCE
Employee/Petitioner

Case# **13WC020497**

ABM INDUSTRIES INC
Employer/Respondent

16IWCC0727

On 11/24/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.35% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1993 ROMANUCCI & BLANDIN
FRANK A SOMMARIO
321 N CLARK ST SUITE 900
CHICAGO, IL 60654

2999 LITCHFIELD CAVO LLC
ANITA S JOHNSON
303 W MADISON ST SUITE 300
CHICAGO, IL 60606

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

CONSTANCE SARLO
Employee/Petitioner

Case #13 WC 20497

v.

ABM INDUSTRIES, INC.,
Employer/Respondent

16IWCC0727

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on September 30 and October 28, 2015. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

K. ☒ What temporary benefits are due: ☐ TPD ☒ Maintenance ☒ TTD?

L. ☒ What is the nature and extent of injury?

M. ☒ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On May 3, 2013, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $41,964.00; the average weekly wage was $807.00.
- At the time of injury, the petitioner was 37 years of age, married with two children under 18.
- The respondent agreed that the petitioner is entitled to temporary total disability benefits for 58-5/7 weeks, from June 24, 2013, through August 15, 2014.

ORDER:

- The respondent shall pay the petitioner the sum of $484.20/week for a further period of 43 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 20% loss of use of her right leg.
- The respondent shall pay the petitioner compensation that has accrued from May 3, 2013, through October 28, 2015, and shall pay the remainder of the award, if any, in weekly payments.

- The medical care rendered the petitioner for her right knee through July 9, 2014, was reasonable and necessary and is awarded. The medical care rendered the petitioner for her lumbar spine, left knee, fibromyalgia and right knee after July 9, 2014, was not reasonable or necessary and is denied. The respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

- The petitioner's request for penalties and fees is denied.

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

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

Robert E. Williams

Signature of Arbitrator

November 24, 2015

Date

NOV 24 2015

FINDINGS OF FACTS:

The petitioner, an accounting manager, gave a written injury statement on May 3, 2013, that she experienced right knee pain while moving timesheet files from the top drawer of a filing cabinet to the bottom drawer and bending/squatting. She sought care for her right knee at Concentra on May 6th and reported bending, squatting and moving files from one drawer to another on May 3, 2013. Specifically, she reported that she was squatting down to remove files and developed pain when she stood up. The doctor noted that the pain was located over the posterior aspect of her right knee. Conservative care was prescribed for a knee strain. She saw Dr. Ashish Rawal on May 9th, who noted a history of lifting files from a bottom to a top shelf in a squatted position and her complaints of pain in the posterior aspect of her knee and swelling later that night. He opined that x-rays revealed some mild thinning and spurring of the patellofemoral joint consistent with her previous history of patellofemoral pain. His assessment was right knee medial joint line pain consistent with a meniscus tear. An MRI on June 3rd revealed a small to moderate joint effusion, a small to moderate Baker's cyst, a cyst at the proximal tibia medially inferior to the medial tibial plateau, mild cartilaginous thinning of the lateral patellar facet and no meniscal or ligament tear. She was given a cortisone injection on June 3rd and 6th. A CT scan on June 20th revealed mild medial compartment oseteoarthritis, a subchondral cystic focus within the proximal tibia adjacent to the posterior cruciate ligament insertion and metallic foreign bodies in the posteromedial soft tissue of her knee. The same day, the petitioner informed Dr. Rawal that she had recurrent swelling in her right knee, weight bearing difficulty and pain in the posterior aspect of her knee. Dr. Rawal opined on June 21st that the CT scan revealed that her tibia

cyst was benign. Dr. Rawal recommended an arthroscopic partial medial meniscectomy. The petitioner reported continued posterior right knee pain to Dr. Rawal on July 9th. The doctor noted posterior knee tenderness, mild lateral joint line tenderness and no medial joint line tenderness. An independent medical evaluation of her knees by Dr. Ali on July 16th was negative except for diffuse tenderness over the joint lines of her right knee. His diagnosis was a knee strain.

The petitioner reported a recent fall on August 7th. Dr. Rawal noted posterior swelling and medial joint line tenderness. On September 19th, Dr. Rawal performed a right knee arthroscopic patellar and medial femoral condyle chondroplasty and extensive synovectomy. The postoperative diagnosis was medial femoral condyle trochlea lesion and synovitis. The petitioner followed up with Dr. Rawal and started physical therapy. Dr. Rawal noted mild tenderness over the medial joint line, tenderness posteriorally over her Baker's cyst and mild pain with patellofemoral range of motion on October 16th. On November 14th, the petitioner reported left knee and low back pain. It was noted that the petitioner had tenderness in the lower paraspinal region and mild soreness and tenderness over the IT band and minimal joint line tenderness in her left knee. She reported improved back pain on November 20th and bilateral patellofemoral knee pain. Dr. Rawal's assessment on December 30th was bilateral patellofemoral syndrome and on February 10, 2014, right patellar chondromalacia. On March 17th, the petitioner reported to Dr. Rawal treatment for a recent exacerbation of her fibromyalgia. Physical therapy was restarted by Dr. Rawal on April 16th.

X-rays of her knees on May 10, 2014, revealed bilateral patellofemoral degenerative changes with joint space narrowing and hypertrophic spurring, unchanged

compared to x-rays on October 5, 2010. Her knees were aspirated on June 24th and injected with Depo Medrol. The petitioner saw Dr. Koutsky on July 9th and reported bilateral knee pain. She was given work restrictions in accordance with an FCE. The petitioner's knees were aspirated and injected with Hyalgan on September 3rd, 7th and 24th, and October 1st and 8th. Dr. Koutsky's bilateral knee examination was unchanged at eight follow-ups from August 21, 2014, through August 19, 2015.

Surveillance videos of the petitioner on May 7 and 8, 2015, show her picking up toddlers, bending and putting a toddler into the rear of a car, pushing a stroller with two toddlers, bending to the ground, liftng, running, squatting, carrying toddlers and walking to, around and from a park for approximately an hour.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for her right knee through July 9, 2014, was reasonable and necessary and is awarded. The medical care rendered the petitioner for her lumbar spine, left knee, fibromyalgia and right knee after July 9, 2014, was not reasonable or necessary and is denied. Dr. Rawal released the petitioner with restrictions pursuant to the FCE. Dr. Ali opined on August 7, 2014, that the petitioner was at maximum medical improvement and capable of returning to work pursuant to the FCE. The petitioner was at maximum medical improvement on July 9, 2014.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that her current condition of ill-being with her right knee is causally related to the work injury. The petitioner had a pre-existing degenerative condition in her right knee that was

aggravated while performing her work duties on May 3, 2013. The petitioner failed to prove that her current condition of ill-being with her lumbar spine, left knee and fibromyalgia is causally related to the work injury. The petitioner did not report or receive treatment for her lumbar spine, left knee and fibromyalgia initially after the May 3, 2013, incident.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

The petitioner was at maximum medical improvement on July 9, 2014, and is entitled to temporary total disability benefits up to that date. The respondent agreed to pay the petitioner temporary total disability benefits from June 24, 2013, through August 15, 2014; therefore, no temporary total disability benefits are awarded.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner failed to prove that she is obviously incapable of employment or that she cannot perform any services except those which are so limited in quantity, dependability or quality that there is no reasonably stable labor market for them. The petitioner can perform some form of employment without seriously endangering her health or life. She has extensive experience in the sedentary labor market of accounting. Also, she failed to prove that she conducted a genuine and diligent search for employment. Her efforts were perfunctory and not a convincing legitimate job search effort. Vocational counselors, Courtney Goodman and Julie Bose, both opined that the petitioner was employable and knows how to find employment. The surveillance videos also disprove the petitioner's testimony and reveal her ability to run, squat, bend, and carry and lift. The petitioner is not believable or credible. The petitioner's request for permanent total disability disability benefits is denied.

There is no AMA impairment rating or evidence concerning the impact of the petitioner's injury in regard to her occupation, age or future earning capacity, as delineated in Section 8.1(b)(i) through (iv) of the Act, nor can any effect be reasonably inferred from the evidence. Regarding Section 8.1(b)(v), the petitioner complains of pain and swelling in her right knee and difficulty with using stairs. She has good and bad days and uses medication.

The respondent shall pay the petitioner the sum of $484.20/week for a further period of 43 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 20% loss of use of her right leg.

FINDING REGARDING PENALTIES AND FEES:

The petitioner failed to prove that she is entitled to §19(l) and §19(k) penalties and fees. There was a genuine dispute regarding the issues. The petitioner's request for penalties and fees is denied.

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

Alicia Garcia Zavedra,

Petitioner,

vs.

NO: 14WC002764

John B. Sanfilippo & Sons, Inc.,

Respondent,

16IWCC0728

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 2, 2016, is hereby affirmed and adopted.

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

16IWCC0728

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 9 - 2016
MJB/bm
o-9/12/16
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

ZAVEDRA, ALICIA GARCIA
Employee/Petitioner

Case# **14WC002764**

JOHN B SANFILIPPO & SONS INC
Employer/Respondent

16IWCC0728

On 2/2/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.46% 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:

2932 KUGIA AND FORTE PC
MARTIN V KUGIA
711 W MAIN ST
WEST DUNDEE, IL 60118

1505 SLAVIN AND SLAVIN LLC
DAVID VanOVERLOOP
100 N LASALLE ST 25TH FL
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Alicia Garcia Zavedra
Employee/Petitioner

v.

John B. Sanfilippo & Sons, Inc
Employer/Respondent

Case # 14 WC 2764

Consolidated cases: N/A

16IWCC0728

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Jessica Hegarty, Arbitrator of the Commission, in the city of GENEVA, on 9/10/15. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. X 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, **10/9/13**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$28,759.12**; the average weekly wage was **$553.06**.

On the date of accident, Petitioner was **62** 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 $ **21,385.18** for TTD, $0 for TPD, $0 for maintenance, and **$1,244** for other benefits, for a total credit of $ **22,629.18**.

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

ORDER

1. **THE RESPONDENT IS ORDERED TO AUTHORIZE, APPROVE AND PAY FOR THE PETITIONER'S RIGHT SHOULDER ARTHROSCOPY, AS PRESCRIBED BY DR. LEVI, PURSUANT TO SECTION 8(A) OF THE ACT.**

2. **RESPONDENT IS ORDERED TO PAY TTD AT THE RATE OF $368.71 FOR THE PERIOD OF 2/7/14 THROUGH 9/10/15, A PERIOD OF 82 AND 6/7 WEEKS.**

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.

Jessica C. Hogarty

Signature of Arbitrator

1/29/16

Date

ICArbDec19(b)

FEB 2 - 2016

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ALICIA GARCIA ZAVEDRA,
Employee/Petitioner,

v.

JOHN B. SANFILIPPIO & SONS, INC.
Employer/Respondent.

Case No. 14 WC 2764

16IWCC0728

ADDENDUM TO THE DECISION OF THE ARBITRATOR

On September 10, 2015, this matter was heard by Arbitrator Jessica A. Hegarty in Geneva, Illinois.

The issues in dispute are:

- Accident
- Causal Connection
- TTD
- Prospective Medical Treatment. (Arb. 1).

The parties agreed to reserve ruling with respect to all issues related to medical bills for determination at a later date. (Id., TX. 5)

Petitioner was granted leave to amend the date of accident from November 21, 2013 to October 9, 2013 on the Application for Adjustment of Claim (Application for Benefits). Respondent had no objection. (Id. at 7)

Petitioner testified at the hearing through an interpreter. (Id. at 9)

FACTS OF THE CASE

Petitioner's Testimony

Petitioner, Alicia Garcia-Zavedra, was employed by Respondent, John B. Sanfilippo & Sons, Inc., on October 9, 2013 as a cleaning person. (Id. at12) Petitioner is 65 years old and 5'3" tall. (Id. at 10)

Petitioner worked from 6 am to 4:30 pm cleaning various areas in the Sanfilippo facility which was comprised of a store, a factory and a shipping area. (Id. at 13)

Petitioner testified she began each work day by her filling her cleaning cart with supplies. She then proceeded to the store area of the facility where she was required to clean the windows, sweep the floors, clean two bathrooms as well as the store offices. (Id.)

Cleaning the bathrooms consisted of cleaning the mirrors, the walls, the sinks and the toilets, as well as sweeping and mopping the floors. (Id. at 14) In order to clean the bathroom mirrors, she had to climb onto a sink and reach with her right hand, over her head, to spray windex on the mirror and wipe it. (Id. at 14-15) There were two toilets in each bathroom that she cleaned using her right arm to scrub. (Id.) She cleaned the bathroom floors by lifting a 20 pound bucket of water off the cart (that was knee-high to her body) and carrying it a short distance to the bathroom. (Id. at 16-17) She used a 5 or 6 pound mop to mop the floors. (Id. at 15) In addition to her bathroom tasks, she emptied the bathroom garbage cans and dumped them into a larger bag. (Id. at 18-19)

The store offices required cleaning the windows and taking out the garbage. (Id. at 23) There were four windows in each office, the top of each, was higher than Petitioner's head. (Id. at 24) Petitioner testified she stood on her tip toes, reached over her head with her right hand and wiped the windows with paper towels. (Id.)

Petitioner testified she also cleaned the office doors which were made of glass. (Id. at 25) She used a stepstool and stretched her arms as far as she could to wipe the doors with windex. (Id.) According to her testimony, Respondent also had her clean the air vents in the offices which were located close to the ceiling. (Id.) To enable this task, she would reach up with her arms over her head and stretch her arms all the way up with a duster to clean them. (Id. at 25-26) Besides the windows, doors, and air vents, Petitioner also had to sweep and mop the floors in each office. (Id. at 26)

In addition to the store bathrooms and offices, the Petitioner also had to clean the store itself. (Id.) She testified that there were 7 or 8 windows in the entire store. (Id. at 27) First, she dusted the windows by reaching over her head with a cloth and then washed the windows by reaching over head in the same manner that she washed the office windows. (Id. at 27-28) The Petitioner testified that when she was finished cleaning the store, she would carry large trash bags, weighing 40 pounds, to the trash container outside. (Id. at 28) She would throw the garbage bags into the container with her hands by stretching her arms out above her head and tossing them in. (Id.) She testified that each day she would throw out as many as 4 garbage bags from the store. (Id. at 29)

When she finished cleaning the store she would start cleaning the factory area. (Id.) There were 13 or 14 bathrooms in the factory. (Id.) There were up to 2, large mirrors in each bathroom that she cleaned by getting on her tip toes and reaching over her head in the same manner that she washed the other mirrors.

Petitioner testified that she also cleaned the factory bathroom walls which required her to reach over her head with a "fiber" to scrub. (Id. at 31- 32). She would spend

about an hour scrubbing the walls. (Id. at 32). She testified that she would scrub the walls using her hand, not a broomstick. (Id. 32). She was also required to clean 3 toilets in each of the factory bathrooms. (Id. at 31)

Petitioner also cleaned the 5 factory offices. Each office had four windows which required the same type of over-head cleaning as Petitioner described earlier. (Id. 33, 34). She testified that her boss would also tell her to clean the doors in the office. (Id.33). The factory office doors were not made of glass so she would clean those with a different solution. This task also involved reaching over her head. (Id. 34). She testified that she also had to reach over her head to clean the air vents on the ceiling in the factory offices. (Id.) She also mopped the office floors. (Id. 34).

The Petitioner next cleaned 2 rubber rugs located at the entrance floor every day. (Id. at 35) She estimated the rugs weighed 30 pounds. (Id. 36). She testified that she had to bend over and stretch out her arms to fold the rugs. (Id. 36).

According to her testimony, she also had to clean 3 hand washing sinks in the factory located near the entryway. (Id. at 37) The sinks were waist high and she would have to reach with her arms extended to scrub the inside of the sinks. (Id. 37, 39).

Petitioner testified that she was also required to clean a wall [near the entryway]. She would use a broom stick to enable this task, stand on her tippy toes and reach with her hands above her head to scrub the wall. (R. 38). When she was done scrubbing, she would throw water onto the wall. She would spend about an hour scrubbing the wall. (Id. 38).

In addition to the factory and the store, the Petitioner testified that she had to clean the bathrooms and the offices in the shipping area. (Id. at 40.) There were 4 bathrooms and 4 offices in the shipping area which she cleaned in the same manner as the other bathrooms and offices. (Id.).

The Petitioner testified that in the afternoons "they would have me clean the machines or walls or throw away the garbage – the whole factory's garbage." (Id. at 41) She testified that the machines were "pretty big...very high up...[v]ery tall...[a]bove my head". (Id. 42). In order to clean the machines, she would fill a bucket with soapy water and use a "spatula" to scrub the machines. (Id. 42). She testified that the machines were very dirty and she had to apply a lot of pressure with the spatula to scrape off the grease. (Id. 42). She had to reach with the spatula above her head to scrub the machines. She estimated that she would typically spend between 2 to 4 hours working with the spatula over her head scrubbing the machines (Id. 43).

In mid-October, 2013 the Respondent switched her job duties after she brought in a note with restrictions from her doctor. (Id. at 55, 56). At that time she was given a job assembling boxes. She testified that she would retrieve boxes that were stacked on a pallet above her head, standing on her tip toes. (Id. at 56). She would

then assemble the boxes on a waist high table. She testified that she would reach over her head for a box more than 60 times in a shift. (Id. at 60)

On cross exam, Petitioner agreed that she has the broom and brush that she uses to clean the [entrance] walls "available" to her in her cart, when she cleans the bathrooms. (Id. at 84) She agreed that she performed the same cleaning tasks every morning, throughout her work week. (Id. at 85) In the afternoon, she had different job tasks, day-to-day, depending on what was needed at the company. (Id.) She agreed she did not clean the walls and machines every afternoon, "some days they would ask us. Some days they wouldn't". (Id. at 85-86) When asked the total number of bathrooms at Respondent's facility, she estimated 15-16, all of which she was responsible for cleaning on a daily basis. (Id. at 86-87) She further testified that there were 8 offices in the facility that she cleaned every day of her workweek. (Id. at 86-87)

Petitioner testified on cross that Respondent's facility is the biggest in Elgin. She agreed that spent a significant part of her morning walking between the different bathrooms and offices she was cleaning. (Id. 87-88)

Petitioner next identified her signature contained in Respondent's Exhibit 1 (IWCC Application for Adjustment of claim) listing a date of accident as November 21, 2013. (Id. at 91) Petitioner testified that she understood that the document initiates a worker's compensation claim in Illinois and further agreed that it is her belief and understanding that her right shoulder injury occurred on November 21, 2013. (Id. at 93)

On re-direct, Petitioner testified that with respect to cleaning the bathrooms, "the walls and the doors and the mirrors" took the longest to clean. (Id. at 94) When asked by her attorney why she did not utilize the broom stick to clean the bathroom walls and mirrors, Petitioner replied that there was fecal matter on the walls "and sometimes even on the doors" which required her to [scrub] "really, really hard with the broom". (Id). When asked why she did not use the broom stick to clean the bathroom mirrors, Petitioner replied, "How am I supposed to scrub a mirror with a broom? You don't scrub mirrors. I was on my tippy toes with that." (Id. at 94-95)

Petitioner further testified on re-direct that every afternoon workday she either had to clean the walls or the machines, "one or the other". (Id. at 96) She also testified that prior to the onset of her shoulder pain in "October" she did not have any shoulder pain. (Id.)

After Petitioner's testimony, Petitioner rested his case subject to the admission of exhibits.

Phillip Shiavone

The Respondent called Phillip Schiavone who has been employed by the Respondent for 8-9 years as the Sanitation Supervisor. (Id. at 98-99) He is in

charge of overseeing the sanitation personnel which included Petitioner in October and November of 2013. (Id. at 99-100) Mr. Shiavone testified that Respondent's facility is located in Elgin and is approximately 1.1 million square feet in size: "100,000 square feet are office and one million square feet are plant." (Id. at 98)

Mr. Schiavone testified that as a level 1 janitorial employee, Petitioner was required to clean bathrooms and the outlet store at the facility. Level 1 janitorial employees also clean the hand wash sinks and perform mopping jobs throughout the day, as well as cleaning windows and walls. (TX, 101) A level 1 janitorial employee would typically spend a total of 3 hours a day, cleaning all of the bathrooms at the facility. Mr. Schiavone described the tasks of cleaning the bathrooms as sweeping the floor, checking the toilet paper, checking the soap, cleaning mirrors, cleaning the sink and counter, cleaning the toilets and mopping. (TX, 102)

Mr. Schiavone testified that the walls in the bathrooms were standard eight foot walls, and that level 1 janitorial personnel are provided with a 51" stick with a brush on it to clean the walls. (TX, 104) Mr. Schiavone testified that the employees were not cleaning the tops of the walls, but only cleaned about 4 feet down where the walls were dirty from people putting hands or feet on the wall. (Id.). Anything located overhead level is cleaned maybe once a month on a "spot check" basis. (Id.) Mr. Schiavone testified that he was 5'5", and that only 2% of the tasks required to clean a bathroom would require working at or above shoulder level, and such tasks were essentially limited to "spot checking". (TX, 106)

Petitioner's duties in cleaning the store area required her to clean the bathrooms, as well as sweep and mop. (TX, 105) Regarding the store offices, Mr. Schiavone testified that the ceiling vents were not cleaned any more than once a month, and that specific task was rotated on a weekly basis between different scheduled level 1 janitorial employees. Mr. Schiavone testified that cleaning doors is not part of the cleaning tasks of a level 1 janitorial employee, and they at most may wipe down a door handle. Mr. Schiavone also testified that the windows in the store were not cleaned daily, but only on a weekly basis.

Mr. Schiavone described the task of cleaning the hand wash sink as removing the rugs in front of the sink, washing the sink, checking and refilling the soap, washing and sanitizing the hand driers, and performing a final sweep and mop. Mr. Schiavone testified that the sinks the level 1 janitorial personnel were required to wash were at his waist level. Mr. Schiavone further testified that in cleaning the hand wash sink area, none of the tasks required use of arms above his shoulder level. (Id. at 105)

According to Mr. Schiavone, the size of the facility required level 1 janitorial employees to spend a significant amount of time walking between different areas: "I would say 20 to 25 percent of the time is actually physically walking from area to area getting ready to do your job". (Id. at 107)

Mr. Schiavone testified that he would have been notified if a level 1 janitorial employee reported any injury. He further testified that Petitioner engaged in the job duties of level 1 janitorial employee up to October 23, 2013, and during that time she never made any reports of injury. (Id. at 108-109)

Mr. Schiavone testified that Petitioner was taken off of janitorial duties after October 23, 2013 due to a hip and knee problem, and moved to light duty work assembling boxes. (TX, 110)

He described the box assembly as occurring at a waist high table with stools available for individuals if they needed to sit. (Id. at 111) The unassembled boxes are delivered to the table on pallets set on the ground with stacks of unassembled boxes stacked up four feet high. (Id. at 112) The employees would take stacks of the unassembled boxes to the table, assemble the boxes, then move them to a separate table for the packers. (Id.). Mr. Schiavone testified that the job tasks of box assembly did not require any over the shoulder activity, and that box assemblers would make about 400 per shift. (Id. at 113)

On cross exam, Mr. Schiavone admitted that the bathroom mirrors are not to be cleaned with a stick. (Id. at 115) Regarding the ceiling air vents, Mr. Shiavone testified that the workers were "supposed" to clean them on a weekly basis but "If I can get them to do it more than once a month, it would be a miracle." (Id. at 115-116)

Mr. Schiavone testified that the doors in the store offices are made of metal, not glass, and the workers were not required to clean them. (Id. at 116). He agreed that Petitioner's duties "probably" included washing the store windows on a weekly basis. (Id. 118) He testified that if the walls in the bathroom, higher than 4 feet, were dirty, he would expect Petitioner to clean them. (Id. at 119) He did not inspect the bathrooms before they were cleaned. (Id.). He inspected the bathrooms every other day after they were cleaned as part of a "finish inspection". (Id.). Mr. Schiavone also agreed that after Petitioner's morning cleaning duties, she would work on the machines or walls in the afternoon, and he did not refute that she had to reach overhead to clean the machines. (R. 122).

Mr. Shiavone agreed that Petitioner was one of the better workers. (R 116).

With respect to the box assembly job, Mr. Schiavone agreed that the Petitioner had to retrieve boxes from a pallet and assemble them. He testified that the boxes were stacked four feet high. (R. 112).

Injuries and Medical Treatment:

On October 9, 2013, Petitioner presented to Dr. Victor Colon of Elgin Family Physicians West with complaints of pain in the back of her legs radiating down behind the knees and down her calves. She further described upper and lower back pain as well as her shoulders and arms. Dr. Colin noted that she worked in housekeeping and that reaching above over her head and squatting down causes

her to have pain especially at the end of the day. He diagnosed Petitioner with hypothyroidism and arthalgias, noting he discussed with the patient possibilities including arthritis vs. muscular vs. overuse. (PX1)

The Petitioner testified that Dr. Colin gave her a note which she gave to Jose Dellatore in Human Resources. (TX. 54).

She continued working and was seen by Dr. Colin on October 23, 2013 for foot pain and pain in her right lower extremities. Mr. Schiavone testified that the Petitioner brought in a note from her doctor that day. He had no recollection as to what medical condition she was complaining of that day. (Id. at 109). Both the Petitioner and Mr. Schiavone agreed that at some point in mid-October the Respondent changed her duties from housekeeping to the box assembly job. (Id. at 55, 110).

The Petitioner was seen by Dr. Colin again on November 20, 2013. The records indicate she was being seen for right arm pain and leg pain which was better. She reported that she was working lite duty and not walking as much. Dr. Colin diagnosed osteoarthritis. (PX1)

The Petitioner testified that after working with the boxes her right arm pain worsened. (TX at 61). She reported her pain to her supervisor, Jose Dellatore, who sent her the same day in a cab to the Company Clinic, Physicians Immediate Care. (Id. at 62).

The records from Physicians Immediate Care indicate that she was seen there for the first time on November 22, 2013. (PX2). The records indicate that the Petitioner gave a history of pain in her right arm from her shoulder to her waist. She stated she was unable to raise her right arm and has throbbing pain. She stated that she had pain previously, but that it was aggravated after building boxes yesterday at work, at which time she noticed a significant increase in the pain and weakness of her right shoulder. (Id.) The record states that she has had no similar problems in the past, and that she denies any non-work related event or illness that could have contributed to the symptoms. (Id.) The physical exam noted weakness in the right shoulder, reduced right shoulder range of motion, right acromioclavicular joint tenderness, and tenderness in the rotator cuff. (Id.) The doctor diagnosed a right rotator cuff strain, ordered an MRI of the right shoulder, and prescribed pain medication. Regarding causation, the doctor stated that it was a work related condition. (Id.)

On December 11, 2013 the Petitioner returned to Dr. Colin who noted her complaints of knots in her arm and her inability to lift up her right shoulder. (PX1) His exam noted decreased range of motion in her right arm due to pain, and edema over the mid-upper bicep and triceps. He diagnosed arthralgias and osteoarthritis and continued her pain medications. (Id.)

A right shoulder MRI was performed on January 3, 2013 which revealed infraspinatus tendinopathy, supraspinatus tendinopathy and moderate partial undersurface tear. (Id.)

On January 7, 2014, Petitioner presented to Dr. Colin who noted a history of ongoing right shoulder and upper back pain. (Id.) The doctor reviewed the MRI results and examined Petitioner noting reduced range of motion and tenderness in her right shoulder. Dr. Colin noted that the treatment options were surgery or physical therapy and he suggested she first proceed with physical therapy. Petitioner was seen the next day, January 8, 2014, at Physicians Immediate Care where the doctor noted complaints of increased shoulder pain with overhead lifting. The doctor noted that the pain started at work, that she has no non-work related events that have contributed to her pain, and that she had no similar problems in the past. The doctor gave her a right shoulder injection and agreed she should proceed with physical therapy. On January 15, 2014 she returned to Physicians Immediate Care. The doctor noted that she had 50% improvement after the injection. She noted that her shoulder pain had improved but that she continued to have burning in her elbow. (Id.)

The Petitioner was evaluated by Dr. Levi, an orthopedic surgeon, on February 7, 2014 who noted a history of right shoulder pain and right elbow pain beginning in October 2013. (PX3). Petitioner also reported right elbow and bilateral knee pain. Dr. Levi's exam demonstrated positive impingement maneuver on the right shoulder, positive across the chest maneuver and pain with abduction and both internal and external rotation. (Id.) Dr. Levi's impression was that she had at least a partial rotator cuff tear of the right shoulder, lateral epicondylitis of the right elbow and osteoarthritis of her right knee. He opined that with respect to the right shoulder and elbow: "It is evident of the fact that she was working for four years doing the same work of cleaning with the right arm. It is what produced the symptoms." Dr. Levi prescribed physical therapy, a TENS unit and off work restrictions. (Id.) The Petitioner testified that following that visit with Dr. Levi she went off work and has not worked for the Respondent since February 7, 2014. (TX. 64).

The records from ATI Physical Therapy indicate that Petitioner began physical therapy for her right shoulder on February 13, 2014. (PX4). The Petitioner testified that she did physical therapy at ATI through June of 2014 (TX. 65, 67).

Petitioner continued to see Dr. Levi who performed additional right shoulder injections on April 11, 2014 and July 7, 2014. (PX3) Dr. Levi also ordered a right shoulder arthrogram and CT which was completed on April 16, 2014. (Id.) The test showed a slightly irregular anterior glenoid labrum. (Id.) A tear could not be excluded. A slight irregularity of the distal supraspinatus tendon, and hypertrophic spurring in the AC joint with probable impingement was also noted. Due to her ongoing pain and the failure of conservative treatment to relieve her symptoms, Dr. Levi recommended right shoulder arthroscopic surgery. (Id.)

Dr. Levi has kept the Petitioner off work and has been waiting for approval for the right shoulder surgery since July 7, 2014. His most recent visit with the Petitioner prior to trial was July 29, 2015 at which time he reiterated that he is awaiting approval from workers' compensation for the right shoulder surgery and recorded her ongoing complaints of right shoulder pain.

On March 17, 2014, Petitioner presented to Dr. Aaron Bare for an IME at Respondent's request. Dr. Bare then issued two reports, and later testified via evidence deposition. (RX2) Dr. Bare is an orthopedic surgeon who specializes in shoulder and knee problems. (Id. at 5) In his report dated March 17, 2014, Dr. Bare noted a history of the onset of right shoulder pain after cleaning walls for the Respondent, worsening after she was assembling boxes. (RX2, attached as Respondent's deposition Ex. 2) The doctor reviewed the right shoulder MRI and examined Petitioner. He diagnosed her with a partial thickness rotator cuff tear, and agreed that she needed physical therapy. He stated that her job activity did not cause the rotator cuff tear, but that they "aggravated a pre-existing problem." (Id.). Dr. Bare further stated that "[d]ue to the fact that she denies any previous problems, treatments, or injuries to her shoulder, causation likely exists linking her current condition today to her work aggravation." Dr. Bare believed she would not require surgery but did believe light duty restrictions were appropriate. He suggested that if her symptoms continue, she might benefit from an injection or a repeat MRI to obtain a clear picture of the rotator cuff. (Id.)

The Respondent took the evidence deposition of Dr. Bare on May 13, 2015. (RX2). Approximately eight weeks prior to the deposition, The Respondent sent a letter to Dr. Bare for his review. The letter is attached as Petitioner's Exhibit 1 to Dr. Bare's deposition. The letter summarizes the additional treatment that the Petitioner had since Dr. Bare's first exam, including the injections and the subsequent CT and MRI arthrogram. The letter also contains new information about what the Respondent alleges the Petitioner's job duties were. The letter alleges that the Petitioner had pain in her shoulder for years that the Petitioner was not engaged in cleaning activities when her pain began, that she did not have to reach overhead on the box assembly job, and that the majority of her job duties while cleaning were not overhead.

At his evidence deposition, Dr. Bare testified that Petitioner may have suffered a temporary aggravation of a pre-existing condition, but that any ongoing right rotator cuff condition or need for surgery was unrelated to Petitioner's work for Respondent. (RX2 at 14) He believed that the MRI showed some degenerative fraying or partial-thickness tearing of the rotator cuff, and that there was no evidence of any traumatic event or incident causing the tear. (Id. at 10) He testified that partial-thickness degenerative tearing is an attritional phenomenon present in a high number of individuals over the age of 50 or 60, and Petitioner's history of events corroborated his opinion that the findings of the MRI were a pre-existing problem. (Id. at 11) According to his testimony, an individual with a pre-existing partial-thickness rotator cuff tear whose job does not require heavy-lifting duties above the head, shoulder or chest level, the work is unlikely to cause a permanent aggravation of the pre-existing tear. (Id. at 14)

The doctor testified on cross that "an individual with a rotator cuff tear that I think is pre-existing, that any type of activity can cause an aggravation." (Id.) He testified that the letter sent by Respondent provided more information about Petitioner's job duties related to a lack of overhead work and that "due to the fact that she did no heavy lifting, she didn't hardly ever lift above her waist level, the boxes were small, I don't think there is any substantial inciting event that could have caused a long-standing aggravation to her problem." (Id. at 18-19) He further testified that Petitioner may have suffered a temporary aggravation by "tweaking" her shoulder, but that any activity of daily living, even as small as picking up a piece of paper, could cause such a temporary aggravation. (Id. at 19)

The doctor agreed that if Petitioner's symptoms began while washing walls at work, then he could consider Petitioner's work to be a causative factor. He also testified that based on the updated information that he was provided, surgery is a potential need for her right shoulder. (Id. at 23).

The Petitioner was sent by her attorney for an independent medical exam with Dr. Anthony Cummins, an orthopedic surgeon at Lake Cook Orthopedic who evaluated her on August 12, 2014. (PX5) He testified in his evidence deposition that she gave a history of ongoing right shoulder pain and difficulty reaching overhead which began after she was cleaning walls and assembling boxes at work. (Id. at 6). On exam he noted tenderness in the shoulder region around the sub-acromial space, a positive impingement sign, a positive O'Brien's test and decreased range of motion. (Id. at 9). Dr. Cummins also reviewed the MRI. His diagnosis was a partial rotator cuff tear. Dr. Cummins reviewed her medical records from Dr. Levi and the report from Dr. Bare. Dr. Cummins testified that her temporary relief following the injection in her shoulder confirmed the diagnoses, and that her treatment had been appropriate to date. Dr. Cummins testified that he agreed with the treating doctor, Dr. Levi, that she should undergo surgery to repair her shoulder. (Id. at 13.) Dr. Cummins testified that if Petitioner's job duties required her to reach overhead to wash mirrors, windows, and walls and if she used a brush on a broomstick to reach over head to wash walls, then it was his opinion that those job duties were a causative factor in her condition and need for surgery given the Petitioner's history and exam findings,. (Id. at 14-15).

The Petitioner testified that she continues to have pain in her right shoulder equivalent to a 9 out of 10 point scale. (R. 69). She wants to have the surgery to her right shoulder.

CONCLUSIONS OF LAW:

With respect to issues (C), did an accident occur that arose out of and in the course of employment, and (F), whether the Petitioner's current condition of ill being in her shoulder is causally related to the work accident, the Arbitrator finds the following:

Petitioner described seven different cleaning tasks that required her to lift her arm over her head: cleaning the mirrors, the windows, the doors, the walls, the

machines, the air vent on the ceiling, and throwing out the garbage bags. The Petitioner's specificity, including her explanation of how she climbed onto the sinks, used step stools, scraped the machines with a spatula, and her frequent reference that she had to get on her "tippy toes" to reach many of the areas, lends credibility to her testimony.

Mr. Schiavone's testimony was less specific. Notwithstanding the fact that he admitted that the Petitioner was one of the better workers (R. 116), most of his testimony was about the tasks required of Level 1 janitors in general, not the Petitioner specifically. When Mr. Schiavone described the job requirements on direct, he did not mention that they had to clean the vents on the ceiling; however, he admitted that the vents did need to be cleaned during cross examination. (R. 115). He admitted that the Petitioner had to clean the machines and did not dispute that the task required her to reach over her head with a spatula to scrape them. He did not dispute that she had to throw the garbage bags over her shoulder to dispose of them. He did not dispute that she had to reach over her head to clean the mirrors in all the bathrooms.

Other parts of Mr. Schiavone's testimony were vague with respect to the duties of a cleaning person working for Respondent. He testified that the job required cleaning the door handles on the bathrooms, but not the door handles on the offices. (R. 117). He claimed that the workers were not expected to clean the doors to the offices, contrary to the Petitioner's specific testimony, notwithstanding the fact that he stated they were expected to clean everything that was dirty (R. 104, 119). Mr. Schiavone suggested that the walls in the factory and bathrooms do not get dirty over four feet high, but later admitted that he only inspected the bathrooms every other day and he only did so after they had been cleaned (R. 119). As such, he would have no way of ascertaining how dirty the walls or other areas of the bathrooms became before they were cleaned. When he was asked if he ever inspected the bathrooms in their dirty state he replied: "I am not that kind of supervisor." (R. 119).

The Arbitrator finds that the Petitioner's description of her job duties is credible, and that she did have to reach over her head on a regular and frequent basis while cleaning the factory and when she assembled boxes.

The parties agree that the Petitioner did not transfer out of her cleaning job to the box assembly job until mid-October, after she brought in a note from her doctor. The records of Dr. Colin confirm that she was seen there on October 9, 2013 with complaints of pain in both her shoulders, among other things, and that she attributed her pain to lifting over her head doing her housekeeping duties at work. This is this consistent with her testimony about her job duties, and her testimony regarding the onset of shoulder pain during the performance of her housekeeping duties, before she was transferred to the box assembly job. This is also consistent with her first visit to Dr. Levi wherein she states that her shoulder pain began in October 2013 from cleaning with her arms at or above shoulder level. The records from Physicians Immediate Care dated November 22, 2013, where she was sent by the Respondent after she complained of increased pain assembling boxes, states

that her shoulder pain had actually began previously and was "aggravated" when she started lifting boxes at work. All of the foregoing indicates that her overhead housekeeping duties contributed to the onset of her shoulder pain, which was made worse when she began the box assembly job.

The onset of her shoulder pain prior to her October 9, 2013 visit, at a time when she was still performing her housekeeping duties, is contrary to the information provided to Dr. Bare prior to his deposition. In the letter that the Respondent sent to Dr. Bare, the Respondent claimed that she did not have pain in her right shoulder until after she started the box assembly job. Furthermore, the letter also erroneously states that she did not have to reach overhead while performing her job duties. The letter states that she only had to clean mirrors, walls or windows once per day, contrary to the Petitioner's testimony that she cleaned the bathrooms daily. Moreover, the letter fails to mention her need to clean the machines, take out the garbage and clean the ceiling vents. The letter states that "[u]se of a broomstick allowed her to complete the cleaning without extending her arms over her shoulder, as the tops of the mirrors she was cleaning were approximately six feet from the floor.

There is no dispute that the Petitioner did not use the broomstick to clean the mirrors. Mr. Schiavone agreed that she would use a window cleaner and a hand towel to complete that task. It is counterintuitive to imagine someone using a broom stick to reach areas over one's head with raising her arms to at least shoulder level. Notwithstanding the letter, Dr. Bare testified that if the Petitioner's history is correct, then her job duties are a causative factor in her condition. (RX2, at 18, 20, 21, 24, 32).

Causation is also supported by the testimony of Dr. Cummins, and the records of Dr. Levi. The hypothetical posed to Dr. Cummins is consistent with the Petitioner's credible testimony of her job duties. Dr. Cummins testified that it is his medical opinion, based upon a reasonable degree of medical and surgical certainty, that her work activities caused the shoulder pain she is experiencing. (PX5 , page 15). Dr. Levi states in his records that "It is evident of the fact that she was working for four years doing the same work of cleaning with the right arm. It is what produced the symptoms." He has requested that workers' compensation authorize the surgery from the beginning.

There is no evidence that the Petitioner had any non-work related causes of her pain. While the records from Physicians Immediate Care contain somewhat contradictory comments (they state she has "no similar problems in the past" and that "she has had pain in her right shoulder for years"), no records were discovered that would indicate prior pain complaints.

Based on the above mentioned facts and the records as a whole, the Arbitrator finds that the Petitioner suffered an accident that arose out of and in the course of her employment with the Respondent, and that her current condition of ill being in her shoulder is causally related to her job duties for the Respondent.

With respect to issues (K), is the Petitioner entitled to any prospective medical care, the Arbitrator finds the following:

The Petitioner has attempted conservative measures to cure her condition, including physical therapy, medications, injections and activity modification. She continues to have severe right shoulder pain and desires the surgery. Dr. Levi and Dr. Cummins agree that she needs right shoulder surgery. Dr. Bare stated on direct exam that, after learning of her updated treatment subsequent to his initial report, he has no opinion as to whether she needs surgery or not as of the date of his deposition. However, he admitted in cross examination that he thinks surgery is a potential need (RX2, page 23).

For the foregoing reasons the Arbitrator finds that the arthroscopic surgery recommended by Dr. Levi is medically necessary and orders the Respondent to authorize and pay for same and its related treatment.

With respect to issues (L) what TTD benefits are owed, the Arbitrator finds the following:

The Petitioner testified that she has not worked since Dr. Levi took her off work on February 7, 2014. The records of Dr. Levi indicate that he has kept her off work since then as he awaits approval for her surgery. Consequently, the Arbitrator awards TTD from February 8, 2014 through September 9, 2015, the date of trial.

With respect to issues (O), Prospective medical:

Petitioner asserts that the Arbitrator should find that the "knee surgery" prescribed by Dr. Levy and Dr. is "medically necessary" and should therefore order the Respondent to authorize and pay for same.

Petitioner's testimony at the hearing was focused on overhead work activities with respect to her right shoulder condition. Petitioner has offered insufficient evidence with respect to how her job duties related to any alleged knee condition. Accordingly, The Arbitrator declines to make such a finding as there is insufficient evidence contained in the record that would support such an award.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL WAGNER,

Petitioner,

vs. NO: 14 WC 34318

FN SMITH,

Respondent.

16IWCC0729

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 average weekly wage (AWW), causal connection, medical, prospective medical, and temporary total disability (TTD), and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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).

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

After examining the record and wage statement, the Commission finds that Michael Wagner failed to prove that his overtime hours were mandatory. Wagner was never questioned regarding his overtime hours and whether they were mandatory. Rather, Wagner was handed the

wage statement and asked to "quickly leaf through the pages...and confirm that that appears to be information about the wages that you'd earned the year before the injury." Wagner responded "yes." No other testimony was offered regarding his hours worked.

The Commission examined the wage statement and notes that Wagner worked overtime. Wagner, however, did not work overtime every week and the hours of overtime varied when worked.

There is no evidence or testimony establishing that Wagner's overtime hours were a condition of his employment, were a part of his regular work schedule, or that he consistently worked a set number of overtime hours each week.

Accordingly, the Commission finds that the overtime hours are to be excluded from his AWW. Per the wage statement, Wagner worked 1,879 hours earning $17.19 per hour during the 52 weeks preceding his injury. His gross earnings were $32,300.01, resulting in an AWW of $621.16 and a TTD rate of $414.11.

The Commission, therefore, modifies the AWW from $870.74 to $621.16 and the TTD rate from $580.49 to $414.11. Respondent is entitled to a credit for any resultant TTD overpayment. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 26, 2015 is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $414.11 per week for a period of 65-2/7 weeks, March 17, 2014 through May 4, 2014 and July 18, 2014 through August 31, 2015, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $9,027.12 for medical expenses under §8(a) of the Act, and subject to the medical fee schedule.

IT IS FURHER ORDERED BY THE COMMISSION that Respondent authorize and approve prospective medical treatment with an orthopedic of Petitioner's choosing and any additional treatment recommended by the treating doctors.

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 $23,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 9 - 2016

MJB/tdm
O: 9/12/16
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

WAGNER, MIKE
Employee/Petitioner

Case# **14WC034318**

FN SMITH
Employer/Respondent

16IWCC0729

On 10/26/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

5074 QUINTAIROS PRIETO WOODS ET AL
IAN FULLER
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Lake)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Mike Wagner
Employee/Petitioner

v.

FN Smith
Employer/Respondent

Case # **14** WC **34318**

Consolidated cases:

16IWCC0729

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Waukegan**, on **August 31, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **1/31/2014**, 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 $**45,278.46**; the average weekly wage was $**870.74**.

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

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

Respondent shall be given a credit of $**12,233.52** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**12,233.52**.

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

ORDER

Arbitrator orders Respondent to pay to Petitioner TTD benefits from March 17, 2014 to May 4, 2014 and from July 18, 2014 to August 31, 2015 for a total of 65 2/7 weeks at a weekly rate of $580.49 for a total of $37,897.70. Respondent is entitled to a credit for $12,233.52 already paid leaving a balance owed of $25,664.18. The Respondent shall pay the TTD to the Petitioner and his attorney per Rule 7080.20.

Arbitrator orders Respondent to pay to Petitioner ongoing TTD benefits until such time as he is no longer entitled to benefits under Section 8(b).

Arbitrator orders Respondent to approve and pay for prospective medical treatment with an orthopedic of Petitioner's choosing and any additional treatment recommended by the treating doctors.

Arbitrator orders Respondent to pay to Petitioner & his attorneys Jones and Black unpaid medical bills of $9,027.12 subject to the fee schedule.

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.

George J. Andros #01

Signature of Arbitrator

Oct. 22, 15

ICArbDec19(b)

OCT 26 2015

STATEMENT OF FACTS 14 WC 34318

This case was tried before the undersigned, Arbitrator Andros, on August 31, 2015. The issues in dispute were: accident, causal connection, average weekly wage, medical bills, temporary total disability benefits after November 15, 2014, and entitlement to penalties.

Petitioner testified that on January 31, 2014, he was employed with the Respondent as a machinist. He had worked for the employer for approximately eight years. FN Smith is a custom precision machine shop and the petitioner was a journeyman machinist. During the third week of January 2014, Petitioner was working on the Landis OD Grinder. The grinder had retrofitted custom doors that were 6 feet tall by 8 feet long and made of solid steel. Each door weighed around 300 pounds. While trying to load a hundred pound solid steel pole, the petitioner had to open the doors of the machine. He demonstrated how he would open the doors. With his arms at chest level, grasping the handles at the level above the solar plexus, Petitioner pulled the doors apart by pulling his hands apart from each other to slide the doors open in a "fly" weight lifting motion. Petitioner testified that he felt pain in his left shoulder and neck while doing this maneuver. He reported it to his supervisor Bill Smith and continued to carry out his work for the rest of the day. (emphasis added)

Because the symptoms did not entirely go away, Bill Smith and the petitioner's supervisor Joe Stevens asked him to move to the surface grinder machine. He ran this machine for approximately four days. On January 31, 2014 he was working the surface grinder machine. He had to take metal totes with 100-150 metal parts and move them onto a cart to be transported to the shipping and receiving department. These parts had already been machined by the second shift but had not yet been delivered to shipping and receiving. Joe Stevens asked Petitioner to move these parts prior to running new ones. Each tote was approximately 18" x 1' in length x 1' deep. He demonstrated grasping the metal tote in the front and the back of the tote by reaching his left arm over the tote and grabbing the rear handle while his right hand grasped the front handle. The bench the tote sat on was approximately chest level. Petitioner reached out his arms at chest level, grasped the tote, lifted it up above the solar plexus level, twisted to the left and loaded the tote onto the cart. Petitioner testified that while doing this, he felt a pop and tear in his left shoulder with pain shooting up into his neck. He tried to continue to finish the job, but he couldn't because he could not raise his left arm over the magnet in the machine to load it. He reported the incident to his supervisor Bill Smith and was sent to the emergency room at KSB hospital.

Petitioner was seen in the emergency room on March 31, 2014. PX 3. A history was obtained that patient "complaints of pain shooting from neck since lifting something at work at 9 o'clock today. FN Smith patient states last week was pulling apart 300 pound doors and felt pain in low neck that went into left scapula. Today around 9 AM lifted a bin that is 100 pounds and immediately got low neck pain into left scapula down left shoulder and arm." PX 3 p. 193. He was diagnosed with cervical radiculopathy. PX 3 p. 199. Petitioner was told to follow up with Dr. Mohammed for a follow-up visit on February 6, 2014. Dr. Mohammed discussed the need for an MRI of his cervical spine at that time. PX 3. He then followed up with Dr. Rozman on February 25, 2014. PX 1 p. 000019. Dr. Rozman took a history "that the petitioner was injured on January 31, 2014, while at work he felt a popping sensation in his neck pain radiating to his left upper extremity and immediate weakness with numbness and tingling." Dr. Rozman noted the patient continued to suffer from pain and weakness in the left upper extremity. It was noted he had pain with palpation to the left shoulder and pain in his neck. The diagnosis was cervicalgia, cervical disc disease, cervical radiculopathy. PX 1 p. 000019. Dr. Rozman also recommended physical therapy and an MRI of the cervical spine. The MRI was carried out on March 7, 2014. Dr. Rozman then ordered an EMG that was done on March 12, 2014, the results of which were normal.

Importantly, when he began physical therapy, the therapist recorded a history that "patient expressed concern that when he originally hurt himself that he tore something in his shoulder and no one has really looked at his shoulder?" PX 3. He was then referred to Dr. Howard Weiss for a cervical epidural steroid injection and a trigger point injection to the left shoulder. PX 2 p. 000051. Dr. Rozman then referred him to Dr. Alexander for a surgical consult regarding his neck. Dr. Alexander opined on April 28, 2014 that Mr. Wagner was not a surgical candidate. RX 7. Thereafter, Dr. Rozman ordered physical therapy which was done at KSB hospital. PX 3. Petitioner continued to follow up with Dr. Rozman and began work conditioning on September 19, 2014.

Respondent then arranged a Section 12 exam with Dr. Soriano on October 14, 2014. Dr. Soriano diagnosed a left upper extremity strain without evidence of electric diagnostic or physical exam radiculopathy. RX 1. Dr. Soriano opined that the diagnosis of the strain was directly related to the work injury of January 31, 2014. He stated that the "mode of injury would require trapezius muscle movement as well as shoulder muscle movement." He also opined that there were "no non-occupational conditions that existed that would be the actual cause of the injury."

Based on Dr. Soriano's report, temporary total disability benefits were terminated on November 14, 2014.

Petitioner continued to treat with Dr. Rozman following the Section 12 exam. On October 17, 2014 Dr. Rozman noted that Petitioner was adamant to finish his work conditioning. PX 1 p. 06.

On November 17, 2014, Dr. Rozman noted that work conditioning and prior treatment had not alleviated all of the symptoms, the patient was frustrated, and he continued to have pain in his shoulder. PX 1 p. 032. Dr. Rozman suspected that his problem was not cervical but instead was related to his shoulder.

In December 2014 Dr. Rozman ordered an MRI of the left shoulder. Due to lack of insurance approval, the MRI was not carried out until May 28, 2015. PX 1 p. 042. The radiologist interpreted the MRI is showing a "glenoid labrum anterior superior tear at the 1 o'clock position with communicating paralabral cyst coracohumeral ligament." Based on the MRI showing a labral tear. (emphasis added)

Dr. Rozman referred the petitioner to an orthopedic surgeon for evaluation of his shoulder on June 1, 2015. PX 1 p. 041. As of the time of hearing, the petitioner had not seen an orthopedic doctor for actual treatment as it was not authorized by the insurance company. As to lost time, Petitioner testified that he was off of work from March 17, 2014 through May 4, 2014 and again beginning July 18, 2014 through the date of hearing per Dr. Rozman. PX 1. However he was only paid temporary total disability benefits through November 14, 2014.

As of the hearing, Petitioner testified that he had not yet seen an orthopedic surgeon, his left shoulder symptoms were still severe enough that Dr. Rozman had not released him to go to work, and that he still wanted to see an orthopedic and consider having surgery. He testified he was not receiving any income from any source.

During well prepared, insightful cross-examination Petitioner testified that although he had been treating with Dr. Rozman prior to the work injury going back to 2007, that treatment was exclusively for his low back for which he had undergone an L5 – S1 lumbar fusion. And although he was taking medication, Petitioner testified that he had never had any prior complaints, symptoms, or treatment to his left shoulder or neck before the work injury of January 31, 2014.(emphasis added)

Respondent did not offer any witnesses (including Mr. Smith above) at hearing to refute petitioner's testimony on accident/body mechanics, assigned tasks, weight of objects, presentations to the ER and alike. However, most issues were put in dispute. Petitioner presented as a very forthright, long term employee and skilled craftsman. He was very articulate and specific and demonstrative on the body mechanics of his moving of the objects above. He answered well proposed questions from the defense quickly and with assurance. (3)

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

Based upon the totality of the evidence, the Arbitrator finds as a matter of law and fact that Petitioner sustained an accidental injury that arose out of and in the course of his employment with Respondent on January 31, 2014 as alleged in the case at bar.

In support thereof, the Arbitrator adopts all of the evidence including testimony from the petitioner, histories contained in the medical records, and the history contained in the Section 12 report which is all consistent.

Specifically, Petitioner describes two separate incidents that caused his pain in his neck and left shoulder. The first occurred when he was trying to pull apart to solid stainless steel doors weighing 300 pounds each by grasping the handles and pulling apart or outwards at chest level. Petitioner testified that that mechanism caused pain in his left shoulder and neck. A week later on January 31, 2014 the petitioner testified that he was reaching with his arms at chest level to grasp a metal tote weighing approximately a hundred pounds, lifted the tote up to above the solar plexus level of his body, twisted to the left, and felt pain in his left shoulder and neck. Petitioner testified that he felt a popping or tearing sensation during this maneuver. Given these activities I make the inference that Mr. Smith would have agreed with the worker in that setting and working on the assigned tasks as per this long time craftsman / worker's testimony.

The histories in the medical records all support Petitioner's testimony as to how the injury occurred. The initial ER report noted that same history of an injury when he was seen on January 31, 2014. PX 3 p. 0193. When the petitioner was first seen by Dr. Rozman on February 25, 2014, the report contained the same history of injury. PX 1 p. 000019. When Petitioner was examined under Section 12 by Dr. Soriano, the same history was obtained. RX 1. Based on all of the above, the Arbitrator finds that the Petitioner did sustain an accident that arose out of and in the course of his employment with the respondent on January 31, 2014.

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

Based upon the totality of the evidence, the Arbitrator finds as a matter of law and fact that Petitioner's current condition of ill being in his neck and left shoulder is causally related to the work injury of January 31, 2014, as alleged in the case at bar.

Based on the chain of events in this case, as well as the opinion of Dr. Soriano, it is clear that Petitioner's left shoulder condition (strain per Dr. Soriano without the benefit of the later MRI) is directly related to the injury that occurred at work.

Petitioner testified that he told each and every doctor he saw that he felt like he had a hot poker in his shoulder shooting pain up into his neck.

The initial ER visit clearly references neck pain and left shoulder pain. PX 3 p. 000193. Initially the doctors did a workup assuming that the symptoms were related to a cervical radiculopathy.

Petitioner even voiced his concerns that his shoulder may be the problem while he was doing physical therapy

. On March 24, 2014, the therapist noted "Patient expressed concern that when he originally hurt himself that he tore something in his shoulder and no one has really looked at his shoulder." PX 3.

After extensive conservative treatment and diagnostic testing, Dr. Rozman determined that his problem was not due solely to the neck. It wasn't until Dr. Rozman's visit of November 17, 2014 that he felt it was likely that his shoulder had damage which needed to be addressed. As such Dr. Rozman ordered an MRI of the left shoulder which revealed a glenoid anterior labral tear. Dr. Rozman referred Petitioner to an orthopedic for consultation regarding the left shoulder tear.

Although not every record with Dr. Rozman clearly records in haec verba states that pain was in the left shoulder, the Arbitrator finds that it was overwhelmingly clear that Mr. Wagner's pain was both in the shoulder and the neck. It was also clear that the doctors didn't simultaneously work up both the neck and the shoulder at the same time but instead worked up and ruled out the neck prior to evaluating the shoulder. Prior IWCC Decisions are replete with the system of differential diagnosis in such shoulder and neck manifestations and referred pain cases. Petitioner's complaints of his shoulder and his concerns that it was his shoulder, and not his neck, that needed further workup were evident almost immediately-based upon a close reading of the record. PX 3.

Furthermore, Dr. Soriano found that as of October 14, 2014, the Petitioner's condition was a left upper extremity or shoulder strain. RX 1. Dr. Soriano opined that the mechanism of injury was the cause of the left shoulder condition. Giving him the benefit of the doubt in his diagnosis without a radiographic MRI, Dr. Soriano lacked the benefit of the diagnostic testing that was carried out subsequently on May 28, 2015 by way of that MRI.

The fact that Dr. Soriano did not have the MRI to review, explains why he felt, at the time he saw Petitioner that he had suffered only a shoulder strain.

However, once the MRI results were available the Arbitrator must decide if the conduct of the Respondent in still denying benefits and treatment was reasonable under the circumstances. In other words, Respondent can not hold to the denial based upon strain when the later focused radio graphics showed otherwise, and, could have been obtained and sent to Dr. Soriano himself for review, or a second section 12 exam requested given the change in available evidence. Diagnoses evolve based upon a continuum of treatment and diagnostics that can not be ignored. This ignoring of the MRI is troubling the Arbitrator in terms of determining if the denial on the old, pre MRI evaluation by Dr. Soriano is unreasonable under the case law.

The Arbitrator finds based on the totality of the evidence, that the cervical condition and tear in the left shoulder is directly caused by the injury at work on January 31, 2014.

G. What were Petitioner's earnings?

Based upon the totality of the evidence, the Arbitrator finds as a matter of law and fact that Petitioner's total earnings including overtime at straight rate was $45,278.46 for the 52 weeks preceding the injury of January 31, 2014. This results in an average weekly wage of $870.74. Respondent offered a wage statement which Petitioner confirmed accurately portrayed his wages during the relevant period of time. RX 5. Based on the wage statement, it is clear that Petitioner's regular work week was more than the standard 40 hours. Over the 52 week period, Petitioner worked a total of 442 hours of overtime averaging 8.5 hours of overtime per week. (emphasis added)

The only weeks that he did not receive overtime pay were when he took vacation time. As such, the overtime was not only consistent and regular but Petitioner's regular work week was 48.5 hours. His hourly pay rate was $17.19.

Therefore, his regular earnings, including overtime at $17.19/hour totaled $45,278.46. His average weekly wage then is $870.74. His corresponding TTD rate is $580.49 and his PPD rate is $522.44.

J. Has Respondent paid all appropriate charges for all reasonable medical services?

The Arbitrator finds that Respondent has not paid all appropriate charges for reasonable medical services associated with the work injury. The Arbitrator notes that medical bills were disputed by the Respondent based on liability for accident and causal connection only. According to Petitioner's exhibits, there are outstanding medical bills totaling $9,027.12. This includes $412.51 to Forest City Diagnostic. It also includes $7,323 to KSB Hospital. And finally it includes $1,291.61 to Rockford Medical Rehabilitation. PX 4.

Based upon the totality of the evidence and the holdings above, the Arbitrator finds as a matter of law and fact the outstanding bills are for causally related conditions, and are for necessary treatment to relieve the conditions of ill being.

Thus, the Respondent is herby ORDERD to pay or to satisfy forthwith the related medical bills outlined in Petitioner's Exhibit 4 pursuant to Sections 8(a) and 8.2, the fee schedule.

K. Is Petitioner entitled to any prospective medical care?

Based upon the totality of the evidence, the Arbitrator finds as a matter of law and fact, that Petitioner is entitled to prospective medical care, as alleged and sought in the case at bar.

Most specifically the arbitrator adopts in part as persuasive and probative, the actual results of the MRI, it is clear that the Petitioner has a glenoid labral tear. (emphasis added)

Dr. Rozman referred him to an orthopedic physician for evaluation who specializes in shoulder conditions. To date the Petitioner has not been seen by a treating orthopedic surgeon. As of the hearing, Petitioner testified that his shoulder was still symptomatic and that he wanted to be evaluated by the orthopedic to discuss the potential surgery to repair the problem.

Based upon the totality of the evidence, The Arbitrator ORDERS prospective medical care. The Arbitrator ORDERS the Respondent to authorize in writing an evaluation with an orthopedic surgeon as chosen by the Petitioner and orders Respondent to authorize any ongoing medical treatment relative to the neck and left shoulder conditions, subject to the provisions of the Act.

L. What temporary total disability benefits are due?

Based upon the totality of the evidence, the Arbitrator finds as a matter of law and fact that Petitioner is entitled to temporary total disability benefits based on the opinion of Dr. Rozman who has continued to keep the Petitioner off of work related to the injury.

The parties stipulated that the Petitioner was off of work and entitled to TTD benefits from March 17, 2014 through May 4, 2014 and from July 18, 2014 through November 15, 2014 for a total of 24 weeks. The only dispute was entitlement to TTD benefits from November 15, 2014 through the date of trial and ongoing. This would be an additional 41 2/7 weeks.

Based upon the MRI and its consistency with the clinical impressions of Dr. Rozman as opposed to the "strain" diagnosis of Dr. Marc Soriano, the Petitioner's adopted condition of the rotator cuff tear by radiograph and diagnosis is the foundation for the Award for TTD post IME by Dr. Soriano.

Based on the fact that the Petitioner's treating physician had him off of work subsequent to November 15, 2014 and that the Petitioner was not receiving any benefits, the Arbitrator awards TTD benefits from March 17, 2014 through May 4, 2014 and from July 18, 2014 through the hearing date at a weekly rate of $580.49 for a total owed through the date of hearingl of August 31, 2014 of $37,897.70.

The Arbitrator notes that the respondent is entitled to a credit for TTD benefits already paid in the amount of $12,233.52. Respondent is ordered to pay to the Petitioner and his attorney, Black & Jones, the balance owed of $25,664.18.

The Arbitrator also orders Respondent to pay ongoing temporary total disability benefits until such time as medical condition stabilizes and or his work status changes according to his medical providers.

M. Should penalties or fees be imposed upon Respondent?

Petitioner is seeking penalties for Respondent's failure to pay medical benefits and TTD benefits under Sections 19(k), 19(l), and attorneys fees under Section 16. Section 7110.70(d) of the Rules Governing Practice Before the Industrial Commission, 50 Ill. Admin. Code Ch. II § 7110.70, states that "Where an employer denies liability for payment of the cost of all or part of an employee's medical care ... the employer shall promptly notify the employee with a written explanation of the basis for the denial of liability or further responsibility."

Section 19(l) of the Illinois Workers' Compensation Act (IWCA) entitles Petitioner to an award of penalties "of $30 per day for each day that a weekly compensation payment has been so withheld or refused." "A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay." 820 ILCS 305/19(l). Under Section 19(k) of the IWCA, Petitioner is entitled to an award of penalties "equal to 50% of the amount payable at the time of such award" for unreasonable or vexatious delay of payment of compensation payable under the Act. 820 ILCS 305/19(k). This applies to both medical compensation under 8(a) and TTD compensation under 8(b), even if not yet awarded by an arbitrator or the Commission. McMahan v. The Industrial Commission, 183 Ill. 2d 499, 508 (1998).

Finally, under Section 16 of the IWCA, Petitioner is entitled to an award of attorneys fees whenever there has been a finding that Respondent has been guilty of unreasonable or vexatious delay within the purview of Section 19(k) of the Act. 820 ILCS 305/16. This applies to TTD compensation under Section 8(b).

Here, Respondent refused to pay for medical bills in the amount of $9,027.12. Respondent also refused to state the basis of their denial of said bills in writing to Petitioner as required by 7110.70(d). Although at trial Respondent claimed they were denying liability for accident and causal connection as their basis for denial, their denial was unreasonable and vexatious based on the evidence submitted at trial. There was absolutely no evidence submitted at trial upon which the Arbitrator can point to which would justify a denial of medical benefits in this case, even a bad basis for denial.

Petitioner's testimony about the accident was not refuted. Each and every medical provider noted the same and consistent history in the records of how the accident occurred. Respondent has no evidence to suggest that Petitioner did not sustain a work related accident. After Respondent obtained a Section 12 exam with Dr. Soriano, they still did not have a basis for denying payment of the medical bills or TTD. Dr. Soriano opined that Petitioner's left shoulder condition was directly related to the mechanism of injury.

Since he did not have any diagnostic films to state otherwise, his opinion that the shoulder was only strained was reasonable at that moment of time. But the shoulder injection provided temporary relief of pain and Dr. Rozman clearly thought the ongoing symptoms warranted further workup.

Once the MRI was ordered, Respondent should have approved the testing. Even if the Arbitrator assumes that Respondent denied the testing based on Soriano's report, it was questionable to do so. Claims management never took the step to resolve any possible open issue on the shoulder by sending the MRI to Dr. Soriano, or , with more logic, to a doctor specializing in sports medicine shoulder conditions.

The Act's purpose is to expedite such matters in a simple and summary matter. Given the clear MRI results never sent to the IME doctor, the Arbitrator herein attempts to expedite the shoulder treatment by not writing penalties avoiding an issue to appeal.

Arbitrator George J. Andros #01

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Angelique Garzon,

Petitioner,

vs.

NO: 08 WC 32254
10 WC 44158
11 WC 45344

City of Chicago,

Respondent.

16IWCC0730

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, temporary total disability and nature and extent, reverses the Decision of the Arbitrator with respect to claim 10 WC 44158 and awards compensation, while affirming and adopting the Decisions of the Arbitrator with respect to claims 08 WC 32254 and 11 WC 45344, for the reasons stated below.

Findings of Fact

I. Prior History

Petitioner testified that she had previously injured her right wrist, shoulder and neck in 2006 and received a settlement for same. (T.9-10). Petitioner noted that her job duties as an administrative assistant in 2006 involved "[b]asically data entry work, proofreading, copying, filing." (T.10). She indicated that the data entry work included "[p]roduction daily work sheets from the crews, requests from the alderman's offices for tree trimming or removals [of] stumps or planting, anything that had to do with city trees." (T.10). Petitioner is right hand dominant. (T.11).

A review of the record shows that prior to the accidents in question Petitioner presented to MercyWorks on 8/19/05 complaining of pain in the right wrist radiating to the forearm, elbow,

upper arm and right shoulder. (RX2). At that time Petitioner related that she "... has been typing continuously throughout the week and has been straining her neck and head." (RX2). Petitioner was diagnosed with a strain of the right wrist, right hand, right arm, right elbow and right neck. (RX2).

In a MercyWorks "memo" dated 10/4/05, Dr. Homer Diadula noted that Petitioner "... saw Dr. Nagle who diagnosed the patient to have CTS and/or cubital tunnel syndrome... Dr. Nagle also mentioned also [sic] about pronator syndrome and cervical radiculopathy. Still complaining of same pain in the right wrist, elbow, hand, shoulder and right side of neck ..." (RX4). Dr. Diadula's diagnosis was right carpal tunnel syndrome and right cubital tunnel syndrome. (RX4).

Petitioner underwent a right carpal tunnel release by Dr. Nagle on 1/23/06. (RX2).

In a MercyWorks "memo" dated 2/28/06, Dr. Diadula noted that in addition to right wrist pain Petitioner was "... still bothered by the right shoulder pain[,] is 3/10 on the scale especially when she does repetitive movements." (RX4).

Petitioner visited Dr. William Heller at Midland Orthopedic Associates on 3/7/06 complaining of right shoulder pain that "...began sometime prior to the carpal tunnel release surgery [on 1/26/06]. She works in a clerical capacity but states that she lifts files during her work duty and that she thinks the lifting of files from a drawer to a desk on a repetitive basis has caused her shoulder pain. It does not awaken her at night and does not bother her at all times, but at times she finds it very limiting." (RX2).

In a MercyWorks "memo" by Dr. Diadula dated 3/7/06 it was noted that "... Dr. Heller called me and told he [sic] that the right shoulder is related to the job that she was doing, pulling the file[s] that are tightly packed, pulling them out of the drawer adn [sic] then back in for 15 years..." (RX4).

Midland Orthopedic Associates records also contain a "Work-Related Injury" form filled out and signed by Petitioner on 3/7/06 describing the injury on 8/15/05 as follows: "I believe that I have worn out the cartiledge [sic] inbetween [sic] the shoulder and arm, from repetitive use from typing, also pulling files from file cabinet (sometimes jammed pack and tightly fitted) it is not easy to pull the file out and/or to return the file when they are tightly packed together. I have been doing the above duties for 15 years, with continued movement it feels like its [sic] inflaming. Also the neck from looking down at my sheets, and then the computer, approx. 2-3 X per address, approx. 200-500 addresses daily. The neck is stiff and hurts when I turn to the Rt." (RX2;RX3).

An MRI of the right shoulder performed on 3/15/06 revealed "[f]indings consistent with supraspinatus tendinopathy and hypertrophic degenerative changes of the acromioclavicular joint." (PX2).

In an office note dated 3/31/06, Dr. William Heller noted that the MRI of the right shoulder "... basically demonstrates rotator cuff tendinosis, no significant tear, and there is also some AC joint hypertrophy." (RX2). Dr. Heller administered a corticosteroid injection and noted that

Petitioner "... is now discharged from care to follow up only if symptoms recur or do not respond to the injection. She will return to all regular work duties on 4/3/06 once the injection has taken effect." (RX2).

In a MercyWorks "memo" by Dr. Diadula dated 3/23/06 it was noted that Petitioner was full duty as of 3/27/06. (RX4). The diagnoses included strain, right wrist, right hand, right arm, right shoulder, right neck and right elbow; right shoulder supraspinatous tendinopathy; status post carpal tunnel surgical release. (RX4).

In a MercyWorks "memo" by Dr. Diadula dated 3/31/06 it was noted that "[t]oday the patient saw Dr. Heller, who gave her a final release to full duty." (RX4).

In a MercyWorks "memo" dated 5/12/06 it was noted that Petitioner had seen Dr. Nagle the prior day and had been released. (RX4). It was also recorded that Ms. Garzon was "[d]oing home exercises, complaining of intermittent pain to right shoulder, takes Darvocet/Flexeril periodically. Minimal tenderness right shoulder over supraspinatous, full range of motion to shoulder, elbow, wrist ... Dx: S/P right shoulder tendinopathy. Right wrist, right elbow strain. Tx: Full duty and discharged." (RX4).

In a MercyWorks "memo" by Dr. Diadula dated 8/28/06 it was noted that Petitioner "... feels the shoulder to be worse. Positive on and off right shoulder clicking. The right wrist is 80% better. She requests to see Dr. Heller again for the right shoulder." (RX4).

Petitioner returned to Dr. Heller on 9/11/06 complaining of recurrent pain at which time an additional injection was administered. (RX2). Dr. Heller also noted that he explained to Petitioner that he did not think that therapy would benefit her "... because she has completely normal motion and basically normal strength and I am afraid that therapy will only aggravate her condition." (RX2).

In an office note dated 10/6/06, Dr. Heller noted that "[s]he states the right shoulder feels a little bit better after her last injection but she still has symptoms." (RX2). Dr. Heller concluded that "[a]t this point, she's had two injections. She's had symptoms for greater than 6 months, they are tolerable. She has normal motion. I think she should continue to tolerate her symptoms and if they worsen in the future to the point where she can no longer perform work duties or tolerate the pain and weakness, we can discuss arthroscopic management. In the meantime she is discharged from care to regular duties to follow up as necessary." (RX2).

In a MercyWorks "memo" by Dr. Diadula dated 10/6/06 it was noted "[t]oday, the patient saw Dr. Heller, who released her to regular duty and advised to return to him only as needed. Right shoulder pain is 3/10 on the scale. Right shoulder: full range of motion, tender deltoid and anteriorly. Right side of the neck is tender in the SCM and paracervical, full range of motion, not pain-free. Dx: Right shoulder tendinopathy. Strain, right neck. Tx: Cyclobenzaprine, Darvocet, warm soaks, apply ice/heat. Full duty and discharged." (RX4).

Petitioner agreed that she filed a workers' compensation claim alleging an accident date of 8/15/05 with respect to these prior problems with her right shoulder. (T.50-51). She noted that

she was working in the Department of Forestry at the time and received treatment in the form of two cortisone injections and physical therapy. (T.51-52). She also acknowledged that she would have no reason to doubt the records if they show that the Commission approved settlement contracts in that matter on 11/28/07. (T.52-53). The IWCC printout admitted at RX1 shows the settlement included 2% loss of use of the right arm and 17.5% loss of use of the right hand.

Petitioner indicated that she believed she had physical therapy possibly in 2007 following the 8/15/05 injury to her right shoulder and that when she settled her workers' compensation case for that injury she was done with her medical treatment. (T.88). She denied receiving any treatment to her right shoulder between the time she resolved her 2006 case and April of 2008. (T.88).

II. History re: current claims

A) "*the right shoulder injury*" (10 WC 44158)

1) Accident

Petitioner testified that on 1/25/08 (or less than three months prior to the claimed date of accident) her office moved to the third floor at 2342 South Ashland. (T.12). She indicated that the building was considered a "green building." (T.12-13). She noted that the windows did not open and that she would have to walk through a vacuum or "LEED" door ten (10) to fifteen (15) times a day. (T.14,19-20,45). She indicated that "... the door would try to close itself while you're pushing it open, and you had to push the door forcibly to open it or to go into the office." (T.20). She noted that she would have to push the door when she was going into operations, and that after she was done making copies and the like she "... would have to go back out and pull it..." (T.20). Petitioner indicated that she would have to go through the door "[t]o make copies, to pick up faxes, to make books for the aldermen's offices, the Arbor Day program, basically copies[,] faxes and books, pamphlets that [she] would put together." (T.21). In addition, she would do data entry at her desk as well as filing using cabinets that were lower than the five-drawer cabinets in the old building. (T.21). Petitioner noted that she is 5'2" tall. (T.22). She also noted that the top drawer in the five-drawer cabinets in the old building was approximately at her eyebrow and that she noticed the files were "... very compacted together. We would have to wiggle the files out, wiggle them back in. It was just too much in there." (T.22). She stated that she would use her right arm to do the filing. (T.22).

Petitioner testified that the move to the new building entailed unpacking filing cabinets, putting the files in file boxes, labeling the boxes and then unpacking the boxes when they were transported and putting them into the new filing cabinets. (T.23). She noted that the move took probably more than a week to pack the files and about a week of unpacking, in addition to her regular work duties. (T.23). Petitioner indicated that she was not alleging any injury from the move to the new office. (T.69-71).

Petitioner indicated that she did not have that much pain before the move, other than a little bit of pain in her shoulder, and that she was "... still fine with the shoulder and the arm until later when [she] received more duties." (T.24-25). Along these lines, she noted that in February of 2008 they started doing planting and fire hydrant permits in addition to her regular data entry

operations, which meant she "... would have to type them up in the system, print them out, pick them up from the copy machine, fax them over to the private contractors and then come back and file them." (T.25-26). She was not sure how many of these she would do a day. (T.26).

Petitioner agreed that her job was primarily data entry and that she only had access to the door in question starting at the end of January 2008. (T.67). She indicated that she typed 6-1/2 hours a day and that she was required to leave her desk for photocopies, faxes and making pamphlets for schools. (T.67-68). She agreed that her shoulder began bothering her with the preparation of the Arbor Day pamphlets. (T.68). She noted that they "... started [the pamphlets] approximately the middle of March, and then by the first week or so of April going back and forth and everything it became too much, so [she] asked for help." (T.69). She agreed that it would be about a 2-1/2 to 3 week period from when she started the pamphlets until she reported pain occurring in the first week of April. (T.69).

Petitioner testified that in March 2008 she "started with the Arbor Day celebration duties; and that's when [she] had 50 aldermen's offices to call, 50 plus schools to call, coordinate 50 volunteers with that, update everything into the subsystem, spread sheets, fax over paperwork, get permission from principals and vise[sic]-principals and just total coordination of the entire Arbor Day celebration which was done in April around Mayor Daley's birthday ..." (T.26-27). At that time she "started getting tired doing with [sic] all the data entry, going in and out of the doors, making copies, faxes. The machine didn't have a stapler on it. [She] had to manually staple the pamphlets." (T.27). She agreed that she had to manually staple 50 pamphlets for 50 schools, or 250 [sic] with three staples per manual. (T.27). She indicated that they would also do extra copies. (T.27). She stated she would have to go through two doors, including the vacuum door shown in RX8 to get to the printer, copier and fax in the office next door. (T.28). On re-cross, Petitioner agreed that she had regularly done the Arbor Day duties in prior years as well. (T.89).

Petitioner testified that there was no other door to the area with the copy machine than the LEED door. (T.74-75). She agreed that she would not have to go through that door in the morning to get to her office, to take a break or when she went home for the day. (T.75-76). She indicated that she would sometimes have to go through the door several times per hour to make copies during the busy season, which was basically the one month around the Arbor Day celebration. (T.76). She stated that she was not allowed to use copy machines in other parts of the building. (T.77).

Petitioner shot a video of the office setting and the LEED door using her phone in 2014. (T.45-47). She later attempted to submit this video into evidence at PX23. The exhibit was rejected. (T.175). The parties agreed that to enter the operational room the door has to be pushed away from you, and that the door has to be pulled toward the individual to exit the room. (T.111).

2) Treatment

A City of Chicago "Report of Occupational Injury or Illness" prepared by Eamon Gaughan and signed by Petitioner on 4/17/08 shows a date of injury of 4/16/08 and contains the following

description of the injury: "Admin. Asst. Garzon began feeling pain in right wrist and arm and shoulder. Pain began last week on or around April 9th. She stated she has been given additional duties and this increased her pain level." (PX1).

Petitioner agreed that she visited MercyWorks on 4/17/08. (T.28). In a MercyWorks "Patient & Employer Information" form dated 4/17/08 the following description of the injury was recorded: "pain in my wrist, and shoulder area, when typing, or writing, copying, filing." (PX1).

Petitioner testified that she subsequently visited the physicians at MacNeal Physicians Group. (T.28). In a letter dated 5/15/08, MacNeal Physician Group's Dr. Joyce Tarbet recorded that Petitioner "... complains of anterior right shoulder pain since April 9, 2008. The patient does data entry. The patient states that as a result of increased workload she began to experience her right shoulder pain. She was evaluated by her company physician on April 17, 2008... [T]he patient has complained of right shoulder pain in the past. She states that in March 2006[] [s]he had an MRI of the right shoulder. Then in October 2006 she had a cortisone injection. She states that this helped for about a year and a half. In January 2007 she also had some physical therapy for her neck and arm. The patient has undergone a right carpal tunnel release back in January 2006. This was under workman's compensation. With regards to the right shoulder today, the patient has had no recent treatment." (PX4). Dr. Tarbet's impression at that time was bicipital tendonitis and her recommendation was physical therapy for iontophoresis treatments. (PX4).

Petitioner testified that she underwent physical therapy at MacNeal Hospital in June and July of 2008. (T.29).

In a MacNeal Hospital "Outpatient Physical Therapy Peripheral Evaluation" form dated 6/10/08, it was noted that "pt [with] occasional dull ache in r[ight] sh[ou]ld[e]r – worsened April '08 [with] having [increased] workload; had similar pain [approximately] 1 yr ago – rec'd relief [with] PT/cortisone injection." (PX3). The diagnosis noted at that time was "r[ight] biceps tendinitis/RC tendinitis." (PX3).

An MRI of the right shoulder was performed on 7/31/08. (PX5). While noting that the study was slightly limited secondary to patient motion, the radiologist's impression was 1) small partial tear involving the anterior insertion of the supraspinatus; 2) suspicion for tear of the capsular portion of the long head of the biceps tendon; 3) fraying and increased T2 signal involving the superior labrum as well as suspected subtle injury to the labrum; and 4) moderate acromioclavicular joint degenerative changes predisposing to impingement. (PX5).

On 3/30/09 Petitioner visited Dr. Erling Ho at Orthopedic Associates of Riverside. (T.29-30). In a letter addressed to Dr. Ralston on that date, Dr. Ho noted that Petitioner had worked in a job performing data entry for approximately 18 years, and that "[s]he was also doing quite a bit of filing and all of this overuse caused her to have shoulder pain." (PX5). Dr. Ho concluded that "[a]s she has already exhausted conservative treatment she is interested in going forward with surgical treatment. I think this is reasonable, however, I think I would like to update her imaging studies. We are going to order an MRI arthrogram of her shoulder in order to fully evaluate the

rotator cuff and labrum." (PX5).

An MR arthrogram of the right shoulder performed on 4/14/09 revealed 1) a full-thickness tear of the anterior fibers of the distal supraspinatus tendon with mild interstitial tearing extending to the musculotendinous junction, 2) mild distal subcapularis tendinosis, and 3) no evidence of labral injury. (PX3).

In a letter dated 2/3/10, Dr. Ho noted that "[w]e last saw [Petitioner] about a year ago, at which point, it was noted she had a small full-thickness rotator cuff tear. She was unable to go ahead with surgery because of job considerations, but now she returns today and she wishes to proceed with the shoulder arthroscopy." (PX5). Dr. Ho indicated that this would be scheduled to be done in approximately one month's time. (PX5).

Dr. Ho subsequently performed surgery on Petitioner's right shoulder on 3/16/10 in the form of 1) arthroscopic debridement of glenohumeral joint; 2) arthroscopic rotator cuff repair; and 3) arthroscopic decompression. (PX3;PX5). The pre and post-operative diagnosis was right shoulder rotator cuff tear. (PX3;PX5).

An EMG study performed on 6/22/10 revealed no significant abnormalities, noting that "[t]hese electrodiagnostic findings would suggest that by far most likely the patient's current pain symptoms are on a musculoskeletal basis, likely related to overuse type tendonitis in the wrist and elbow, etc. Clinical correlation is suggested." (PX5;PX6).

In an undated letter addressed "to whom it may concern", Dr. Ho noted that Petitioner "… still has limited use of her right arm and she is unable to return to work full time without restrictions. It is my estimation that she is able to return to work approximately 10/8/10. Currently she is undergoing therapy and rehabilitating her right shoulder." (PX5).

In a letter dated 10/8/10, Dr. Ho indicated that overall Petitioner was doing well, that she "… still has occasional trouble sleeping but has resumed all of her normal activities. She is ready to go back to regular duty work." (PX5). Dr. Ho thereupon released Petitioner to return to regular duty on 10/18/10, noting that "[s]he will continue her home therapy exercises. We will see her back in three months for a final clinical check. She tells me, as an aside, her left shoulder has really begun to hurt her as well…" (PX5).

Petitioner noted that she had physical therapy and lost time from work following the first surgery, specifically from 3/17/10 to about 10/17/10. (T.30-31). She recalled that while she was off work she received benefits from the City of Chicago pension fund for four months at about half her salary. (T.31-32). Petitioner testified that she still had pain when she returned to work in 2010 after the first surgery. (T.32). At that time she was working at the auto pound because she had been told that she was on a layoff list. (T.32). She worked at the auto pound from 1/5/09 until 5/13/13. (T.33). Petitioner has not returned to work since. (T.34).

In a letter dated 10/29/10, Dr. Ho noted that Petitioner had "… return[ed] to work but has been doing quite a bit of writing as well as light lifting. This has been giving her discomfort in the shoulder." (PX5). Dr. Ho's impression was that "Ms. Garzon has done very well after her

right shoulder arthroscopic rotator cuff repair. Because she is still somewhat sore, I think some of this is due to inflammation of muscle spasm, I am ordering a TENS unit for her right shoulder..." (PX5).

In a letter dated 2/25/11, Dr. Ho noted that Petitioner "... has done very well one year post right shoulder arthroscopic rotator cuff repair. From my standpoint, she is released. She may continue with all of her normal activities. She is still using her TENS unit for help with her musculoskeletal pain and I do think that she would benefit from an evaluation by Dr. Rizvi (for fibromyalgia) because she does have diffuse body musculoskeletal aches and pains which do not appear to be localized." (PX5).

In a letter dated 4/4/12, Dr. Ho recorded that Petitioner "... had previously seen an orthopedic surgeon for evaluation of the right shoulder in 2006. By the time I saw her [on 3/30/09], she had already been seen by Dr. Tarbet and scheduled for decompression of the right shoulder but because of job security issues, she did not go forward with surgery at that time. She was able to return to work in a limited capacity secondary to persistent pain but by 2009, her shoulder had progressed to the point where she is having severe discomfort almost on a daily basis..." (PX7). Dr. Ho went on to state that Petitioner "... did have an MRI in 2006 of her right shoulder which showed rotator cuff tendinopathy. She also had an MRI of the right shoulder on July 31, 2008 which showed a partial tear of the supraspinatus tendon. The subsequent MR arthrogram of the right shoulder on April 14, 2009 showed a full-thickness tear. Based on these MRIs as well as the physical examinations that occurred during these periods of time, it seems fairly clear that her rotator cuff pathology progressed between the years of 2006 and 2009. I think it is highly possible that the work that she was performing during these years certainly exacerbated the preexisting rotator cuff tendinopathy and potentially caused a full-thickness tear of her shoulder. It is consistent that constant lifting as well as filing at chest and shoulder level work could irritate the partially torn rotator cuff and potentially cause of [sic] full thickness rotator cuff tear which was eventually treated surgically." (PX7). Dr. Ho concluded that "[i]t is my medical opinion that Ms. Garzon's rotator cuff injury was definitely exacerbated by her work activities and potentially caused by her work activities." (PX7).

At the request of Respondent, Petitioner visited Dr. Brian J. Cole on 2/18/13 for purposes of a §12 examination. (RX9). Following his examination and review of the medical record, Dr. Cole's diagnosis was "[p]ersistent right shoulder pain, subjectively, relatively well preserved. Exam findings are most consistent with rotator cuff tendinitis." (RX9). On the question of causation, Dr. Cole noted that "[t]he claimant described a mechanism whereby she was doing different activities outside of her typical day, and these also included 5-12 repetitions of pushing through a 'vacuum door in the new green building,' which allegedly entailed a lot of strain. I cannot categorically state that there was anything inherently unique to her work place, such that it would be that much more destructive and load bearing to her shoulder than generalized activities of daily living. This being said, however, I think she did develop pain in the work place with specific activities and over a long enough period of time that her workplace exposure, on a more likely than not basis, is culpable for her need for treatment subsequently." (RX9). In addition, Dr. Cole opined that Petitioner could work full duty with no restrictions. (RX9). Furthermore, Dr. Cole noted that "[a]t this point, her condition remains with a need for treatment that hopefully will only be a short course of physical therapy preceded by a simple cortisone

injection. MMI remains to be determined, however." (RX9).

An MRI of the right shoulder performed on 3/22/13 revealed 1) sequelae of interval rotator cuff repair, with large recurrent full-thickness, incomplete supraspinatus tendon tear; 2) mild subscapularis tendinosis, not significantly unchanged, intact infrapinatus and teres minor tendons; 3) torn long head of biceps tendon, retracted to the bicipital groove; 4) suspected superior labral tearing; and 5) mild acromioclavicular joint degeneration, unchanged. (PX3).

In a consultation report dated 3/29/13, Dr. Sunavo Dasgupta recorded that Petitioner presented with whole body pain that "... began in 2010 and had been averaging approximately 5-6/10 in severity. They are located throughout her entire body, but they seem to be worse in the region of the right buttock as well as her hands and feet. She states her symptoms began after a right rotator cuff repair..." (PX3). Following his examination, Dr. Dasgupta noted that "[a]t this point, her symptoms seem very consistent with fibromyalgia. Oftentimes, a minor traumatic events [sic] such as a surgical procedure can induce fibromyalgia in somebody who is somewhat predisposed to it. She unfortunately has had sensitivities to different types of medications that we typically used to treat fibromyalgia. In addition, she may have some focal pain in the right buttock area secondary to sacroiliitis. We can consider both diagnostic and therapeutic right SI joint injection at least to help locally treat this area." (PX3).

In an "IME Addendum" report dated 7/8/13, Dr. Cole, Respondent's §12 examiner, noted that he had reviewed the auto pound custodial job description for the City of Chicago and was of the opinion that Petitioner "... can work full duty with no restrictions." (RX9). However, he noted that Petitioner was not at MMI and that "... her condition warrants further management as aligned in [his] IME report." (RX9). Finally, Dr. Cole indicated that "[r]egarding causality, it is still a bit circumspect as to whether the duties of her job are inherently repetitive enough to incite a response of rotator cuff tendonitis or any other inflammatory condition to the shoulder. I cannot categorically state that her condition is due to the nature of her job. Furthermore, I also cannot state that it is the 'vacuum door' that she opened on a total of 5-12 instances inciting pain. As a result, I cannot categorically state that the resultant need for treatment in Ms. Garzon's right shoulder is the result of her employment with the City of Chicago. However, the nature of her job as she described to me does appear to have brought her to a need for treatment sooner. In other words, might have been necessary absent of the described activities." (Underlined portion supplied by Dr. Cole)(RX9).

Dr. Ho performed a second surgical procedure on Petitioner's right shoulder on 8/6/13 in the form of 1) arthroscopic revision rotator cuff repair; 2) arthroscopic debridement of glenohumeral joint and subacromial space; and 3) arthroscopic subacromial decompression with acromioplasty. (PX3). The pre and post-operative diagnosis was right shoulder rotator cuff retear. (PX3;PX5).

Petitioner testified that she was unable to undergo physical therapy after the second surgery because "... it became inflamed over and over again." (T.40-41).

In a chart note dated 9/27/13, Dr. Ho's physician assistant, Alan Moses, recorded that Petitioner still had some discomfort and "... was requesting a new MRI just for the right

shoulder which I think is reasonable due to the fact that she may have had a separate issue of injury when she reached for something in her car the other day…" (PX5).

An MRI of the right upper extremity on 10/4/13 revealed 1) reidentified full-thickness tear of the supraspinatus tendon with tendon retraction and muscle atrophy; 2) large amount of fluid in the subacromial/subdeltoid bursa as well as in the glenohumeral joint space; 3) moderate AC joint degenerative changes; 4) hypertrophic changes at the acormioclavicular joint space; and 5) post-surgical changes at the right humeral head. (RX5).

Dr. Ho performed the third and final surgical procedure on Petitioner's right shoulder on 1/21/14. This procedure consisted of 1) arthroscopic debridement and examination of right shoulder; and 2) open rotator cuff repair with application of decellulized dermis graft. (PX5). The pre and postoperative diagnosis was right shoulder recurrent rotator cuff tear. (PX5).

An MRI of the right shoulder performed on 5/3/14 was interpreted as evidencing 1) a full thickness tear of the supraspinatus tendon with at least 1.5 cm tendon retraction and muscle atrophy; 2) small amount of fluid in the subacromial/subdeltoid bursa and small glenohumeral joint effusion, 3) long head of the biceps tendon and labral anchor is not identified suggesting possible tear, and 4) moderate degenerative change of the acromioclavicular joint. (PX5).

In a letter dated 5/14/14, Dr. Ho noted that Petitioner was status post right shoulder rotator cuff repair with two subsequent revisions, the most recent using a dermal augmentation patch. (PX5). Dr. Ho stated that the most recent MRI of the right shoulder "… shows that the patch is in position. However, she does have a small retear at the junction of the patch with the previous rotator cuff. There may be a 15 to 20 millimeter gap in that region…" (PX5). Dr. Ho concluded that "[a]t this point Ms. Garzon is essentially at maximal medical improvement from our standpoint. I told her to just live with this, and she states that she is able to do her basic daily activities. She is still sleeping in a recliner. She finds Flexeril helpful, so we gave her a prescription for the Flexeril. She is currently on permanent disability, so work is no longer an issue. I will see her back in six months just for another clinical check. I would like to see how she is doing. Further surgery would probably not be beneficial for her, and in any case, she is not interested in any further aggressive treatment." (PX5).

Currently, Petitioner notices that with respect to her right shoulder she is "… unable to do most things that [she] used to do without having pain." (T.36). She noted that she has pain from her shoulder all the way down her arm, and that "… two, three minutes of using [her] arm [and] the pain starts becoming severe." (T.36). She indicated that she cleans her bathroom "… usually using [her] left arm as much as possible. That's why everything takes longer to do." (T.37). Petitioner also noted that she stopped driving a car right before her third surgery on 1/21/14 "[b]ecause [she] was unable to move [her] arm away from [her] body without severe pain." (T.38-39). She stated that she notices difficulties "[e]ven taking a bath, brushing [her] teeth. It's difficult to wash [her] personal area. [She] ha[s] to use [her] left arm. When [she's] going potty and [she] use[s] [her] right arm, [she] ha[s] pain, but that's the only way [she] can reach." (T.39-40). In addition, Petitioner indicated that she has treated for fibromyalgia and is taking medication for anxiety. (T.78-79,81).

Petitioner indicated that she has been off work since May of 2013. (T.81). She stated that she has not looked for any other employment. (T.81). Petitioner agreed, more or less, that Dr. Ho placed her at MMI for her shoulder in May of 2014. (T.82). She indicated that she has not looked for work because she "can't use [her] arm..." (T.82). On cross, she agreed that no physician has ever told her that she can't physically use her right arm. (T.83). However, on redirect, Petitioner agreed with the records of Dr. Ho dated 5/7/14 if they show that she was currently unable to use her right arm following rotator cuff repair. (T.85).

Petitioner testified that she received long-term disability through insurance she purchased from work. (T.34). The parties stipulated that Respondent would be entitled to an §8(j) credit for non-occupational disability benefits paid. (T.179). Petitioner also indicated that her medical bills have been paid through her health insurance with Respondent. (T.35).

3) Testimony of Minerva Benitez Morales

Ms. Morales was called to testify by Petitioner. Ms. Morales testified that in 2008 she was employed as a data entry operator with the City of Chicago in the Streets and Sanitation Bureau of Forestry. (T.90-91). Ms. Morales worked with Petitioner and two other individuals in the same office. (T.92). When asked to describe what it was like to open the door to the operations room, Ms. Morale indicated that "[t]o me, okay, it was very, very hard to open for the fact that this window [transom] up here needed to be opened ..." (T.93-94). She went on to explain that the door is more difficult to open when the window or transom above the door is closed, and that it was closed all the time. (T.96).

On cross, Ms. Morales indicated that she had worked with Petitioner in the Department of Forestry for about 20 years. (T.101). She noted that they were co-workers and would talk at work, but that they were not personal friends. (T.101). She indicated that she appeared pursuant to subpoena. (T.102). Ms. Morales testified that she worked with Petitioner at the Ashland address until about 2010 or 2011 when Ms. Garzon was transferred to another department. (T.103). When asked if she had ever injured her arm using the door in question, Ms. Morales at first testified that she "... didn't have to go through it that often just maybe once in a blue moon." (T.105). However, she then went on to state that she had to go to MercyWorks one time after opening it one day. (T.105-106). She noted that she did not file any workers' comp claim as a result of that incident. (T.106). Ms. Morales also indicated that now there is an alternate door that one can use, but there was not back then. (T.108). In addition, she noted that she would see Petitioner use the door in question "[d]aily at least 10, 12 times a day, maybe more. [She] never counted them. [Petitioner] was constantly in and out, in and out through that door." (T.110).

4) Testimony of Ladiva Young

Ms. Young was called to testify by Respondent. Ms. Young has worked for Respondent in the forestry department as a tree trimer for 18 years. (T.129-130). She noted that her office moved from South Kedzie to South Ashland in early 2008. (T.130-131). Ms. Young knew Petitioner, having worked in the same department; however, she did not share an office space with her and only worked with Petitioner at the Ashland location for approximately a year.

(T.132). She indicated that she interacted with Petitioner at the Kedzie location "[a]ll the time." (T.133).

Ms. Young testified that she recalled the move from the Kedzie location to the Ashland office. (T.133). She noted that there were files that needed to be packed and transferred to the new office, but she did not see Ms. Garzon packing up those files or unpacking them upon arrival at the Ashland office. (T.133-134). However, Ms. Young indicated that Petitioner was in another separate office at the Ashland location and that she could not see Ms. Garzon's work area from where she worked. (T.134).

Ms. Young stated that she did work in the operations room and did not notice anything noteworthy about the door. (T.135). However, she did state that "[i]f the window or something is open, it's probably – you have to push it a little harder." (T.136). She denied ever injuring herself using that door. (T.136). Ms. Young also indicated that she did not know how many times a day Petitioner would enter through the operations door. (T.136-137). She did note, however, that Petitioner would not have to enter through that door to get to her desk or for breaks, if she didn't want to. (T.137). Instead, Ms. Young indicated that if Petitioner had to go through the door it was probably because she had printed something to the printer in that room or to speak to another employee. (T.137). She stated that she could not recall anything about Petitioner's job that required her to enter through that door, noting that the data entry work that she did was handed to her by Sandra, unless she chose to get up and get it herself. (T.137-138). She also believed that there was some filing involved. (T.138-139).

Ms. Young indicated that there are [currently] two different ways to enter the operations room, the other being through a door to an adjoining room. (T.140). However, she noted that when Petitioner worked in that office there was only one way to the operations room. (T.140). She also confirmed that the department participated in Arbor Day festivities each year by distributing pamphlets with little saplings and seeds to students. (T.141).

On cross, Ms. Young acknowledged that her office was on the floor below Petitioner's. (T.142). However, she noted that she "… was always upstairs because [her] mom worked there, so when [she] finished [her] job, [she] came upstairs, and [she] did have to travel back and forth to do things that required [her] to come upstairs all the time…" (T.143). She noted that she would take the elevator between floors and that she would have to go through the operations door to get into the operations room and into her mother's office. (T.143). She also indicated that when the exterior windows in the room are closed, opening the door is not a problem. (T.147). In addition, she stated that her job sometimes required her to be upstairs in the operations room. (T.147-148). She indicated that how much time she spent in the room depends on the day, and that when there are storms she is there all day long. (T.148). She also conceded that she would not have any reason to watch Petitioner while she was in the operations room. (T.148). Ms. Young is 5'9-1/2" tall. (T.148). On re-direct, Ms. Young indicated that she has never personally had difficulty using the operations room door. (T.149).

5) Testimony of Danny Munoz

Mr. Munoz was called to testify by Respondent. Mr. Munoz testified that he has worked

for the City of Chicago's Bureau of Forestry, Streets and Sanitation as a tree trimer for fifteen years. (T.151-152). He agreed that he worked at the South Kedzie office for about two years before the office was transferred to Ashland Avenue in early 2008. (T.152). Mr. Munoz noted that he worked with Petitioner for about a year at the Kedzie location and then about a year on the third floor at the Ashland Avenue office. (T.152-153). He stated that he was in operations and that his understanding was that Petitioner was data entry, and that her office was in front of his and to the right. (T.153). He noted he was not a supervisor but he would give the data operators work to do. (T.155). Mr. Munoz testified that he recalled Petitioner would enter through the operations door "[p]robably a couple of times [a day] because that's where the copier was at." (T.155-156). He could not think of any other reason that Petitioner's job would bring her into the operations room, although he conceded that it's been a long time. (T.156).

When asked whether he had ever had any difficulty opening the operations door, Mr. Munoz testified that "[w]ell, I'm a bigger guy; so not really myself, no." (T.157). However, he noted that there is "… a little pull because the top [of] it is a little, you know, like you got to give it a snug [sic] to get in." (T.157). Mr. Munoz was not aware that Petitioner was claiming an injury to her right shoulder in 2008 and denied that he was ever personally told about such a claim. (T.157-158).

On cross, Mr. Munoz indicated that while he was not technically a supervisor, he did watch over data entry and their work. (T.160). In addition, he agreed that his work area was about 20 feet away and faced the door; thus, he knew exactly who was coming in and who was going out all the time. (T.161). He denied that data entry people would come into his office more often preparing for Arbor Day, noting "[p]robably by the foresters, but not in our office [in operations]." (T.161-162). He also indicated that he was aware of the need to enter planting permits into the computer, but not fire hydrant permits. (T.162-163). He was also aware that Arbor Day preparations required that data entry people be involved with contacting the aldermen and participating schools. (T.163). In addition, Mr. Munoz agreed that it was his testimony that it required a little bit of a tug to open the door to the operations room. (T.163-164).

On re-direct, Mr. Munoz agreed that he would delegate work to all the clerks, including Petitioner, as part of his duties. (T.164). He also indicated that the work load was "[p]retty much consistent", presumably with respect to the data entry people. (T.164). He indicated that he could not really think of anytime where the clerks would be overloaded with work as opposed to another time. (T.165).

B) "*the slip and fall injury*" (08 WC 32254)

Petitioner testified that on 5/29/08 (08 WC 32254) she slipped on a wet floor that was being mopped by a janitor, hitting her buttocks on the left side as well as her head. (T.42). She agreed that she went to MercyWorks following the incident and was given a "work status sheet" before being discharged from care on 6/10/08. (T.43). Currently, with respect to her buttocks, she noted that she has "… trouble with [her] hip, but it's [her] right hip." (T.43).

Petitioner acknowledged that she did not miss any time from work and has not treated for any injuries related to the slip and fall since that time. (T.84).

C) *"the scissors incident"* (11 WC 45344)

Petitioner testified that on 5/16/11 (11 WC 45344) she was "... opening up a box cartridge for the fax machine, and the scissors slipped and cut [her] [left] wrist." (T.43-44). She was taken to Mercy Hospital on the date of the incident and received a tetanus shot. (T.44). Mercy Hospital records dated 5/16/11 contain a history of "45-year-old female was opening a package with some scissors when the scissors slipped and hit her left wrist. Profuse amount of blood was noted... She was at work at the time and wanted to come in for further evaluation..." (PX2). The wound was irrigated, a tetanus shot was given and Petitioner was discharged back to work. (PX2). She was also instructed to follow up with her primary care provider in three days, 5/19/11. (PX2).

When asked at arbitration if she currently notices anything about her left wrist, Petitioner replied "[n]o. That's fine." (T.44). On cross, Petitioner agreed that she did not lose any time from work with respect to the 5/16/11 injury to her left wrist. (T.83). She also reiterated that the left wrist injury has resolved since that time. (T.83).

Conclusions of Law

An employee seeking benefits for gradual injury due to repetitive trauma must meet the same standard of proof as a petitioner alleging a single, definable accident. *Three "D" Discount Store v. Industrial Commission*, 144 Ill.Dec. 794, 797, 556 N.E.2d 261, 264 (Ill.App. 4 Dist. 1989); citing *Nunn v. Industrial Commission*, 157 Ill.App.3d 470, 109 Ill.Dec. 634, 510 N.E.2d 502 (1987). The petitioner must prove a precise, identifiable date when the accidental injury manifested itself. "Manifested itself" means the date on which both the fact of the injury and the causal relationship of the injury to the petitioner's employment would have become plainly apparent to a reasonable person. *Three "D" Discount Store*, 556 N.E.2d at 264; citing *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill.2d 524, 106 Ill.Dec. 235, 505 N.E.2d 1026 (1987). The test of when an injury manifests itself is an objective one, determined from the facts and circumstances of each case. *Id.*, at 264; citing *Luttrell v. Industrial Commission*, 154 Ill.App.3d 943, 107 Ill.Dec. 620, 507 N.E.2d 533 (1987).

In the present case, Petitioner credibly testified that following her move to Respondent's Ashland Avenue location in January 2008 her normal data entry duties, which involved typing 6-1/2 hours per day, were increased to include planting and fire hydrant permits as well as the preparation of pamphlets for the department's Arbor Day celebration. She noted that as a result she was required to repeatedly leave her desk to make photocopies and send faxes in a room that she could only access through a vacuum or "LEED" door. Petitioner stated that she would have to walk through this door ten (10) to fifteen (15) times a day and that she would have to forcibly push the door open, which would try to close itself given the vacuum seal, just to get through. Various witnesses, including Ms. Morales, Ms. Young and Mr. Munoz all seem to confirm the fact that this was not your typical door, and that it would require at the very least a "tug." They also confirmed that Petitioner would have to exit and enter the operations room using this door numerous times a day. Furthermore, Petitioner credibly testified that it was during the period associated with the increased activities associated with the Arbor Day preparations, including the manual stapling of hundreds of pamphlets starting in March of 2008, that her shoulder really began to bother her. This history was also reflected in the "Report of Occupational Injury or

Illness" prepared by Eamon Gaughan dated 4/17/08 wherein it was noted that "Admin. Asst. Garzon began feeling pain in right wrist and arm and shoulder... [beginning] last week on or around April 9th. She stated she has been given additional duties and this increased her pain level." (PX1). Likewise, in a letter dated 5//15/08, Dr. Tarbet recorded that Petitioner "... complains of anterior right shoulder pain since April 9, 2008. The patient does data entry. The patient states that as a result of increased workload she began to experience her right shoulder pain..." (PX4). A similar history can be found in a MacNeal Hospital physical therapy form dated 6/10/08 wherein it was noted that Petitioner presented "... [with] occasional dull ache in r[ight] sh[ou]ld[e]r – worsened April '08 [with] having [increased] workload ..." (PX3).

Based on the above, and the record taken as a whole, the Commission reverses the decision of the Arbitrator with respect to claim 10 WC 44158 and finds that Petitioner proved by a preponderance of the credible evidence that she sustained accidental injuries arising out of and in the course of her employment with Respondent and that said injury manifested itself on or about 4/9/08. More to the point, the Commission finds that Petitioner suffered an aggravation of her pre-existing right shoulder condition due to the repetitive activities associated with her job as an administrative assistant, most notably the increased duties associated with the preparation of pamphlets and the like for the City's Arbor Day celebration as well as the need to repeatedly enter and exit the operations room through a vacuum sealed or "LEED" door.

In addition, the Commission reverses the Arbitrator with respect to claim 10 WC 44158 and finds that Petitioner proved by a preponderance of credible evidence that her current condition of ill-being concerning her right shoulder is causally related to said accident on 4/9/08. The Commission notes that although Petitioner had a prior history of right shoulder complaints and treatment, and even received a prior settlement for an injury involving her right wrist, arm and shoulder (06 WC 4645), the record clearly shows that Petitioner had been released to full duty work with respect to that claim on 10/6/06, or more than a year-and-a-half prior to the accident in question. The record further shows that at the time of this release Petitioner was found to have full range of motion, albeit with continued complaints of pain and weakness that were described as "tolerable", and was diagnosed with right shoulder tendinopathy. Petitioner thereupon returned to regular duty work for Respondent after having received nothing more by way of treatment than physical therapy and injections.

Following the accident on 4/9/08, Petitioner presented to various care-givers complaining of worsening right shoulder pain in April of 2008 following an increase in her workload, and on 7/31/08 she underwent another MRI of the right shoulder that this time revealed a small partial tear involving the anterior insertion of the supraspinatus as well as a suspicion of a tear of the capsular portion of the head of the biceps tendon and a suspected subtle injury to the labrum. (PX5). A subsequent MRI arthrogram of the right shoulder performed on 4/14/09 was interpreted as revealing a full-thickness tear of the distal supraspinatus tendon with mild interstitial tearing and no evidence of labral injury. (PX3). Thereafter, Petitioner underwent no less than three (3) surgical procedures to repair tears and re-tears of her right rotator cuff.

In a letter dated 4/4/12, treating orthopedic surgeon Dr. Ho opined that "... [b]ased on these MRIs (performed before and after the accident) as well as the physical examinations that occurred during these periods of time, *it seems fairly clear that her rotator cuff pathology*

progressed between the years of 2006 and 2009. I think it is highly possible that the work that she was performing during these years certainly exacerbated the preexisting rotator cuff tendinopathy and potentially caused a full-thickness tear of her shoulder. It is consistent that constant lifting as well as filing at chest and shoulder level work could irritate the partially torn rotator cuff and potentially cause of [sic] full thickness rotator cuff tear which was eventually treated surgically." (Emphasis added)(PX7). Dr. Ho concluded that "[i]t is my medical opinion that *Ms. Garzon's rotator cuff injury was definitely exacerbated by her work activities and potentially caused by her work activities*." (Emphasis added)(PX7).

Even Dr. Cole, Respondent's §12 examining physician, noted that while he could not "… categorically state that there was anything inherently unique to her work place, such that it would be that much more destructive and load bearing to her shoulder than generalized activities of daily living" he believed that Petitioner "… did develop pain in the work place with specific activities and over a long enough period of time that her workplace exposure, on a more likely than not basis, is culpable for her need for treatment subsequently." (RX9). Dr. Cole was equally ambivalent in a subsequent addendum dated 7/8/13 wherein he reiterated that "… it is still a bit circumspect as to whether the duties of her job are inherently repetitive enough to incite a response of rotator cuff tendonitis or any other inflammatory condition to the shoulder" but that "… the nature of her job as she described to me does appear to have brought her to a need for treatment sooner…" (Underlined portion supplied by Dr. Cole)(RX9).

As a result, the Commission finds that Petitioner's current condition of ill-being relative to her right shoulder is causally related to the accident on or about 4/9/08. (10 WC 44158).

In addition, while the Arbitrator found that Petitioner sustained accidental injuries arising out of and in the course of her employment on 5/29/08 (08 WC 32254) and 5/16/11 (11 WC 45344), the Arbitrator failed to adequately address the issue of causation with respect to those claims. Given that Petitioner's unrefuted testimony shows that she slipped on a wet floor on 5/29/08, injuring her buttocks, and cut her left wrist while trying to open a box on 5/16/11, the Commission finds that a causal relationship existed between those injuries and her subsequent need for treatment.

Furthermore, the Commission finds that Petitioner was temporarily totally disabled with respect to claim 10 WC 44158 from 3/16/10 through 10/17/10 and from 8/6/13 through 5/15/14, for a period of 71-2/7 weeks. In support of this finding, the Commission notes that Petitioner was initially taken off work at the time of her first surgery on 3/16/10. (PX3;RX5). Dr. Ho subsequently released Petitioner to return to regular duty on 10/18/10. (PX5). Dr. Ho performed a second surgical procedure on Petitioner's right shoulder on 8/6/13 and a third and final surgery on 1/21/14. (PX3;PX5). In a letter dated 5/14/14, Dr. Ho found that Petitioner was at maximal medical improvement, noting that "[s]he is currently on permanent disability, so work is no longer an issue. I will see her back in six months just for another clinical check. I would like to see how she is doing. Further surgery would probably not be beneficial for her, and in any case, she is not interested in any further aggressive treatment." (PX5). For her part, Petitioner testified that she has been off work since May of 2013. (T.81). She indicated that she has not looked for work since that time because she "can't use [her] arm…" (T.82). However, Petitioner agreed that no physician has ever told her that she can't physically use her right arm. (T.83).

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As a result, the Commission finds that Petitioner was temporarily totally disabled with respect to her right shoulder injury (10 WC 44158) from 3/16/10 through 10/17/10 and from 8/6/13 through 5/15/14, for a period of 71-2/7 weeks. However, the Commission finds that Petitioner failed to prove her entitlement to TTD for the remaining two claims. Along these lines, Petitioner testified that she lost no time from work as a result of either the slip and fall incident on 5/9/08 (08 WC 32254) or the scissors incident on 5/16/11 (11 WC 45344). Likewise, the Request for Hearing forms introduced into evidence with respect to both claims do not reflect any request for TTD benefits for those dates of accident. (JX1,JX3).

The Commission further finds that pursuant to the agreement of the parties, Respondent is entitled to a credit pursuant to §8(j) for non-occupational disability benefits paid. (T.179).

In addition, the Commission finds that Petitioner is entitled to reasonable and necessary medical expenses relating to her right shoulder, buttocks and left wrist/hand injuries as set forth in PX8-19 and pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act. Furthermore, the Commission finds that Respondent is entitled to a credit for any and all amounts paid on account of said injuries pursuant to §8(j) of the Act, with Petitioner being held harmless for any outstanding balances relating to the expenses for which Respondent is receiving this credit.

Finally, the Commission finds that as a result of the right shoulder injury (10 WC 44158), Petitioner suffered the permanent partial loss of use of 15% person-as-a-whole pursuant to §8(d)2 of the Act. In support of this finding, the Commission notes that Petitioner was 42 years old on the date of the accident (4/9/08) and worked for Respondent as an administrative assistant II. The record shows that she has undergone three (3) surgical procedures to her right shoulder for a full-thickness tear and re-tears of her supraspinatus tendon, the last taking place on 1/21/14 when she underwent 1) arthroscopic debridement and examination of right shoulder; and 2) open rotator cuff repair with application of decellulized dermis graft. (PX5). The last diagnostic study, an MRI of right shoulder performed on 5/3/14, was interpreted as evidencing 1) a full thickness tear of the supraspinatus tendon with at least 1.5 cm tendon retraction and muscle atrophy; 2) small amount of fluid in the subacromial/subdeltoid bursa and small glenohumeral joint effusion, 3) long head of the biceps tendon and labral anchor is not identified suggesting possible tear, and 4) moderate degenerative change of the acromioclavicular joint. (PX5).

In his letter dated 5/14/14, Dr. Ho noted that Petitioner was status post right shoulder rotator cuff repair with two subsequent revisions, the most recent using a dermal augmentation patch. (PX5). Dr. Ho stated that the most recent MRI of the right shoulder "… shows that the patch is in position. However, she does have a small retear at the junction of the patch with the previous rotator cuff. There may be a 15 to 20 millimeter gap in that region…" (PX5). Dr. Ho concluded that "[a]t this point Ms. Garzon is essentially at maximal medical improvement from our standpoint. I told her to just live with this, and she states that she is able to do her basic daily activities. She is still sleeping in a recliner. She finds Flexeril helpful, so we gave her a prescription for the Flexeril. She is currently on permanent disability, so work is no longer an issue. I will see her back in six months just for another clinical check. I would like to see how she is doing. Further surgery would probably not be beneficial for her, and in any case, she is not interested in any further aggressive treatment." (PX5).

Petitioner has been off work since May of 2013 and admittedly has not looked for any other employment. (T.81). Currently, she notices that with respect to her right shoulder she is "... unable to do most things that [she] used to do without having pain." (T.36). She noted that she has pain from her shoulder all the way down her arm, and that "... two, three minutes of using [her] arm [and] the pain starts becoming severe." (T.36). She indicated that she cleans her bathroom "... usually using [her] left arm as much as possible. That's why everything takes longer to do." (T.37). Petitioner also noted that she stopped driving a car right before her third surgery on 1/21/14 "[b]ecause [she] was unable to move [her] arm away from [her] body without severe pain." (T.38-39). She stated that she notices difficulties "[e]ven taking a bath, brushing [her] teeth. It's difficult to wash [her] personal area. [She] ha[s] to use [her] left arm. When [she's] going potty and [she] use[s] [her] right arm, [she] ha[s] pain, but that's the only way [she] can reach." (T.39-40).

Based on the above, the Commission finds that Petitioner suffered the permanent partial loss of use of 15% person-as-a-whole pursuant to §8(d)2 of the Act with respect to claim 10 WC 44158.

With respect to the two (2) remaining claims, 08 WC 32254 and 11 WC 45344, the Commission notes that Petitioner did not testify as to any ongoing complaints relative to her buttocks or her left hand/wrist, respectively, and admittedly lost no time from work for same. Accordingly, the Commission finds Petitioner suffered no permanent disability with respect to either claim, and declines to award any permanency with respect to said dates of injury.

As an aside, the Commission notes that the dates of accident in all three (3) cases predate the effective date of the amendment (9/1/11), and as a result an analysis pursuant to §8.1b is not required.

All other aspects of the Arbitrator's decision are otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that with respect to claim 10 WC 44158 Respondent pay to Petitioner the sum of $605.41 per week for a period of 71-2/7 weeks, from 3/16/10 through 10/17/10 and from 8/6/13 through 5/15/14, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that with respect to claims 08 WC 32254, 10 WC 44158 and 11 WC 45344 Respondent shall pay to Petitioner the reasonable and necessary medical expenses set forth in PX8-19 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that with respect to claim 10 WC 44158 Respondent pay to Petitioner the sum of $544.87 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 permanent partial disability to the extent of 15% person-as-a-whole relative to the right shoulder.

16IWCC0730

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury, including a credit pursuant to §8(j) for non-occupational disability benefits paid.

The party commencing 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: NOV 10 2016
o:9/12/16
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

With respect to claim 10WC44158 I respectfully dissent from the decision of the majority. Arbitrator Williams' findings are thorough and well-reasoned and are grounded in the evidence. This decision is correct and should be affirmed. Regarding claims 08WC32254 and 11WC45344 I concur with the majority and would affirm and adopt.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

GARZON, ANGELIQUE
Employee/Petitioner

Case# **08WC032254**

10WC044158
11WC045344

CITY OF CHICAGO
Employer/Respondent

16IWCC0730

On 2/18/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0139 CORNFIELD & FELDMAN
JIM M VANIKOS
25 E WASHINGTON ST SUITE 1400
CHICAGO, IL 60602

0010 CITY OF CHICAGO DEPT OF LAW
ELIZABETH MANNION
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

16IWCC0730

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

CORRECTED ARBITRATION DECISION

ANGELIQUE GARZON
Employee/Petitioner

v.

CITY OF CHICAGO
Employer/Respondent

Case #08 WC 32254
#10 WC 44158
#11 WC 45344

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on November 20, 2014. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

L. ☒ What is the nature and extent of injury?

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

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On April 9, 2008, May 29, 2008, and May 16, 2011, the respondent was operating under and subject to the provisions of the Act.
- The dates are the subject matter of claim #10 WC 44158, #08 WC 32254 and #11 WC 45344.
- On those dates, an employee-employer relationship existed between the petitioner and respondent.
- Timely notice of the accidents was given to the respondent.
- In the year preceding the injuries, the petitioner earned $46,962.21, $47,413.45 and $53,547.78, respectively; the average weekly wages were $908.12, $911.80 and 1,029.77, respectively.
- At the time of injuries, the petitioner was 42, 43 and 45 years of age, respectively, single with no children under 18.
- The parties agreed that there are no unpaid bills for medical services for the dates of May 29, 2008, and May 16, 2011.
- The parties agreed that the respondent paid $109,459.63 in medical costs for claim #10 WC 44158.

ORDER:

- The petitioner's request for temporary total disability and permanent disability benefits is denied.
- The medical care rendered the petitioner by MercyWorks on May 29 and June 10, 2008, and May 16, 2011, was reasonable and necessary and is awarded. The medical care rendered the petitioner for her right wrist, arm and shoulder was not related to a work injury and is denied. The respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. The

respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

- The petitioner's request for benefits for claim #10 WC 44158 is denied and the claim is dismissed.

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

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

Robert E. Williams

Signature of Arbitrator

February 18, 2015
Date

FEB 18 2015

FINDINGS OF FACTS:

On November 28, 2007, the petitioner, a right-handed Administrative Assistant II employed with respondent since 1990, settled her repetitive right wrist and shoulder injury claim #06 WC 4645. In 2008, she was working at the 3200 S. Kedzie building in Chicago. Her duties through 2008 were data entry for daily production, tree trimming and tree removal, proofreading, copying and filing. She used five-drawer filing cabinets, a paper cutter, a copier, a fax and a telephone. The respondent's office was moved on January 25, 2008, to the 3rd floor at 2342 S. Ashland. The petitioner packed the files into three-foot boxes for moving and unpacked the boxes at the new facility over a two-week period. At the new facility, the petitioner used the printer/copier 10 to 15 times a day, which required her to enter another room through a closed door.

On April 17, 2008, the petitioner reported to the respondent that she began to feel pain in her right wrist, arm and shoulder on April 9, 2008, after being given additional duties that increased her pain level. The incident is the subject matter of claim #10 WC 44158. Pursuant to a referral from Dr. Brian Ralston, the petitioner saw Dr. Joyce Tarbet at the MacNeal Physicians Group on May 15, 2008, and complained of anterior right shoulder pain, which she attributed to an increased workload. The doctor found maximal tenderness in the region of the long head of the biceps tendon, less tenderness over the subacromial space and a minimally positive impingement sign.

On May 29, 2008, the petitioner sought care at MercyWorks for scalp, left elbow and buttocks symptoms. The incident is the subject matter of claim #08 WC 32254. She was given medication and instructions for home exercises. She followed up on June 10th and was discharged.

The petitioner began physical therapy at McNeal Hospital for her right shoulder on June 10, 2008, but reported no change in her symptoms when discharged on July 18, 2008. An MRI of her right shoulder on July 31, 2008, revealed a small partial tear of the anterior insertion of the supraspinatus, a possible tear of the capsular portion of the long head of the biceps tendon, fraying involving the superior labrum and moderate acromioclavicular joint degenerative changes.

Pursuant to a referral from Dr. Brian Ralston, the petitioner saw Dr. Erling Ho at Orthopaedic Associates of Riverside on March 30, 2009, for right shoulder pain attributed to overuse from filing. An MR arthrogram of her right shoulder on April 14, 2009, revealed a full-thickness tear of the anterior fibers of the distal supraspinatus tendon and mild distal subscapularis tendinosis. The petitioner also received a right shoulder injection the same day. Dr. Ho recommended a rotator cuff repair on April 20, 2009.

The petitioner saw Dr. Ho on February 3, 2010, and requested to proceed with a rotator cuff repair. On March 16, 2010, Dr. Ho performed an arthroscopic right rotator cuff repair, a debridement of the glenohumeral joint and a subacromial decompression. An electroneuromyography study on June 22, 2010, was negative for evidence of significant abnormalities, previous or ongoing cervical radiculopathy, brachial plexopathy or medial, ulnar or radial mononeuropathy in her right upper extremity. She received physical therapy and was released to her full duties on October 18, 2010.

On May 16, 2011, the petitioner sought care at MercyWorks for a left wrist puncture wound. The incident is the subject matter of claim #11 WC 45344. She received emergency care at Mercy Hospital and reported scissors slipping and hitting her wrist

while opening a package. Her wound was irrigated and she was given tetanus and bacitracin. The petitioner had a chest scan on August 16, 2011, that revealed no evidence of an acute cardiopulmonary process. A bone scan on August 30, 2011, revealed signs of early arthritic changes in her large joints.

An MRI of her right shoulder on March 22, 2013, revealed a large recurrent full-thickness incomplete tear of the supraspinatus tendon, mild subscapularis tendinosis, a torn long head of biceps tendon with retraction to the bicipital groove, suspected labral tearing and mild acromioclavicular joint degeneration. She sought care at MacNeal Hospital for whole body pain on March 29, 2013. The doctor noted that a 2011 right knee MRI was negative for a meniscal tear. Their assessment was fibromyalgia for her body pain and sacroiliitis for her right buttock pain. On August 6, 2013, Dr. Ho performed an arthroscopic right rotator cuff repair, debridement of the glenohumeral joint and subacromial space and a subacromial decompression with acromioplasty. On September 27, 2013, the petitioner had some shoulder discomfort and reported that she reached in her car the other day. She requested another MRI. The MRI on October 4, 2013, revealed a full-thickness tear of the supraspinatus tendon with retraction and muscle atrophy, fluid in the subacromial/subdeltoid bursa and glenohumeral joint space and moderate acromioclavicular joint degenerative changes.

On January 21, 2014, Dr. Ho performed an arthroscopic right rotator cuff repair and debridement. The petitioner reported pain down her entire right arm, elbow and wrist on April 23, 2014. An MRI of her right shoulder on May 3, 2014, revealed a full-thickness tear of the supraspinatus tendon with a minimal 1.5 mm tendon retraction and muscle atrophy, fluid in the subacromial/subdeltoid bursa, small glenohumeral joint

effusion, an absent long head of biceps tendon and moderate acromioclavicular joint degenerative changes. An MRI of her right elbow the same day revealed mild bone marrow edema in the proximal radius/neck. Dr. Ho noted on May 7, 2014, that the petitioner was unable to use her right arm due to her January surgery. Dr. Ho opined that the petitioner was at maximum medical improvement on May 14, 2014.

FINDING REGARDING WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that she sustained an accident on April 9, 2008, arising out of and in the course of her employment with the respondent.

The petitioner had pre-existing symptoms in her right shoulder due to tendinopathy and degenerative changes in her acromioclavicular joint. In her report to the respondent on April 17, 2008, she attributed the increase in her pain level to additional work duties. Also, when she saw Dr. Tarbet on May 15, 2008, she attributed her right shoulder pain to an increased workload. However, currently the petitioner attributes her shoulder symptoms to the difficulty she had entering and exiting a "vacuum" door and the extra paperwork and stapling in March 2008 for an Arbor Day celebration. Other than the door required a little tug when the windows were opened, there is no evidence of the force needed to either pull or push open the door or how the effort would affect a shoulder. Nor, was there clear and detailed evidence regarding the movements required of the petitioner's right arm to perform her duties, how the movements aggravated her shoulder condition and, except for stapling, the amount and extent of time involved for each task. The evidence presented is not sufficient to establish that the general duties associated with typing, filing, copying, stapling, faxing and opening a door permanently

aggravated or accelerated the petitioner's pre-existing shoulder condition. The opinion of Dr. Ho is conjecture and is not consistent with the evidence. The petitioner's request for benefits for claim #10 WC 44158 is denied.

Based upon the testimony and the evidence submitted, the petitioner proved that she sustained an accident on May 29, 2008, arising out of and in the course of her employment with the respondent. The petitioner slipped, fell and injured her scalp, left elbow and buttock.

Based upon the testimony and the evidence submitted, the petitioner proved that she sustained an accident on May 16, 2011, arising out of and in the course of her employment with the respondent. The petitioner punctured her left wrist with scissors.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner by MercyWorks on May 29 and June 10, 2008, and May 16, 2011, was reasonable and necessary and is awarded. The medical care rendered the petitioner for her right wrist, elbow, arm and shoulder, heart, right knee, fibromyalgia, and right buttock was not related to a work injury and is denied.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that her current condition of ill-being is causally related to a work injury.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that she is entitled to any temporary total disability benefits for her work injuries

on May 29, 2008, and May 16, 2011. The petitioner's request for temporary total disability benefits is denied.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner failed to prove that she is entitled to any permanent partial disability benefits. The petitioner's request for permanent disability benefits is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

- ☐ 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

IWCC, INSURANCE COMPLIANCE DIVISION,

16IWCC0731

Petitioner,

vs. NO. 14 INC 306

BYUNG KIM, individually and
Owner of 680 CLEANERS,

Respondent.

DECISION AND OPINION ON REVIEW

This matter comes before the Commission on the Petitioner's action for penalties for willful failure to comply with the requirement to maintain workers' compensation insurance pursuant to Section 4(d) of the Workers' Compensation Act. Petitioner, the Illinois Workers' Compensation Commission Insurance Compliance Division, represented by the Office of the Attorney General, brought its motion before Commissioner Ruth White in Chicago on June 21, 2016. Respondent, Byung Kim, appeared *pro se* and a record was taken.

Findings of Fact and Conclusions of Law

1. Petitioner called Respondent, Byung Kim, as an adverse witness. The Commission notes that Respondent is not a native English speaker and testified without the benefit of an interpreter.

2. Mr. Kim testified he is 75 years old and operates a dry cleaning business with locations at 680 North Lake Shore Drive and 600 North Lake Shore Drive in Chicago. The location at 600 is only available for residents of the building. The location at 680 is open for business to the general public. Mr. Kim believed he had the 680 location for about 13 years and the 600 location for about two and a half years.

3. The business accepts clothes for dry cleaning from customers and sends them out to a plant to be dry cleaned. Mr. Kim acknowledged he had an employee at both locations. He also acknowledged that his wife performs clothing alterations using scissors, an electric sewing machine and a steam iron which items are used on the premises. There is also an electrically operated device to revolve racks of dry cleaned clothing to retrieve orders. Mr. Kim denied that any chemicals are used on the premises.

4. After his testimony, Commissioner White allowed Respondent to make statements. He stated that he was unaware that he was required to carry workers' compensation insurance until about three years previously when a woman came onto his premises and advised him that he should purchase insurance within 10 days or he would have "trouble or citation or something like that." Mr. Kim stated that he purchased the insurance within three or four days of that conversation.

5. Petitioner called Frank Capuzi to testify. He is Chief of Investigators of the Insurance Compliance Division of the Workers' Compensation Commission. He investigated Respondents' alleged non-compliance. Mr. Capuzi testified he received documentation from the Illinois Department of Revenue and the Illinois Department of Employment Security. Those documents confirmed that Respondent's business declared having employees to both State agencies, every year since at least 2009.

6. Mr. Capuzi also testified that pursuant to his investigation he consulted the official records of the National Commission of Compensation Insurers ("NCCI"). That entity tracks workers' compensation insurance policies issued throughout the country. He believed insurers have to report any change in such insurance policies to that Commission within 24 to 48 hours.

7. Mr. Capuzi identified the official records from NCCI which showed that Respondent had workers' compensation insurance from July 11, 2004 to July 11, 2011. Respondent then did not have workers' compensation insurance from July 12, 2011 to August 24, 2014.

8. Mr. Capuzi noted that when Respondent obtained the new insurance policy in 2011, it used a different Federal Employer's Identification Number ("FEIN") in the application. Mr. Capuzi explained that in his experience employers use that tactic to avoid paying back premiums.

9. On cross examination by Mr. Kim, Mr. Capuzi testified that he did not have the information at hand on which company had issued the previous workers' compensation insurance policies.

10. Mr. Capuzi also acknowledged that the Insurance Compliance Division has the discretion to issue citations for violations of the insurance requirement ranging between $500 and $2,500, *in lieu* of the Attorney General filing a formal charge before the Commission. Mr. Capuzi also explained that "if the company did not have workers' compensation [insurance] in the past, it is more likely they would receive a" citation.

16IWCC0731

11. However, Mr. Capuzi did not believe Respondent would qualify for the lesser penalty of a citation because he had workers' compensation insurance but declined to pay premiums beginning in 2010. He also noted that Mr. Kim denied to investigators that he ever had workers' compensation insurance in the past.

12. After testimony, Respondent presented an exhibit titled "Insurance History" purportedly from State Farm Insurance. It indicated a business policy was in effect from August 31, 2005 to August 25, 2015, and workers' compensation insurance policy in effect between August 25, 2014 and August 25, 2015. Premiums for renewal were both due on August 25, 2015.

Petitioner argues that the record is clear that Respondents willfully violated the requirements of the Act to maintain workers' compensation insurance. It cites the previous insurance and the use of different FEIN to obtain the insurance after it had been terminated. Petitioner seeks penalties of $100,000.00. Respondent, Mr. Kim, claims that he did not remember having previous workers' compensation insurance and he only learned about the requirement when specifically informed of such by the woman after which he purchased it. Mr. Kim argues that at the most he should be subject only to a fine pursuant to citation.

The Commission does not find Mr. Kim's claim of ignorance credible. He has operated a business in Illinois for 13 years and clearly had workers' compensation insurance for most of that time. His decision to cancel/non-renew that insurance appears conscious. In addition, the fact that he reapplied for new insurance with a different FEIN number suggests his knowledge of the process and his attempt to avoid the consequences of previous non-compliance. Finally, Respondent's exhibit is not persuasive. It was unauthenticated and in any event only identified some policies that had been in effect and did not prove that no previous workers' compensation policies had been in effect.

Nevertheless, the Commission finds Petitioner's request for an imposition of a fine of $100,000.00 to be excessive. The Commission is cognizant of the public policy goal of encouraging compliance with the insurance requirement and that high fines could result in higher incentive for such compliance. In addition, fines collected for non-compliance are the only source of money for the Injured Workers' Benefit Fund, which pays benefits to injured workers of non-insured employers. However, in the opinion of the Commission imposing a $100,000 fine probably would result in nothing except the likely discontinuation of Respondent's business; a result which would be of benefit to nobody.

The Commission does not have the authority to convert the instant non-compliance action into a citation action. The power to issue a citation rests solely with an investigator with the compliance division and not a Commissioner. Once a non-compliance action has been instituted and the Commission finds the violation of the insurance requirement was willful, the Commission can levy a fine of up to $500 per day the employer is in noncompliance. However, the Act provides that "the minimum penalty under this Section shall be the sum of $10,000." Therefore, the Commission does not have the discretion to impose a fine of less than $10,000.00.

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The Commission finds the minimum fine of $10,000.00 to be appropriate in this matter. The Commission notes that Respondent's business is small with total payroll ranging between about $3,000 to less than $26,500 per year. Petitioner always had a very limited number of employees and the work activities of employees were not of a particularly dangerous nature. Therefore, the risk of a serious injury, especially a catastrophic injury, was relatively small. The lack of danger associated with Respondent's business operation is supported by the fact that there is no evidence of any workers' compensation claim or any injury associated with Respondents.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondents, Byung Kim and 680 Cleaners pay to the Illinois Workers' Compensation Commission the sum of $10,000.00 pursuant to Section 4(d) of the Act.

DATED: NOV 10 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
R-6/21/16
46

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Constance Orasco,
Petitioner,
vs.

K-Mart,
Respondent,

NO: 12 WC 23412
16IWCC0732

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 prospective medical, temporary total disability, 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 April 27, 2016, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $48,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 10 2016
o110316
DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ORASCO, CONSTANCE
Employee/Petitioner

Case# **12WC023412**

K-MART
Employer/Respondent

16IWCC0732

On 4/27/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.40% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0053 LYNN D BARNETT PC
906 OLIVE ST
SUITE 400
ST LOUIS, MO 63101

4136 ADELSON TESTAN & BRUNDO
MARCY BENNETT
125 S WACKER DR SUITE 1717
CHICAGO, IL 60606

16IWCC0732

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

Constance Orasco
Employee/Petitioner

v.

K-Mart
Employer/Respondent

Case # **12** WC **23412**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael K. Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **August 19, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 11, 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 **$28,017.60**; the average weekly wage was **$548.19**.

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

Respondent shall be given a credit of **$10,598.34** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$10,598.34**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $365.46/week for 133 weeks, commencing 12/12/11 through 6/26/14, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 12/11/12 through 8/19/15, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $10,598.34 for temporary total disability benefits that have been paid.

Respondent shall authorize and pay for future medical treatment as recommended by Dr. Kennedy, necessary to palliate Petitioner's symptoms, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of **$473.03**/week for life, commencing **6/27/14**, as provided in Section 8(f) of the Act.

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

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

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

4/18/16
Date

ICArbDec p. 2

APR 27 2016

FINDINGS OF FACT

Petitioner is a 64 year old widowed female. On December 11, 2011 she was employed as an electronics manager for Respondent. She had been so employed for many years. Her duties included waiting on customers and stocking shelves. She would have to move flat screen TVs, microwaves, vacuums, steamers, radios, and other small appliances. She would have to push flat beds full of stock, handle patio furniture. She would be required to lift at least fifty pounds several times during the course of a day. The Petitioner was on her feet all day, every day, except for lunch and one break.

On December 11, 2011, Petitioner was waiting on a customer when she made a right turn out of an isle and stepped on a sign holder which was on the floor. She stepped on the holder with her right foot. Petitioner stated that her feet flew out from under her and she flew into the air. When she landed, her right leg was out to the right. She attempted to grab onto shelving to break her fall; however the shelving fell on top of her. She landed on her buttocks and she felt an immediate pop in her right leg and hip. Her supervisor, Rachel Petroff, came to the scene and held her hand while she was lying on the floor. An ambulance was summoned and Petitioner was taken to Gateway Regional Hospital. She was diagnosed with a fracture of the right hip.

Dr. Paul Scherer performed emergency open reduction internal fixation with a 32 cm Biomet Trochanteric nail and screws. The doctor had difficulty approximating the fragments because the iliopsoas was attached to a portion of the lesser trochanter. The fracture reduced very poorly. The superior one half of the lesser trochanter was still attached to the medial neck fragment and the iliopsoas tendon was attached to the lesser trochanter. The fracture could not be reduced fully so the rod had to be removed to adjust the fracture fragments. The rod was then reinserted. Perfect reduction was not obtained (PX 2, p. 89).

The Petitioner stayed in the hospital for one week. She was then transferred to Mercy Rehab for approximately six to eight weeks. From there, she was transferred to the Quarters of Des Peres, a skilled nursing facility. She was either in the hospital or nursing homes until February 22, 2012. She was then provided in home physical therapy and gradually progressed to outpatient therapy at SSM St. Mary's for the hip, leg, and low back.

Petitioner testified that prior to her alleged work injury; she suffered a left foot fracture. At the time of the December 11, 2011 injury, Petitioner was wearing a CAM boot on her left foot. Petitioner candidly admitted she experienced some slight back discomfort as a result of using the boot, but the discomfort was nowhere near as severe as the pain she experienced following the work accident. She missed no time from work as a result of the prior back discomfort, nor had she sought any medical treatment.

The Petitioner continued to treat with Dr. Scherer for her right leg and hip. She was having progressively worsening low back pain and Dr. Scherer recommended that she be seen by a back specialist. Respondent's third party administrator referred Petitioner to Dr. James Coyle. Dr. Coyle ordered an MRI and recommended aqua therapy and injections.

Respondent then referred Petitioner to Dr. James T. Doll for evaluation regarding the injections recommended by Dr. Coyle. Dr. Doll first saw the Petitioner on June 11, 2012. At that time, Dr. Doll made the diagnosis of low back pain, lumbar spondylosis/spondylolisthesis, and recent right femur

fracture/ORIF. Dr. Doll recommended aquatic therapy and lumbar epidural steroid injections with fluoroscopic guidance. Dr. Doll placed restrictions on Petitioner. She was to avoid lifting over fifteen pounds and avoid repetitive bending, twisting and squatting. Petitioner returned to Dr. Doll for a lumbar epidural steroid injection on June 14, 2012. Dr. Doll did not comment on restrictions in the note corresponding to the injection. She next followed up with Dr. Doll on June 28, 2012. At that visit Dr. Doll changed Petitioner's restrictions to no lifting over fifteen pounds, avoidance of repetitive bending, twisting and squatting activities and alternating sitting and standing as needed. Petitioner returned to Dr. Doll on July 12, 2012 and a second lumbar epidural steroid injection was performed. Again, Dr. Doll did not comment on restrictions in the note. (PX3) This was the last notation contained in PX3, however the records of Dr. Scherer contain a "work status report," signed by both Dr. Doll and Petitioner dated August 14, 2012, which indicates that as of that date Petitioner was released without restriction with regard to her lumbar spine. (PX2, p.45) The Arbitrator notes, however that there is no evidence in the record which corresponds to the date of the work status report.

Petitioner next returned to Dr. Scherer on July 26, 2012. It was recommended that she continue physical therapy for her back and hip as well as continue pain management. The doctor indicated that Petitioner was capable of doing office work, but none had been made available to her. (PX2, p. 28) On August 18, 2012 Dr. Scherer noted the hip injury has put "significant increased stress on her lower back causing her to be miserable with symptoms from her low back." *Id.*, at 39. Additional physical therapy for the low back was recommended. Petitioner was next seen on August 30, 2012. Dr. Scherer noted that her back pain has been getting worse since physical therapy was terminated, and recommended that it be continued. This office note further indicates that "she has now officially retired." *Id.*, at 3.

Petitioner testified that after she had seen one of the doctors, she was released with restrictions. She indicated that she was informed by Respondent that no job was available within her restrictions. The Arbitrator notes that as of June 28, 2012 Petitioner was under restrictions placed by Dr. Doll as well as Dr. Scherer. Petitioner's testimony regarding her light duty status is consistent with the June 28, 2012 record of Dr. Doll as well as the notes of Dr. Scherer. When Petitioner was made aware of the fact that there was no work available within her restrictions, she sought voluntary retirement.

After concluding treatment with Dr. Doll, Petitioner continued to have problems with her low back as documented in the records of Dr. Scherer. She eventually sought treatment with Dr. David Kennedy, a neurosurgeon. Petitioner first saw Dr. Kennedy on September 25, 2012. Dr. Kennedy found that the Petitioner's motion of the lumbar spine was reduced by about 50% in forward flexion. Straight leg raising caused significant lower lumbar pain with either leg at about 60 degrees. There was quite a bit of tenderness noted in the paraspinal muscles, right greater than left. Dr. Kennedy made the diagnosis of femur fracture requiring fixation and chronic lumbar pain. Dr. Kennedy felt that the Petitioner would benefit from epidural steroid injections and/or facet injections. Dr. Kennedy opined that her symptoms and need for treatment were directly related to the work related injury of December 11, 2011. (PX1, p. 8-9). No treatment was authorized.

Petitioner returned to Dr. Scherer for the final time on October 18, 2012. At that time she was released from care and allowed to return to work without restriction with regard to her right hip fracture.

Petitioner was seen by Dr. Robert J. Bernardi on April 16, 2013 pursuant to § 12. Dr. Bernardi noted that Petitioner had weakness in her right L5 innervated muscles. He indicated Petitioner did not

exhibit any Waddell's signs. The doctor felt that the Petitioner's complaints should be considered causally related to her work accident at K-Mart. Dr. Bernardi recommended additional treatment including a lumbar myelogram coupled with a set of lateral lumbar spine films with flexion and extension views, with a possible need of an EMG/NCS to be performed. At the time of exam Dr. Bernardi indicated that the Petitioner had not yet reached maximum medical improvement from her low back injury (RX2, p. 6).

The lumbar myelogram was performed at St. Louis University Hospital on September 19, 2013. It revealed atrophy of the right iliopsoas and iliacus muscles.

Dr. Kennedy saw the Petitioner again on February 20, 2014. At that time, Petitioner remained symptomatic with persistent pain in the lower lumbar area radiating into the right buttock, right lateral thigh pain with occasional weakness of the right hip. The symptoms were worsened with slight activity and also with any standing for more than a few minutes. She had significant loss of mobility and flexion of the lumbar spine and there were focal areas of tenderness in the lower lumbar area extending to the right sacroiliac area. There was ongoing evidence of muscle irritation. At that time, Dr. Kennedy made the diagnosis of persistent lumbar strain and significant atrophy of the right iliopsoas and iliacus muscles, as revealed by the myelogram, which he believed were a significant source of her pain (PX 1, p. 9-10). Dr. Kennedy stated that the Petitioner probably tore or seriously damaged the nerves that cause the iliopsoas and iliacus muscles to function as a result of the work accident. Dr. Kennedy explained that the iliopsoas and iliacus muscles are large muscles that have some representation in the lumbar area and some in the hip area and their atrophy has caused a significant imbalance of the Petitioner's spine, function, and gait. Dr. Kennedy felt that some trigger point injections and therapy might palliate the Petitioner's pain to some extent, but the muscles that were injured were not going to recover, they were irreversibly damaged. The doctor felt that given the degree of atrophy that was present, there was either complete disruption of the nerve supply or very nearly complete disruption, because the muscles had shrunk so much. Dr. Kennedy felt that the muscles were no longer functional. He opined that Petitioner's condition was permanent because the muscles are missing and they can't be replaced. Dr. Kennedy felt that Petitioner was not able to work. *Id.*, at 12-15.

Dr. Kennedy next saw Petitioner on June 26, 2014. He indicated Petitioner had reached maximum medical improvement, and should remain off work permanently. *Id.*, at 17-18, 22. Dr. Kennedy felt that the Petitioner would be in need of some palliative treatment over the years; however, the treatment would not make a big impact on her overall functional condition, but may help with pain to some extent *Id.*, at 22-23. Dr. Kennedy felt that Petitioner is limited in her ability to ambulate, is not capable of sitting for two to four hours, is not capable of standing for two to four hours, and needs to change positions frequently.

Dr. Bernardi conducted a second §12 evaluation on February 15, 2015. Again, Dr. Bernardi did not detect any Waddell's Signs. His diagnoses related to the work accident were L3-4 and L4-5 degenerative facet disease; spontaneous L5-S1 facet fusion; iliacus and iliopsoas atrophy; low back pain of uncertain etiology. Dr. Bernardi did not believe that the degenerative facet disease was caused by her work accident. He did, however feel that the atrophy of the right iliopsoas and right iliacus muscles are a direct result of the hip fracture. He disagreed with Dr. Kennedy in that he did not think that there was any correlation between the significant atrophy and Petitioner's back symptoms.

Petitioner testified that she has pain every day. She has pain in her lower back around her waist and in her right leg. Her right leg seems heavy and she loses her balance. She cannot get up and down stairs without holding onto something and using her cane. Petitioner stated that certain activities aggravate her pain levels. She can only vacuum half of a room and then her pain increases and she has to lie down. She cannot stand up very long to do anything. She has to lay down four to five times a day to relieve her pain. When she goes grocery shopping she uses her cane and only carries small amounts of groceries. Petitioner also testified she cannot lean over her bed to make it because it causes her back to hurt. She takes ibuprofen and lays flat on her back to decrease her pain.

CONCLUSIONS

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

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

Respondent's disputes as to accident and notice are simply without merit. The unrefuted evidence in the record clearly indicates that Petitioner sustained serious injuries to her hip and back when, while assisting a customer, she stepped on a sign holder which was left on the floor causing her feet to fly out from under her. When she landed, her right leg was out to the right. She had attempted to grab onto shelving to break her fall; however the shelving fell on top of her. She landed on her buttocks and she felt an immediate pop in her right leg and hip. Further, the evidence indicates that her supervisor, Rachel Petroff, came to the scene and sat with Petitioner while awaiting the arrival of an ambulance.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met her burden of establishing that she sustained accidental injuries which arose out of and in the course of her employment with Respondent on December 11, 2011 and that proper notice was provided to Respondent.

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

All of the expert witnesses in this matter agree that Petitioner sustained a serious injury to her right hip in the accident. The essence of the dispute is whether the ongoing symptoms Petitioner is experiencing in her low back are causally related to the accident.

Immediately after the accident Petitioner was hospitalized and underwent an open reduction and internal fixation of a right hip fracture performed by Dr. Scherer. Dr. Scherer's records clearly indicate that the reduction proved difficult and a less than optimal result was obtained. After the accident Petitioner also began experiencing significant and progressive lower back pain.

When Dr. Scherer recommended the low back be addressed Petitioner was sent to Dr. Coyle by Respondent. Eventually Dr. Coyle referred Petitioner to a pain management physician, Dr. Doll. When Dr. Doll initially saw Petitioner on June 11, 2012 he recommended aquatic therapy and lumbar epidural steroid injections with fluoroscopic guidance. Dr. Doll placed restrictions on Petitioner. She was to avoid lifting over fifteen pounds and avoid repetitive bending, twisting and squatting. Petitioner obtained the injections. When Petitioner returned to Dr. Doll on June 28, 2012 he added alternating sitting and standing as needed to the previous restrictions he had placed. Petitioner returned to Dr. Doll on July 12, 2012 for a second lumbar epidural steroid injection. Dr. Doll did not comment on restrictions at that time. (PX3) This was the last office note contained in the record. However, the records of Dr. Scherer contain a "work status report," signed by both Dr. Doll and Petitioner dated August 14, 2012 which indicates that as

of that date Petitioner was released without restriction with regard to her lumbar spine. (PX2, p.45) The Arbitrator notes that this work status report does not correspond with any treatment record to establish the basis for removal of the previously placed restrictions.

The medical records of Dr. Scherer leading up to and following Petitioner's release by Dr. Doll document Petitioner's on going back symptoms.

Petitioner came under the care of Dr. Kennedy on September 25, 2012 for her persistent low back symptoms. Dr. Kennedy testified by way of deposition. Dr. Kennedy diagnosed femur fracture requiring fixation, as well as chronic lumbar pain. Dr. Kennedy felt that the Petitioner would benefit from epidural steroid injections and/or facet injections. Dr. Kennedy opined that the patient's symptoms and need for treatment were directly related to the work related injury of December 11, 2011. No treatment was authorized.

Ultimately Dr. Scherer released Petitioner without restriction on October 18, 2012 with regard to her hip. The Arbitrator notes, however that the atrophy of Petitioner's right iliopsoas and iliacus muscles had not been detected at that time.

Petitioner was then sent to Dr. Bernardi for a §12 examination on April 16, 2013. Dr. Bernardi noted that Petitioner had weakness in her right L5 innervated muscles. He felt, at that time, that Petitioner's complaints should be considered causally related to her work accident. Dr. Bernardi recommended a lumbar myelogram coupled with a set of lateral lumbar spine films with flexion and extension views, with a possible need for an EMG/NCS. He felt that Petitioner had not yet reached maximum medical improvement from a perspective of her low back injury

The lumbar myelogram was performed at St. Louis University Hospital on September 19, 2013. It revealed atrophy of the right iliopsoas and iliacus muscles.

Dr. Kennedy saw the Petitioner again on February 20, 2014. At that time, Petitioner remained symptomatic with persistent pain in the lower lumbar area radiating into the right buttock, right lateral thigh pain with occasional weakness of the right hip. Dr. Kennedy diagnosed persistent lumbar strain, and significant atrophy of the right iliopsoas and iliacus muscles which he believed were a significant source of her pain. Dr. Kennedy credibly explained how the muscle atrophy was related to Petitioner's ongoing symptoms. Dr. Kennedy saw Petitioner for the last time on June 26, 2014. He indicated Petitioner had reached maximum medical improvement, but should remain off work permanently. Dr. Kennedy felt that the Petitioner would be in need of treatment over the years in order to help with pain to some extent. Dr. Kennedy felt that Petitioner is limited in her ability to ambulate, is not capable of sitting for two to four hours, is not capable of standing for two to four hours, and needs to change positions frequently. It was his opinion that the Petitioner's condition as of that last visit was a direct result of the work injury.

Petitioner saw Dr. Bernardi for a final §12 evaluation on February 15, 2015. He agreed that the atrophy of the right iliopsoas and right iliacus muscles are a direct result of the hip fracture. He disagreed with Dr. Kennedy's opinion in that he did not think that there was any correlation between the significant muscle atrophy and Petitioner's symptoms. He simply felt that she had low back pain of uncertain etiology.

The Arbitrator found the testimony and opinions of Dr. Kennedy much more persuasive than the opinions of Dr. Bernardi in this case.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met her burden of establishing that her current condition of ill-being is causally related to the accident of December 11, 2011.

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

Respondent paid TTD benefits from December 12, 2011 through July 1, 2012. Petitioner claims entitlement to TTD thereafter and Respondent disputes their liability to pay those benefits because Petitioner retired from Respondent in June of 2012.

Respondent asserts that its decision to terminate TTD because Petitioner voluntarily retired (and began receiving retirement benefits which were significantly lower than her TTD benefits) is supported by *Interstate Scaffolding, Inc. v. Ill. Workers' Comp. Comm'n*, 236 Ill. 2d 132, 923 N.E.2d 266, 337 Ill. Dec. 707 (Ill., 2010). Respondent's reliance on *Interstate Scaffolding* is misguided. In *Interstate Scaffolding* the Commission awarded the claimant TTD benefits, finding that the work-related injury had not yet stabilized. The Appellate Court agreed with the Commission's factual findings that the work-related injury had not stabilized and that the claimant remained temporarily and totally disabled. Nevertheless, the appellate court set aside the Commission's award because the claimant had been discharged by his employer due to conduct unrelated to his injury while working light duty. The employer in *Interstate Scaffolding* relied on two cases which it claimed justified denial of TTD benefits, *City of Granite City v. Industrial Comm'n*, 279 Ill. App. 3d 1087, 666 N.E.2d 827, 217 Ill. Dec. 158 (1996)(claimant was denied TTD not because he was simultaneously receiving disability pension benefits, but because the claimant was able to work), and *Schmidgall v. Industrial Comm'n*, 268 Ill. App. 3d 845, 644 N.E.2d 1206, 206 Ill. Dec. 153 (1994)(Claimant was awarded TTD while simultaneously receiving Social Security Pension benefits). In rejecting the employer's arguments our Supreme Court stated:

> In both *Schmidgall* and *Granite City*, the touchstone for determining whether the claimants were entitled to TTD benefits was not the voluntariness of their departure from the workforce, as the appellate court believed. Rather, the touchstone was whether the claimants' conditions had stabilized to the extent that they were able to reenter the work force.

Interstate Scaffolding, 236 Ill. 2d at 148. The Court went on to point out "the determinative inquiry for deciding entitlement to TTD benefits remains, as always, whether the claimant's condition has stabilized. If the injured employee is able to show that he continues to be temporarily totally disabled as a result of his work-related injury, the employee is entitled to TTD benefits. *Id.*, at 149.

Petitioner was under the care of Dr. Doll and Dr. Scherer on the date TTD was terminated. Both doctors had indicated Petitioner was able to work with restrictions in a sedentary position. Respondent never offered work within her restrictions. Petitioner credibly testified that she informed Respondent of the restrictions placed upon her by Dr. Scherer and was advised Respondent had no work for her within those restrictions. Although Dr. Doll apparently released Petitioner to return to work without restriction with regard to her low back on August 14, 2012, she remained under restrictions by Dr. Scherer at that time. Petitioner then came under the care of Dr. Kennedy on September 25, 2012. Dr. Kennedy opined

that Petitioner was incapable of returning to her former employment. When Petitioner returned to Dr. Scherer for the final time on October 18, 2012, she was released from his care and allowed to return to work without restriction, with regard to her right hip fracture. However, she remained under the restrictions placed by Dr. Kennedy due to her low back. Further, Petitioner was seen by Dr. Bernardi on April 16, 2013 pursuant to § 12. Dr. Bernardi noted that Petitioner had not yet reached maximum medical improvement from her low back injury (RX2, p. 6).

When Dr. Kennedy saw Petitioner on June 26, 2014 he indicated Petitioner had reached maximum medical improvement, but should remain off work permanently. He felt that Petitioner is limited in her ability to ambulate, is not capable of sitting for two to four hours, is not capable of standing for two to four hours, and needs to change positions frequently.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met her burden of establishing that she was temporarily and totally disabled from December 12, 2011 through June 26, 2014, the date she reached MMI. Respondent shall, therefore pay Petitioner temporary total disability benefits of $365.46/week for 132 6/7 weeks, commencing December 12, 2011 through June 26, 2014, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $10,598.34 for temporary total disability benefits that have been paid.

Issue (L): What is the nature and extent of the injury?
Issue (O) Is Petitioner entitled to any prospective medical care?

Petitioner sustained serious injuries to her right hip and low back on December 11, 2011. She underwent emergency open reduction internal fixation of her right hip fracture. The doctor had difficulty approximating the fragments and perfect reduction could not be obtained.

The medical records in evidence clearly establish consistent and progressively worsening symptoms in Petitioner's low back. When Petitioner was seen by Dr. Bernardi on April 16, 2013 he noted weakness in her right L5 innervated muscles. Following a lumbar myelogram on September 19, 2013 it was determined that Petitioner was suffering significant atrophy of the right iliopsoas and iliacus muscles.

Dr. Kennedy explained that the psoas and iliacus muscles are large muscles that have some representation in the lumbar area and some in the hip area and their atrophy has caused a significant imbalance of the Petitioner's spine, function, and gait. Dr. Kennedy felt that given the degree of atrophy that was present, that there was either complete disruption of the nerve supply or very nearly complete disruption because the muscles had shrunk so much. He indicated that the muscles were no longer functional. He opined that Petitioner's condition was permanent because the muscles are missing and they can't be replaced. On June 26, 2014 Dr. Kennedy indicated Petitioner had reached maximum medical improvement, and should remain off work permanently. Dr. Kennedy felt that the Petitioner would be in need of palliative treatment over the years to reduce her pain to a some extent; however, the treatment would not make a big impact on her overall functional condition. Dr. Kennedy testified that Petitioner is limited in her ability to ambulate, is not capable of sitting for two to four hours, is not capable of standing for two to four hours, and needs to change positions frequently. Dr. Kennedy felt that Petitioner was not able to work.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that as a result of the injuries sustained on December 11, 2011, Petitioner is permanently and totally disabled pursuant to Section 8(f) of the Act. The Arbitrator further finds Petitioner is entitled to prospective medical care.

Respondent shall pay Petitioner permanent and total disability benefits of $473.03/week for life, commencing 6/27/14, as provided in Section 8(f) of the Act. Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in Section 8(g) of the Act. Respondent shall further authorize and pay for prospective reasonable and necessary medical services as ordered by Dr. Kennedy, as provided in Sections 8(a) and 8.2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF ROCK ISLAND)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cameron Brown ,

Petitioner,

vs.

NO: 14 WC 09652

16IWCC0733

Benson's Appliance,

Respondent,

DECISION AND OPINION ON REVIEW

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

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

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $22,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 10 2016
O110316
DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

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

BROWN, CAMERON
Employee/Petitioner

Case# **14WC009652**

BENSON'S APPLIANCE
Employer/Respondent

16IWCC0733

On 10/27/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.15% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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

0766 HENNESSY & ROACH PC
QUINN M BRENNAN
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

16IWCC0733

STATE OF ILLINOIS)
)SS.
COUNTY OF ROCK ISLAND)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Cameron Brown
Employee/Petitioner
v.

Benson's Appliance
Employer/Respondent

Case # **14** WC **9652**

An *Application for Adjustment 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 **Rock Island**, on **September 3, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **February 17, 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 **$20,800.00**; the average weekly wage was **$400.00**.

On the date of accident, Petitioner was **32** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of **$14,483.50** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$14,483.50**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$286.00**/week for **79 1/7** weeks, commencing **February 27, 2014** through **September 3, 2015**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$76,608.59,** as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay, pursuant to the medical fee schedule, the reasonable and necessary costs associated with the surgical procedure recommended for the Petitioner by Dr. Kube, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Arbitrator Anthony C. Erbacci

October 19, 2015
Date

OCT 27 2015

FACTS:

On February 14, 2014 the Petitioner sustained undisputed accidental injuries arising out of and in the course of his employment with the Respondent as an appliance delivery driver. The Petitioner testified that his job responsibilities included the loading and unloading of appliances into and out of a truck, and the delivery, repair and installation of appliances consisting of washers and dryers, refrigerators, microwaves, etc. The Petitioner testified that he had worked for Respondent since 2009.

The Petitioner testified that on the morning of February 17, 2014, he and a co-worker were loading a washing machine onto a truck with a dolly, and as the two were loading the machine the Petitioner experienced a "pop" in his lower back. He testified that he continued to attempt to work but was unable to continue. He testified that he reported the injury to his supervisor, Scott Benson, who directed the Petitioner to Proctor First Care.

The Petitioner presented to Proctor First Care that same day and gave a consistent history of injury. The Petitioner complained of low back pain, shortness of breath and tingling in all five of his left toes. The note indicates that there was evidence of exaggerated pain behavior and negative straight leg raise. The Petitioner was diagnosed as having low back pain and he was prescribed Norflex and Naproxen. The Petitioner was also placed on light duty restrictions.

The Petitioner continued to follow up at Proctor First Care and continued to complain of low back pain. On February 19, 2014 the Petitioner was continued on light duty restrictions and prescribed physical therapy. On February 28, 2014, X-rays were taken, revealing "minimal narrowing of the L5-S1 disc space level and L4-L5 disc space level without acute fractures or subluxations."

The Petitioner testified that he continued to work in a light duty capacity through February 26, 2014 and that he was then terminated by the Respondent. Scott Benson, the Respondent's President, testified that the Respondent attempted to accommodate the Petitioner's light duty restrictions and that he terminated the Petitioner on March 5, 2014 for an alleged act of theft.

The Petitioner continued to follow up at Proctor First Care and he continued to participate in physical therapy at Accelerated Rehabilitation. The Petitioner testified that he participated in approximately 30 physical therapy sessions. On April 7, 2014 an MRI was recommended for the Petitioner.

On April 17, 2014 the Petitioner sought treatment with Dr. Richard Kube. The Petitioner provided Dr. Kube with a consistent history of injury and reported that his condition was not getting better. Dr. Kube reviewed the imaging studies, and felt that the lumbar spine series demonstrated a loss of disc height, especially toward the low lumbar spine. Dr. Kube diagnosed the Petitioner with a sacroiliac joint injury as well as a probable aggravated degenerative disc from a work injury. Dr. Kube recommended sacroiliac joint injections to see how much of the Petitioner's disorder was coming from that space, and he indicated that, depending the results, he would determine the next steps for treatment.

The Petitioner underwent an MRI at Proctor Hospital on April 25, 2015. The MRI was interpreted to reveal "degenerative disc disease of the lower two lumbar disc spaces."

On May 5, 2014, the Petitioner underwent right and left sacroiliac joint injections. His diagnosis was bilateral sacroiliac joint pain.

On June 9, 2014, the Petitioner underwent right and left epidural steroid injections at L4-5 and L5-S1. His diagnosis at this injection was a left-sided L5-S1 herniated disc.

On June 26, 2014, Dr. Kube recommended an NCV/EMG and a provocative discogram so that he could determine the specific pain generator. Dr. Kube indicated that he was very suspicious of the L5-S1 disc with the annular tear and that he wanted to determine whether the L4-5 disc was also a component.

On July 17, 2014, the Petitioner underwent an EMG/NCV with Dr. Edward Trudeau. Dr. Trudeau's note indicates that the Petitioner's MRI which was interpreted by Dr. Kube to reveal a disc herniation more paracentral on the left side at L5-S1; lumbarized S1 vertebra; and a degenerative disc at L4-5. Dr. Trudeau reported that the nerve conduction studies in the lower extremities were normal and that the EMG showed evidence of a moderately severe right S1 radiculopathy, which Dr. Trudeau surmised was secondary to disc abnormality at L5-S1. Dr. Trudeau also noted evidence of mild left S1 root irritation, but no evidence of L5 or L4 radiculopathy on either side. Dr. Trudeau indicated that he suspected the Petitioner's difficulties were related to the L5-S1 disc herniation compromising the S1 nerve roots bilaterally and especially on the right side.

On July 28, 2014, the Petitioner underwent a provocative discogram at L3-4, L5-5, and L5-S1.

On August 4, 2014, the Petitioner presented to Dr. Kube for follow up. Dr. Kube felt that Petitioner was positive at L4-5 and L5-S1 and noted that the NCV was consistent with L5-S1. Dr. Kube recommended the Petitioner move forward with decompression and fusion versus living with where he was and considering a functional capacity evaluation. The Petitioner testified that he wishes to proceed with the recommended fusion.

At the request of the Respondent, the Petitioner was examined by Dr. Sergei Neckrysh on November 13, 2014. Dr. Neckrysh diagnosed the Petitioner with "low back pain without radiculopathy" and he opined that there was a "significant mismatch between the clinical history, clinical findings, imaging studies and EMG studies in [Petitioner]." Given the inconsistent history, Dr. Neckrysh concluded that the Petitioner's alleged current condition of ill-being was not causally connected to the work accident. He noted foraminal stenosis on the left much worse than the right, but that the Petitioner's symptoms were on the right with no symptoms on the left. He opined that the Petitioner presented with a history of someone who would have had an acute disc herniation, but that there was no evidence of a herniation on the MRI film. He noted that the MRI was of "borderline" quality, and he recommended that the Petitioner get a study of better quality. Dr. Neckrysh also suggested a CT myelogram to potentially identify a lesion which was not identified on the MRI, and to also consider a nerve root block at L5-S1 to eliminate stenosis at that level as a potential pain generator.

The Petitioner underwent a second MRI at the same location as the first on December 19, 2014. This MRI was compared to the previous, and was interpreted to reveal a 7mm right paracentral

disc herniation at L2-3 impinging on the right L3 nerve root; and a disc bulge and degenerative changes.

Dr. Neckrysh authored an addendum report on March 2, 2015. Dr. Neckrysh noted that the updated MRI was performed at the same facility and that it was again of poor quality, but slightly better resolution. Dr. Neckrysh opined that, when compared to the previous MRI, there were some cuts that revealed a disc bulge at L3-4, not L2-3 as noted in the radiologist report and that at L5-S1 there was a degenerative disc bulge producing bilateral foraminal stenosis much worse on the left than on the right side. Dr. Neckrysh again opined that the Petitioner's current condition of ill-being was not causally connected to the work accident and he indicated that he disagreed with the surgical recommendations. Dr. Neckrysh opined that surgery was "very premature and may not be necessary at all" and had a "minimal" chance of a good outcome. He concluded that regardless of cause of the Petitioner's condition, he would hold off on declaring the Petitioner to be at maximum medical improvement from his injury until he receives selective nerve root blocks at the L3-4, L4-5 and L5-S1 levels on the right side, which will determine the need for any further interventions.

The Petitioner continued to follow up with Dr. Kube on a monthly basis and the last visit that the Petitioner had with Dr. Kube was on July 21, 2015. As of that time, Dr. Kube continued to recommend surgery for the Petitioner and he continued to keep the Petitioner off work pending that surgery.

The June 15, 2015 evidence deposition testimony of Dr. Kube's was admitted into the record as Petitioner's Exhibit 8. Dr. Kube testified as to his examinations and treatment of the Petitioner and he also testified as to disagreements with the opinions of Dr. Neckrysh. Dr. Kube opined that, based upon the Petitioner's history of injury and the lack of any significant lumbar or radicular problems prior to the time of the injury, as well as the diagnostic testing that he reviewed including x-rays and MRI, discogram and EMG and the physical examination that he performed on the Petitioner, the Petitioner, at a minimum, aggravated the condition of his low back. Dr. Kube also indicated that the mechanism of injury described was consistent with the Petitioner's condition as the Petitioner injured his back during a lift. Dr. Kube also testified that the treatment he provided to the Petitioner as well as the work restrictions he placed on the Petitioner were reasonable and necessary and causally related to the Petitioner's February 17, 2014 work injury.

The July 21, 2015 evidence deposition testimony of Dr. Neckrysh was admitted into the record as Respondent's Exhibit 5. Dr. Neckrysh testified as to his examination of the Petitioner and the records he reviewed. Dr. Neckrysh testified that he had difficulty connecting the Petitioner's complaints to the work accident and that he questioned whether the Petitioner actually had an accident. Dr. Neckrysh opined that regardless of his causation opinions, the treatment the Petitioner received up until the date of his examination of the Petitioner was medically appropriate. Dr. Neckrysh further opined that Dr. Kube's surgical recommendation was premature and the Petitioner should undergo selective nerve root blocks prior to considering surgery. Dr. Neckrysh indicated that the Petitioner was not at maximum medical improvement and that he should be continued off work until after his actual condition could be determined.

The Petitioner testified that he had no back problems prior to the accident of February 17, 2014, nor had he had any accidents, injuries, or medical treatment involving his back. The Petitioner testified that he currently continues to experience pain in his lower back and that bending, lifting and

prolonged walking causes an increase in his back pain. The Petitioner testified that the more activity he engages in, the more his pain increases.

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 Petitioner sustained undisputed accidental injuries arising out of and in the course of his employment with the Respondent on February 14, 2014 when he experienced pain in his back while lifting a washing machine. The Petitioner immediately reported his injury and began a course of medical treatment at Proctor First Care, a facility to which he was directed by the Respondent. The Petitioner was diagnosed as having low back pain and he was prescribed medications and physical therapy and he was placed on light duty restrictions. The Petitioner continued to follow up at Proctor First Care and continued to work in a light duty capacity through February 26, 2014 when his employment was terminated.

Thereafter, the Petitioner sought treatment with Dr. Richard Kube who ultimately diagnosed the Petitioner with an aggravation of his degenerative discs at L4-5 and L5-S1 with an annular tear at L5-S1 and radiculopathy. Dr. Kube has prescribed surgery for the Petitioner and opined that the Petitioner's condition of ill-being and his need for surgery is causally related to the work injury of February 14, 2014.

Dr. Neckrysh, the Respondent's examining physician, did not connect the Petitioner's complaints to the work accident and he questioned whether the Petitioner actually had an accident. The Arbitrator notes, however, that the accident was not disputed and no evidence which contradicted the Petitioner's testimony regarding the accident was offered into the record. The Arbitrator also notes that Dr. Neckrysh opined that regardless of his causation opinions, the treatment the Petitioner received up until the date of his examination of the Petitioner was medically appropriate, that the Petitioner was not at maximum medical improvement, and that the Petitioner should be continued off work until his actual condition could be determined. Dr. Neckrysh also opined that Dr. Kube's surgical recommendation was premature and the Petitioner should undergo selective nerve root blocks prior to considering surgery.

The Petitioner testified that he had no back pain or problems prior to his work injury, nor had he had any accidents, injuries, or medical treatment, involving his back. The Arbitrator finds that the Petitioner's testimony in that regard was credible and not contradicted or rebutted. The Arbitrator also notes that the Petitioner was employed by the Respondent as an appliance delivery man for over three years prior to his injury and was apparently able to perform the duties of that job without difficulty. The Petitioner testified that he currently continues to experience pain in his lower back and that bending, lifting and prolonged walking causes an increase in his back pain. The Petitioner testified that the more activity he engages in, the more his pain increases.

While the Arbitrator notes the opinions of Dr. Neckrysh, the Arbitrator finds the opinions of Dr. Kube to be sufficiently credible, reliable, and persuasive so as to satisfy the Petitioner's burden of proof in the instant matter. In so finding, the Arbitrator notes that Dr. Neckrysh agreed that the treatment the Petitioner had received was medically appropriate, and he opined that the Petitioner was not at maximum medical improvement and should be continued off work. The Arbitrator also notes the credible testimony of the Petitioner relative to the accident, the lack of evidence of any prior back problems or treatment, and the Petitioner's apparent ability to perform the duties of his job without difficulty for at least three years prior to the injury.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the undisputed work injury of February 17, 2014.

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's findings and conclusions relating to the issue of causation are adopted and incorporated herein.

The Petitioner introduced the following medical bills into evidence as Petitioner's Exhibit 7. The Arbitrator has found that the Petitioner's current condition of ill-being is causally related to the undisputed work injury of February 17, 2014 and Dr.Kube, the Petitioner's treating physiacian, as well as Dr. Neckrysh, the Respondent's examining physician, have opined that the medical treatment the Petitioner received was medically appropriate, the Arbitrator finds the medical treatment the Petitioner received to bereasonable, necessary and causally related to the work injury of February 17, 2014. The Arbitrator, therefore, awards the following medical bills, subject to the limitations of the Medical Fee Schedule provided for in the Act:

PROVIDER	AMOUNT
Accelerated Rehabilitation	$12,570.00
Memorial Medical Center	$1,572.00
Prairie Spine and Pain Institute	$20,825.10
Prairie SurgiCare	$36,745.49
Proctor First Care	$1,198.00
Dr. Edward Trudeau	$3,698.00
TOTAL	**$76,608.59**

In Support of the Arbitrator's Decision relating to (K.), Is Petitioner entitled to any prospective medical care, the Arbitrator finds and concludes as follows:

The Arbitrator's findings and conclusions relating to the issue of causation are adopted and incorporated herein.

The Arbitrator has found that the Petitioner's current condition of ill-being is causally related to the undisputed work injury of February 17, 2014 and that the opinions of Dr. Kube are sufficiently credible, reliable, and persuasive so as to satisfy the Petitioner's burden of proof in the instant matter. Dr. Kube, the Petitioner's treating physician, testified that the Petitioner is in need of a L4-L5 and L5-S1 decompression and fusion. While Dr. Neckrysh, the Respondent's examining physician, opined that Dr. Kube's surgical recommendation was premature and that the Petitioner should undergo selective nerve root blocks prior to considering surgery, he agreed that the Petitioner was not at maximum medical improvement.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the surgical procedure recommended for the Petitioner by Dr. Kube is reasonable, necessary and causally related medical treatment which the Respondent is liable to provide to the Petitioner pursuant to Section 8(a) of the Act.

In Support of the Arbitrator's Decision relating to (L.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Arbitrator's findings and conclusions relating to the issue of causation are adopted and incorporated herein.

The Petitioner was provided with work restrictions when he initially sought treatment at Proctor First Care on February 17, 2014. The Petitioner testified that he continued to work under those restrictions until his employment was terminated by the Respondent on February 26, 2014. The Petitioner testified that the last day that he worked at the Respondent was February 26, 2014 and that he has not returned to any type of work since that time. The medical records as well as the testimony of Dr. Kube and Dr. Neckrysh demonstrate that the Petitioner has been under light duty restrictions or been prescribed completely off work from the time of his initial medical treatment at Proctor First Care on February 17, 2014 through the date of hearing.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner is entitled to Temporary Total Disability benefits from February 27, 2014 through September 3, 2015, a period of 79 1/7 weeks.

The Arbitrator notes that the Petitioner testified and Arbitrator's Exhibit 1 demonstrates that the Respondent has paid $14,483.50 in Temporary Total Disability benefits for which it is entitled to a credit.

In Support of the Arbitrator's Decision relating to (M.), Should penalties or fees be imposed upon Respondent, the Arbitrator finds and concludes as follows:

The Arbitrator's findings and conclusions relating to the issue of causation are adopted and incorporated herein.

The Arbitrator finds that the Respondent reasonably relied on the findings and opinions of Dr. Neckrysh, its examining physician, the Respondent's reliance on those opinions was not objectively unreasonable in the instant matter. The Petitioner's request for penalties and fees is, therefore, 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

Carole Whipple,
Petitioner,
vs.

NO: 13 WC 33187

St. John's Hospital,
Respondent,

16IWCC0734

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 18, 2016, is hereby affirmed and adopted.

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

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

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

DATED: NOV 10 2016
o110316
DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

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

WHIPPLE, CAROLE
Employee/Petitioner

Case# 13WC033187

16IWCC0734

ST JOHN'S HOSPITAL
Employer/Respondent

On 5/18/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.37% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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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HRVA,No. 2289-T7677/BES/aeo

16IWCC0734

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Carole Whipple
Employee/Petitioner

v.

St. John's Hospital
Employer/Respondent

Case # **13** WC **33187**

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 **Springfield**, on **April 15, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0734

FINDINGS

On **July 30, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$38,756.12**; the average weekly wage was **$745.31**.

On the date of accident, Petitioner was **67** 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.

ORDER

Petitioner's current condition of severe osteoarthritis of the right knee is not causally related to the **July 30, 2012**, work accident.

Petitioner's request for prospective medical, including her request for authorization of a right knee replacement is denied because it is not related to the **July 30, 2012**, work accident.

Respondent does not owe any of Petitioner's unpaid medical bills.

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

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

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

D. Dflow McCarty 05/16/2016

Signature of Arbitrator Date

MAY 18 2016

Carole Whipple
Employee/Petitioner

v.

St. John's Hospital
Employer/Respondent

Case # **13 WC 33187**

Setting: **Springfield**

FINDINGS OF FACT

Petitioner Carole Whipple testified that she was employed with St. John's Hospital as a division secretary on July 30, 2012. (Tr. p. 9, 27). On July 30, 2012, Petitioner was 67 years old. (Tr. p. 26). On that date, Petitioner testified that she "fell, went down on my right knee and braced it with my right hand and went down on my right knee." She was not sure what happened, but described metal strips that she must have stepped on and tripped over. (Tr. p. 10-11). Petitioner testified that she went back to her office and about a half hour later her right knee was huge and it was throbbing. (Tr. p. 12). Petitioner testified that she sought treatment at Priority Care the next day, July 31, 2012. (Tr. p. 12).

Petitioner testified that she has used a cane since the July 30, 2012, work incident. (Tr. p. 14). She explained that the cane was given to her by a St. John's manager. (Tr. p. 14). Petitioner admitted that prior to the work incident, she had problems with her right knee but it was not unbearable. (Tr. p. 14). Further, Petitioner admitted she received right knee injections and had also been recommended for a bilateral knee replacement prior to the work incident. (Tr. p. 14-15). Petitioner testified that she had been recommended for a bilateral knee replacement "years ago" and that she "didn't want to do it until [she] absolutely had to." (Tr. p. 28). Petitioner testified that her right knee began to bother her in the late 1990s. (Tr. p. 29-30). She testified that her right knee would swell, she had pain in it, and it would grind. (Tr. p. 30). Petitioner testified that a fall in 1999 may have initially started her knee pain. (Tr. p. 31-32).

Petitioner testified that she obtained a disability placard for handicap parking several years ago because she had told Dr. Juranek that she was having trouble with her knees. (Tr. p. 38). While she testified at trial that only her left knee was bothering her at that time, Petitioner admitted she told Dr. Juranek she needed the placard for both knees. (Tr. p. 38).

Records prior to July 30, 2012

Petitioner's medical records that pre-date the incident of July 30, 2012, show an extensive history of bilateral knee pain. (R.X. 1). As early as February 2, 1996, Petitioner reported bilateral knee pain to Dr. Ludwig. (R.X. 1, p. 1). Petitioner reported her knees hurting and having problems getting up out of a chair, not being able to get out of the car, having trouble stair climbing, and being unable to squat. (R.X. 1, p. 1). The pain in her knees was located in the front of her knees. (R.X. 1, p. 1). Further, Petitioner reported a previous fall and injury to her right knee that was suggestive of torn cartilage. (R.X. 1, p. 1). Dr. Ludwig's physical examination revealed grossly positive patellofemoral

compression test bilaterally and joint lines were minimally tender, especially medially. (R.X. 1, p. 1). X-rays showed medial compartment and patellofemoral arthritis, worse on the right than the left. (R.X. 1, p. 1).

Petitioner was seen by Dr. Borowiecki on September 23, 1999, and reported a fall in a parking lot on August 26, 1999. (R.X. 1, p. 4). She reported having right knee pain. (R.X. 1, p. 4). Dr. Borowiecki diagnosed her with bilateral patellofemoral crepitus and a right degenerative meniscal tear, as well as generalized degenerative changes of the whole right knee. (R.X. 1, p. 4). She had moderately severe degenerative changes with the right medial joint space narrowing, osteophyte formation throughout all 3 compartments, and rather significant degenerative changes involving the whole right knee. (R.X. 1, p. 4). Dr. Borowiecki opined that a right knee "arthroscopy, in the future, may be indicated; however, [he is] concerned that some of her symptoms at least are due to the degenerative process which arthroscopy would not specifically address." (R.X. 1, p. 4).

Petitioner then underwent physical therapy for the right knee and saw Dr. Borowiecki again on October 6, 1999. (R.X. 1, p. 5). Therapy had relieved about 50% of her right knee pain and she had a lot of crepitus with range of motion. (R.X. 1, p. 5). Dr. Borowiecki opined that she exacerbated her arthritic knee and recommended continued therapy. (R.X. 1, p. 5). On November 9, 1999, Dr. Borowiecki saw Petitioner and reported that her symptoms of crepitus and stiffness were mostly due to degenerative arthritis. (R.X. 1, p. 6). On November 30, 1999, Petitioner received an injection to her right knee for moderately severe arthrosis of the knee. (R.X. 1, p. 7). On December 16, 1999, Petitioner obtained another injection to her right knee and reported that the right knee "still kind of clicks and pops and she feels crepitation." (R.X. 1, p. 8).

On May 18, 2000, Petitioner reported her left knee was now bothering her more than the right, with crepitus present bilaterally. (R.X. 1, p. 11). She then underwent a series of left knee injections. (R.X. 1, p. 11-14). On October 11, 2002, Petitioner was seen at Orthopedic Center of Illinois by Dr. VanFleet and his physicians' assistant Ed Burns. She presented with a longstanding history of bilateral knee pain. (R.X. 1, p. 15). The record indicates that she underwent a left knee arthroscopy in 2001 and now her right knee is much worse. (R.X. 1, p. 15). She reported pain with ascending and descending stairs and finds it difficult to kneel. (R.X. 1, p. 15). Petitioner reported that her pain is significant and interferes with her activities of daily living. (R.X. 1, p. 15). Petitioner also reported peripatellar tenderness on the right. X-rays of the right knee revealed posterior bony spurs in addition to loose body, which appears to be intraarticular. (R.X. 1, p. 16). She was diagnosed with bilateral degenerative joint disease and recommended a right knee injection. (R.X. 1, p. 16). Further, Petitioner was informed that "she will come to require bilateral total knee replacements. She states that she plans to carry this out in the first part of 2003." (R.X. 1, p. 16).

On October 30, 2002, Petitioner received bilateral knee injections and indicated that she is contemplating knee replacements. (R.X. 1, p. 17). Her x-rays reviewed bilateral knee osteoarthrosis. (R.X. 1, p. 17). On December 18, 2002, Petitioner received another round of bilateral knee injections and her x-rays demonstrated advanced medial compartment arthrosis bilaterally. (R.X. 1, p. 19).

In December 2006, Dr. Borowiecki signed and completed a "Persons with Disabilities Certification for Parking Placard" stating that because of knee osteoarthritis, Petitioner is severely limited in her ability to walk. (R.X. 3, p. 3-4). In 2010, Dr. Juranek similarly signed and completed a form stating Petitioner is severely limited in her ability to walk due to knee arthritis. (R.X. 3, p. 1-2). Both doctors noted that that her knee condition was a permanent disability. (R.X. 3, p. 1-4).

On August 7, 2009, Petitioner complained of bilateral knee pain, although her left was worse than right. (R.X. 1, p. 24). Dr. Borowiecki's examination revealed mild swelling to both knees, tenderness to palpation over the medial and lateral joint lines bilaterally, significant amount of crepitation and grinding noted with flexion and extension of the knees bilaterally in the patellofemoral region. She was diagnosed with bilateral knee osteoarthritis. Dr. Borowiecki's report stated that Petitioner "knows she is going to need to have the knees replaced, but she is trying to put this off until she retires which is about a year from now." (R.X. 1, p. 24). Dr. Borowiecki injected both of her knees on this date. (R.X. 1, p. 24). On January 30, 2012, Petitioner saw Dr. Juranek for bilateral knee pain. (R.X. 1, p. 29-31). On July 23, 2012, Petitioner saw Dr. Juranek for leg pain, lower back, hip, and upper thigh pain. (R.X. 1., p. 32).

Records post July 30, 2012

Following the July 30, 2012, work incident, Petitioner sought treatment on July 31, 2012, at Priority Care. (R.X. 2, p. 2). Petitioner reported twisting her knee. (R.X. 2, p. 2). While Petitioner had swelling and pain, she had no redness, no bruising, no locking, no clicking, no instability, and no abrasion. (R.X. 2, p. 2). Petitioner was diagnosed with joint stiffness of the knee. (R.X. 2, p. 4). On August 2, 2012, Petitioner went to Orthopedic Center of Illinois as saw Dr. Petersen for complaints of right knee pain. (R.X. 2, p. 6). Dr. Petersen reported that she had localized right anterior knee pain following a tripping incident in which she did not fall. (R.X. 2, p. 6). Petitioner's knee was diffusely swollen, with patellar tenderness noted, full knee extension, reduced knee flexion, and normal knee stability. (R.X. 2, p. 7). She was diagnosed with a right sprain, severe DJD bilateral knees, and chronic LBP. (R.X. 2, p. 7). Dr. Petersen next saw Petitioner on August 15, 2012, and reported she had a contusion of the right knee related to the fall which is slowly improved, but not resolved, in addition to her severe degenerative joint disease. (R.X. 2, p. 9). Petitioner reported that her left knee actually hurt worse than her right knee. (R.X. 2, p. 9). Dr. Petersen recommended two weeks of physical therapy. (R.X. 2, p. 9).

Petitioner began physical therapy at Midwest Rehab. (R.X. 2, p. 13-15). Her physical therapy evaluation on August 25, 2012, notes that Petitioner admitted to having bilateral knee complaints prior to her July 30, 2012, injury. (R.X. 2, p. 13-15). Physical therapist Theresa Delvo reported she believes "client's normal gait pattern, prior to the accident was antalgic or with hip and knee flexion with client stating she would hold onto carts at the grocery store before this incident." (R.X. 2, p. 13-15). Petitioner denied at trial that she ever used a grocery cart for assistance walking. (Tr. p. 37). It appears Petitioner's last date of physical therapy was on August 28, 2012. At that time, her range of motion had improved and she reported the exercises were going well. (R.X. 2, p. 17-19). Petitioner also saw Dr. Petersen on August 28, 2012, and reported improving pain, range of motion, and strength. (R.X. 2, p. 21). Petitioner stated she was happy with her progress and that she had nearly

returned to her baseline with respect to knee function and pain. (R.X. 2, p. 21). Petitioner's range of motion was limited, but symmetrical. (R.X. 2, p. 21). She had an extension deficit of 20 degrees bilaterally, knee flexion was limited to 90 degrees bilaterally, and no joint line tenderness. (R.X. 2, p. 21). Petitioner failed to attend her subsequent physical therapy appointments. (RX. 2, p. 23-24).

On September 10, 2012, Dr. Petersen saw Petitioner and reported that "she states that her right knee pain has returned to baseline level. Physical therapy notes also concur that she has returned to her baseline knee range of motion and strength from prior to her injury." (R.X. 2, p. 25). Further, Dr. Petersen noted that Petitioner "states that she is unable to walk for long periods of time due to her low back pain, but her knee pain has resolved." (R.X. 2, p. 25). Dr. Petersen's assessment was chronic bilateral knee pain with resolved right acute knee pain and he released her from care for her right knee with no restrictions. (R.X. 2, p. 25-26).

Petitioner then went on to treat for her low back pain at Orthopedic Center of Illinois with Dr. VanFleet. On March 18, 2013, Petitioner underwent an L3-L4, L4-L5, and L5-S1 minimally invasive fusion. (Pet. Ex. 3). On September 11, 2013, Petitioner had a six month follow-up with Dr. VanFleet, in which she denied leg pain and reported a little stiffness in her back. (R.X. 2, p. 43).

Petitioner testified that her attorney recommended that she see Dr. Rhode. (Tr. p. 35-36). Petitioner first saw Dr. Rhode on April 9, 2014, almost two years after the work incident. (Pet. Ex. 5). Dr. Rhode reported that he explained to Petitioner that "she certainly demonstrates moderate to significant pre-existing degenerative change." (Pet. Ex. 5). Dr. Rhode recommended an MRI.

Petitioner's April 18, 2014, right knee MRI revealed the following:

1) Compete ACL tear with retraction;
2) Complex medial meniscus tear complete medial extrusion of the medial meniscus. Near total loss of all articular cartilage in the medial knee compartment;
3) Complex tear of the lateral meniscus, primarily involving the anterior horn;
4) Significant 3 compartment degenerative osteoarthropathy;
5) Probable intra-articular loose chondral body within the posterior joint recess.
6) Additional chronic and degenerative changes, as described in more detail in the MRI findings.

(Pet. Ex. 4).

Petitioner returned to see Dr. Rhode on May 7, 2014. After reviewing the MRI, Dr. Rhode opined that "this represents a complex situation where the patient has significant pre-existing degenerative changes superimposed with a new onset mechanical complaint. Dr. Rhode gave Petitioner an injection into the right knee on May 7, 2014. After further failed conservative treatment, Dr. Rhode recommended a right total knee athroplasty on October 22, 2014. Throughout the course of Dr. Rhode's treatment of Petitioner, he has kept Petitioner on full-duty work status.

Dr. Rhode gave his evidence deposition on November 4, 2015. Dr. Rhode opined that "it is possible then within a reasonable degree of medical certainty and surgical certainty that the work accident of

July 30th of 2012 constituted a contributing factor to accelerating the need for the total knee replacement that's been recommended in this case." (Pet. Ex. 7, p. 39). While Dr. Rhode causally related the need for the total knee replacement to the work incident, he agreed that all of the MRI findings of the right knee on April 18, 2014, could have been pre-existing conditions. (Pet. Ex. 7, p. 30). Further, Dr. Rhode admitted that in coming to his causal relationship opinion, he was relying upon Petitioner to be an accurate historian of her symptomatology. (Pet. Ex. 7, p. 30). Dr. Rhode admitted that he was never provided and he did not review medical records that pre-dated the work incident of July 30, 2012. (Pet. Ex. 7, p. 8).

On February 25, 2015, Petitioner saw Dr. Michael Nogalski for an independent medical examination. (R.X. 4). Dr. Nogalski took a detailed history from Petitioner regarding the work incident and also reviewed extensive medical records from 1996 through 2014. (R.X. 4). Those records included records from Dr. Ludwig, Dr. Borowiecki, Dr. Allan, Priority HSHS Care, Orthopedic Center of Illinois, Springfield Clinic, Dr. Rhode, and St. John's Hospital. (R.X. 4).

Dr. Nogalski took x-rays on February 25, 2015, that revealed severe valgus deformity, end stage osteoarthritis, complete bone-on-bone changes in both right and left knees with subcortical irregularities that appear to be long-standing, and no acute findings. (R.X. 4, p. 2-3; R.X. 5, p. 14). Further, he personally reviewed Petitioner's April 18, 2014, MRI study. (R.X. 4, p. 3). Dr. Nogalski opined that the MRI revealed the following:

- Severe osteoarthritis and subchondral irregulateries consistent with long-standing osteoarthritic changes.
- Essential obliteration of the medial joint space with extrusion of the meniscal tissue that remains there.
- Some degenerative tears in the lateral meniscus.
- There is several patellofemoral arthritis.
- There is a Baker's cyst.
- The ACL is absent.
- There are some calcifications in the posterior knee suggestive of old loose bodies.
- No acute findings with respect to bone marrow signal changes.

(R.X. 4, p. 3; R.X. 5, p. 13).

Dr. Nogaski's assessed Petitioner with right knee osteoarthritis. (R.X. 4, p. 5). His report explains that the natural history of osteoarthritis is to progress and that her current stage of osteoarthritis is more than what one would consider "end stage." (R.X. 4, p. 5). Dr. Nogalski opined that the MRI findings do not suggest any acute or new injury. (R.X. 4, p. 5). Dr. Nogalski agreed with Dr. Petersen in finding that Petitioner had reached maximum medical improvement on September 10, 2012. (R.X. 4, p. 5). Dr. Nogalski opined that Petitioner is a reasonable candidate for a total knee replacement, but that it is not related to this injury. (R.X. 4, p. 5).

Finally, Petitioner testified that she has never missed work related to her right knee condition. (Tr. p. 13).

CONCLUSIONS OF LAW

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

The Arbitrator concludes that Petitioner's severe osteoarthritis of the right knee for which she is seeking surgical authorization is not causally related to the work incident of July 30, 2012. The Arbitrator finds that she did sustain a sprain of the right knee in said incident.

The Arbitrator finds that the medical records pre-dating July 30, 2012, establish that Petitioner's right knee required a total knee replacement prior to this work incident. Petitioner was diagnosed with a right degenerative meniscal tear, generalized degenerative changes, osteophyte formation throughout all three compartments, and rather significant degenerative changes involving the whole right knee back on September 23, 1999. Petitioner has subsequently undergone several rounds of right knee injections prior to July 30, 2012. From 1999 through the present, Petitioner has experienced crepitus, stiffness, and swelling in her right knee. At times from 1999 through the present, Petitioner has reported her right knee clicking and popping.

While Petitioner denied at trial that she had any trouble with kneeling or squatting related to her right knee condition, the Arbitrator finds that the records establish Petitioner reported difficulty ascending and descending stairs and difficult kneeling as early as October 11, 2002, when Petitioner reported her right knee was worse than her left. Dr. Ludwig informed Petitioner on October 11, 2002, that "she will come to require bilateral total knee replacements" which Petitioner planned to carry out in 2003. Further, Dr. Borowiecki reported on August 7, 2009, that Petitioner "knows she is going to need to have the knees replaced, but she is trying to put this off until she retires which is about a year from now." In addition, her significant range of motion loss in the knee noted by Dr. Van Fleet's assistant on October 11, 2002 was identical to that measured by Dr. Nogalski during his examination on February 25, 2015.

The Arbitrator gives more weight to the opinions of treating physician Dr. Petersen and Dr. Nogalski than to Dr. Rhode. Dr. Petersen and Dr. Nogalski opined that Petitioner returned to her baseline condition on September 10, 2012. Petitioner did not treat or complain of right knee pain until she was referred by her attorney to begin treating with Dr. Rhode on April 9, 2014. At that point, it is natural that her right knee condition would have continued to progress and that she continued to require a total knee replacement, as she did as early at 2002.

The Arbitrator gives little weight to the causation testimony of Dr. Rhode who admitted that he did not review Petitioner's medical records that pre-date the July 30, 2012, work incident. Dr. Rhode also relied upon his understanding that the Petitioner had locking and catching in the knee following her accident, a finding which is not corroborated by the records from Priority Care and Dr. Peterson. The Arbitrator finds that Dr. Nogalski's opinions are more credible based on his personal review of Petitioner's complete medical records and personal review of the April 18, 2014, right knee MRI. The Arbitrator finds that the MRI did not show any acute or new injury and that Petitioner's pre-existing right knee osteoarthritis is the cause of Petitioner's need for a total right knee replacement.

Further, the Arbitrator finds that Petitioner's credibility was diminished by her attempt to minimize her pre-existing right knee condition. Dr. Nogalski testified that she initially denied any right knee problems prior to her accident. He said that when he pointed them out to her while reviewing her records, she acknowledged the condition but said that it was only arthritis. (RX 5 at 9) The medical records provide convincing evidence that Petitioner's right knee condition was severe and that she had significant limitations related to her pre-existing right knee osteoarthritis. Further, the Arbitrator finds that Petitioner's credibility was diminished by her claim that her right knee hit the ground when all medical evidence indicates she twisted her knee and never actually landed on her right knee on July 30, 2012.

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

Based on his findings related to Issue (F), the Arbitrator finds that all medical charges after 09/10/12 are unrelated to this July 30, 2012, work incident. Therefore, the Arbitrator finds that Respondent owes no outstanding medical bills.

Issue (O): Prospective medical?

Based on the above findings, the Arbitrator finds that Respondent is not responsible for any prospective medical treatment related to Petitioner's right knee, including Petitioner's request for authorization of her total right knee replacement.

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

Sylvia Munguia,
Petitioner,

vs.

No: 13 WC 26927
13 WC 27457

16IWCC0735

State of Illinois,
Illinois Dept. of Agriculture,
Respondent.

DECISION AND OPINION ON REVIEW

A Petition for Review under § 19(b) having been filed timely by Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical, and temporary disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case[1] to the Arbitrator for further proceedings for a determination of a further amount of permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (Ill. 1980).

After considering the entire record, the Commission modifies the Arbitrator's Decision. Relying on Petitioner's testimony and the opinion of Dr. Mark Lorenz, the Arbitrator found that Petitioner's slip-and-fall accident aggravated preexisting conditions in her cervical and lumbar spine; caused radiculopathy and related conditions diagnosed by Dr. Lorenz; caused the prescription for cervical spine surgery issued by Dr. Lorenz; and rendered Petitioner totally disabled from March 2, 2013 through August 19, 2015 (128 and 5/7 weeks). The Commission finds that Petitioner reached maximum medical improvement by December 31, 2013, and any complaints or conditions thereafter were not causally connected to the workplace accident. Based upon our finding on the date of maximum medical improvement, we also modify the Arbitrator's awards of temporary total disability benefits and medical expenses.

[1] There are two case numbers because two duplicate Applications for Adjustment of Claim were filed; the two cases were subsequently consolidated.

Background

Petitioner, a 55-year-old meat and poultry inspector, sustained an undisputed accident when she slipped and fell while descending stairs at an inspection site. In an attempt to break her fall, she grabbed the handrail with her right arm. She slid down 2 to 12 steps[2] and landed on her buttocks. (Tr. 9-10; RX 1). At hearing, she stated that she immediately felt extreme pain in her neck and lower back; upon prompting by her counsel, she agreed that her right arm hurt as well. (Tr. 9-10). She drove herself to the ER at Rush Medical Center, where she complained of severe pain in her neck, low back, and both shoulders. (PX 1). X-rays obtained were negative for any acute injuries in the shoulders and cervical spine, but revealed mild degenerative changes.[3]

On March 13, 2013, she followed up with primary care physician Dr. Brian Donahue. She complained of severe back pain that had persisted ever since the slip and fall. The pain was described as "shooting pains going upwards, sideways and to back of thighs, [left greater than right], neck popping." (PX 2). Dr. Donahue noted that "pain [was] out of proportion to exam." Given the duration of her symptoms, she was referred to orthopedic surgeon Dr. Mark Lorenz. Dr. Lorenz saw her on March 21, 2013. He diagnosed low back and neck strains, with no radicular symptoms. He was optimistic about her prognosis, writing, "I do anticipate the patient to be able to return from this strain fairly soon[.]" (PX 7).

However, Petitioner's pains failed to subside. According to Petitioner, her pain persisted through the following spring, summer, and into fall 2013. Still, as of April 7, 2014, Dr. Lorenz advised against surgery, as there were still no hard radicular findings to her condition ("I would still try to talk her out of surgical intervention"). (PX 8 at 13). In fact, he indicated that Petitioner was ready for a functional capacity evaluation. Dr. Lorenz testified unequivocally as to these opinions during his evidence deposition of April 7, 2014. (PX 8 at 11-13, 22). He also stood by the prognosis of prompt recovery he had made when he first saw Petitioner in March 2013 ("I expected her to recover"). (PX 8 at 19-20).

After that deposition, however, Petitioner's symptoms apparently continued to evolve, worsen and multiply, quickly. Five months after testifying, Dr. Lorenz reversed himself – on September 15, 2014, Dr. Lorenz indicated in his notes that he now recommended surgery. (PX 7). Dr. Lorenz wrote on that day that Petitioner "continues to have pain radiating down the left upper extremity… also has some backache as a secondary issue" and that he recommended cervical fusion surgery. (PX 7). This was the first visit that Petitioner had made to Dr. Lorenz in some months.[4]

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[2] A note dated March 1, 2013 by an ER nurse stated that Petitioner was at status post "slip/fall down about 2 stairs." (PX 1). To her notice of injury to her employer, completed on March 5, 2013, Petitioner attached a letter wherein she suggested she fell 10 steps. ("As I was going down the stairs, at approximately 10 steps from the landing, I felt the computer bag slipping off my shoulder as I got a grip of the strap to reposition computer, my foot slipped off the step, I lost control of my balance, I fell a few steps down, I fell backwards on landing on my back and buttocks. Injuring my back."). (RX 1). On March 21, 2013, Dr. Lorenz indicated in his notes that she had fallen "6 or so stairs". (PX 7). To neurosurgeon Dr. Stanley Fronczak on November 21, 2013, she related that she fell down "10 to 12 stairs." (PX 3).

[3] More specifically, the findings of the cervical spine x-ray were mild generalized osteopenia and minimal reduction in the C6-C7 disc height, degenerative endplate changes, and marginal osteophytes from C4-C5 through C7-T1, most marked at C6-C7. (PX 1).

[4] Prior to that September 2014 visit, Petitioner last saw Dr. Lorenz on February 17, 2014, when she came for a "second opinion" and was described by Dr. Lorenz as "distraught because apparently she saw an IME who had uncovered that she was involved in a motor vehicle accident and had some neck and back pain from a strain in 2004." (PX 7).

On December 18, 2013, Petitioner underwent a Section 12 examination with orthopedic surgeon Dr. Hythem Shadid, who authored a written report dated December 31, 2013. In his report, he wrote that, at the time of the examination, her current complaints were "primarily numbness and tingling over the back of the left shoulder and to the tips of all five fingers along with stiffness and pain in her neck." He noted that her low back symptoms appeared to have resolved significantly, and her shoulders were currently asymptomatic. (RX 2). Dr. Shadid went on to write that there was no evidence in the medical records of any acute injury sustained on March 1, 2013. Ultimately, he concluded, "The March 1, 2013 incident resulted in a strain of her cervical and lumbar spine, both of which would have resolved within a few weeks of the injury. There are simply no objective findings to show any connection between her current complaints and the incident of March 1, 2013." He believed she had reached maximum medical improvement and needed no further treatment. As to her current problems of neck pain and numbness and tingling to her shoulder down to her fingertips, Dr. Shadid opined that they were due to extensive arthritic changes and were unrelated to the March 1, 2013 incident. As well, though she indicated that her low back pain had significantly resolved, any ongoing low back pain as she might voice would be unrelated. (RX 2).

Dr. Shadid was deposed on May 14, 2014. His testimony was consistent with his written report. He opined that, as Petitioner suffered nothing more than strains, primarily to the low back, during the accident, he expected her injury would have resolved in six weeks at most, and that he would not have expected her symptoms to keep changing thereafter. (RX 3 at 10-11). He testified that Petitioner's complaints after the accident were generalized complaints, which typically follow chronic, or degenerative, conditions, not acute conditions. (RX 3 at 36-38). Dr. Shadid further explained that, when comparing an October 2004 MRI of her cervical spine (done in the course of treatment for a 2003 motor vehicle accident) with a post-accident MRI from July 2013, there were no significant differences to be seen between the two.[5] (RX 3 at 48-50). Dr. Shadid recommended against cervical fusion surgery. To the extent that Petitioner did need any treatment to her cervical and lumbar spine, he would attribute that need to the degenerative changes, as opposed to any acute event. (RX 3 at 49-50).

In advance of the Section 12 examination, Dr. Shadid was provided some subpoenaed medical records of Petitioner's treatment with orthopedic surgeon Dr. Bruce Montella from 2004 and 2005 for neck and back pain subsequent to a motor vehicle accident in 2003. Dr. Shadid observed that these records "show evidence of a severe flare of neck pain and spasms with trapezial radiation along with multiple treatments for cervical disc injury and a mild radiculitis, all presumably dating back to a motor vehicle accident of 2003." (RX 3, RX 4). The records of Dr. Montella indicate that, as of February 24, 2005, his diagnoses for Petitioner were neck and low back pain, and cervical and lumbar discogenic pain, and that her condition was chronic. (RX 4).

Petitioner told Dr. Lorenz that "she initially forgot about this episode because it resolved and she had no issues from that time on until the episode where she fell while at work." (PX 7). Although Dr. Lorenz wrote that day that Petitioner "has failed conservative care and is therefore a candidate for a discectomy at C6-7," during his evidence deposition of April 7, 2014, he unequivocally stated that he would discourage her from surgery. (PX 8 at 13).

[5] Dr. Shadid testified that there were only "very, very subtle" differences between the pre- and post-accident MRIs, evidencing nothing more than expected arthritic changes (which changes were already underway before 2004). As Dr. Shadid explained, in the pre-accident cervical MRI of 2004, there was a left paracentral disc herniation of 3-4 mm detected at the C6-7 level. In the 2013 MRI, the herniation at that same level that was now 4-5 mm. According to Dr. Shadid, that was a mild degenerative change that was expected to take place over the period of years. (RX 3 at 48-50).

In his Section 12 report, Dr. Shadid wrote that he specifically asked Petitioner whether she had ever had any neck or back pain in the past. Apparently not aware that Dr. Shadid had those records of Dr. Montella, Petitioner categorically denied any prior history of neck or back pain. (RX 2). Petitioner had not disclosed this prior neck and back injury to any of the medical services providers from whom she sought treatment for the March 1, 2013 accident until then. (See footnote 3). At hearing, Petitioner claimed that she had "completely forgotten" about this prior neck injury and suggested that she had not thought this was important information to disclose. (Tr. 22-24).

Petitioner has been off-work since the March 1, 2013 accident. She was paid workers' compensation benefits through December 31, 2013. Since then, she has received a monthly disability benefit from the State Employment Retirement System. (Tr. 17-18).

Discussion and Conclusion

As noted above, the Arbitrator relied on Petitioner's testimony and the opinions of Dr. Lorenz in his favorable decision for Petitioner. The Arbitrator wrote that he "finds the testimony of Petitioner and the opinions of Dr. Lorenz to be credible and adopts them" and favorably cited "Petitioner's testimony as to the lack of any cervical symptoms, and only minimal low back symptoms, from 2005 until the March 1, 2013 accident." (Arbitrator's Decision at 4). It is apparent that the "opinions" of Dr. Lorenz to which the Arbitrator refers are those contained in the office visit notes beginning in September 2014 – a year and a half after the accident (and a year and a half after Dr. Lorenz made his assessment at the first visit that he expected Petitioner to recover quickly). Dr. Lorenz' testimony from his April 7, 2014 deposition is nowhere mentioned in the Arbitrator's Decision.

Given Petitioner's failure to disclose her prior neck and back injury from the motor vehicle accident and her minimization of this prior history at hearing, the Commission finds Petitioner's credibility to be lacking. Furthermore, Dr. Lorenz's later opinions, insofar as they are starkly at odds with opinions made immediately after her accident and in his earlier evidence deposition testimony, are not reliable.

The Commission deems persuasive the opinion of Respondent's Section 12 examiner, Dr. Shadid. As noted above, Dr. Shadid opined that Petitioner sustained nothing more than soft tissue injury, or strains, as a result of her accident, primarily to her low back, and that these strains should have resolved in six weeks. Thereafter, any ongoing symptoms and complaints – including as they may relate to any presently-diagnosed radiculopathy – were and are due to a degenerative process in her cervical spine that was underway long before the work accident. Accordingly, we modify the Arbitrator's Decision to find that Petitioner reached maximum medical improvement by December 31, 2013, the date of Dr. Shadid's Section 12 report. Based upon our finding on the date of maximum medical improvement, we also modify the Arbitrator's awards of temporary total disability benefits and medical expenses.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on September 8, 2015, is hereby modified as stated herein and otherwise affirmed and adopted.

16IWCC0735

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $ 790.00 per week for 43 and 4/7 weeks, for the period commencing March 2, 2013 through December 31, 2013, that being the period of temporary total incapacity for work under § 8(b). Respondent shall be given credit for all amounts paid to date.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical benefits is modified. Respondent shall pay only the reasonable and necessary medical expenses incurred for treatment to the cervical spine, lumbar spine, and shoulders up to December 31, 2013, under § 8(a) of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of prospective medical care is reversed, as stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

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

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

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

DATED: NOV 14 2016

o-09/13/16
jdl/ac
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Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

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

MUNGUIA, SYLVIA
Employee/Petitioner

Case# **13WC026927**

13WC027457

SOI-ILLINOIS DEPT OF AGRICULTURE
Employer/Respondent

16IWCC0735

On 9/8/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.27% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

5661 ASSISTANT ATTORNEY GENERAL
MALLORY ZIMET
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CHICAGO, IL 60601

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

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

SEP 8 - 2015

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

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Sylvia Munguia
Employee/Petitioner

v.

State of Illinois/Illinois Department of Agriculture
Employer/Respondent

16IWCC0735

Case # **13** WC **026927**

Consolidated cases: **13WC27457**

An *Application for Adjustment 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 **8/19/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **3/1/13**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$61,620.00**; the average weekly wage was **$1,185.00**.

On the date of accident, Petitioner was **55** 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 **$32,504.08** for TTD, $ for TPD, $ for maintenance, and **$0** for other benefits, for a total credit of **$32,504.08**.

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

ORDER
CREDITS

Respondent shall be given a credit of $32,504.08 for TTD, $ for TPD, and $ for maintenance benefits, for a total credit of $32,504.08.

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

Respondent shall be given credit for $ for benefits paid under Section of the Act.

MEDICAL BENEFITS

Respondent shall pay reasonable and necessary medical services of $739.00, as provided in Section 8(a) of the Act, pursuant to the medical fee schedule. Respondent shall have credit for all amounts it may have paid.

TEMPORARY TOTAL DISABILITY

Respondent shall pay Petitioner temporary total disability benefits of $790.00/week for 128 5/7 weeks, commencing 3/2/13 through 8/19/15 as provided in Section 8(b) of the Act.

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

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

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

David A. Kane
Signature of Arbitrator

September 8, 2015
Date

SEP 8 - 2015

FINDINGS OF FACTS

Petitioner testified that she worked eight years for Respondent as a meat and poultry inspector and supervisor. Petitioner testified that on March 4, 2013, she slipped and fell down the stairs while carrying her computer, grabbing the handrail with her right arm and pulling her arm down. Petitioner testified that while at the emergency room she found a piece of grease/fat under her shoe, which caused her to fall. Petitioner testified that following her fall, she had severe pain in her neck, lower back and right arm. Petitioner then was seen at Rush University Medical Center's emergency room that day, who noted that Petitioner's neck, back and bilateral shoulder pain following her fall (PX 1). Petitioner testified she then followed up with her primary care physician, Dr. Donohue at Alexian Brothers Medical Group on March 13, 2013. Dr. Donohue noted Petitioner's continuing pain following her fall and referred her to an orthopedic physician, Dr. Mark Lorenz at Hinsdale Orthopedics (PX 2).

Petitioner commenced treatment with Dr. Lorenz on March 21, 2013. Dr. Lorenz noted Petitioner's ongoing neck, lower back and right arm pain following her fall and prescribed an MRI of the right shoulder. Dr. Lorenz placed a total work restriction on Petitioner. The MRI was performed on March 28, 2013, and showed a partial thickness tear at the anterior supraspinatus. Dr. Lorenz referred Petitioner for a course of physical therapy at ATI from April 9, 2013 to May 16, 2013. Petitioner was also seen by Dr. Chunduri at Hinsdale Orthopedics from April 1, 2013 to August 9, 2013.

Petitioner testified that due primarily to back pain she was seen at Hinsdale Hospital's emergency room on May 20, 2013. She underwent a

lumbar MRI that day, which showed bulging discs at L2-3 and L3-4. Dr. Lorenz prescribed a cervical MRI, which Petitioner underwent on July 11, 2013. This MRI showed cervical disc protrusions at C3-4, C4-5, C5-6, and C7-T1. The MRI showed a C6-7 a left pararentral disc herniation of 4-5 mm, with moderate to severe bilateral nevral formanal narrowing. Petitioner was referred for an additional course of physical therapy at ATI from August 28, 2013 to September 12, 2013 (PX 5). Dr. Lorenz referred Petitioner for a surgical consultation with Dr. Fronczak, whom she saw on November 21, 2013. Dr. Fronczak diagnosed Petitioner with cervical radiculopathy secondary to cervical spondylosis and disc herniation at C6-7, along with lumbar radiculopathy. Dr. Fronczak prescribed an anterior cervical discectomy and fusion with instrumentation (PX 3). Prior to being seen by Dr. Fronczak, Dr. Lorenz referred Petitioner to Dr. Mehta at Elmwood Park Surgery Center, where she was seen on October 9, 2013 and October 30, 2013, undergoing a cervical epidural injection on October 15, 2013. Dr. Mehta noted that the injection provided no relief (PX 4). Therefore, Dr. Lorenz felt her injections were not warranted.

On February 17, 2014, Dr. Lorenz opined that Petitioner had failed conservative care, and was a candidate for discectomy and fusion at C6-7. Dr. Lorenz opined that Petitioner's condition and need for surgery was a result of her fall at work, in which she either sustained or aggravated her pre-existing C 6-7 disc herniation, causing radiculopathy. Dr. Lorenz has continued to see Petitioner on a monthly or bi-monthly basis, setting forth on September 15, 2014 that Petitioner related that she was unable to live with the pain and wanted the prescribed cervical fusion. Dr. Lorenz last saw Petitioner on July 20, 2015, at which time he noted Petitioner's neck

pain radiating down the left arm to the hand, with increased lower back pain. Dr. Lorenz again prescribed the cervical fusion surgery, with a repeat MRI before the surgery. Dr. Lorenz has consistently placed a total work restriction on Petitioner from his initial exam on March 21, 2013, through the last exam of July 20, 2015 (PX 7&8).

Petitioner testified that she had a motor vehicle accident in 2001, and received treatment at Dr. Montella's office in 2004 and 2005. His records reflect treatment from October 6, 2004 to February 24, 2005, with a lumbar MRI on October 7, 2004 and cervical MRI on October 15, 2004 (RX 4). Petitioner testified that from the conclusion of her treatment in 2005 she has not had any further treatment to her neck and back until the March 1, 2013 accident. Petitioner testified that during this time she had had no pain in her neck and it felt fine, and had only occasional back pain. Petitioner testified she worked full duty during this time, with no problems.

Petitioner testified that following by March 1, 2013 accident, her neck and back pain was severe. Petitioner testified she currently has back pain on lifting objects, although this pain is not present every day. Petitioner testified that she currently experiences severe and constant neck pain, with tingling down her left arm and numbness in the tips of all the fingers in her left hand. Petitioner testified the pain is now radiating to her right shoulder and arm. Petitioner testified the pain interferes with her sleep, causing her to nap during the day, and is aggravated by almost any common everyday activity. Petitioner testified that she feels she cannot live with the pain, and wants the prescribed surgery. Petitioner testified that she continues to take hydrocordon and tramadol, as prescribed by Dr. Lorenz, for the pain. Petitioner testified that she has been off of work since the accident, and

receives $2,471.00 per month through the State Employment Retirement System (SERS).

CONCLUSIONS OF LAW

F – CAUSAL CONNECTION

The Arbitrator finds the testimony of Petitioner and the opinions of Dr. Lorenz to be credible and hereby adopts them. Given Petitioner's testimony as to the lack of any cervical symptoms, and only minimal low back symptoms, from 2005 until the March 1, 2013 accident, the Arbitrator finds that the March 1, 2013 accident has aggravated Petitioner's cervical and lumbar condition, causing the present diagnosis of Dr. Lorenz and prescription for cervical surgery. The Arbitrator finds the opinions of Dr. Lorenz to be more credible and persuasive that Respondent's examining physician. Therefore, the Arbitrator finds Petitioner's current cervical and lumbar condition to be causally related to the March 1, 2013 accident.

J – MEDICAL EXPENSES

Based on the Arbitrator's findings regarding causal connection, the Arbitrator awards the balance of Hinsdale Orthopedics of $739.00 per the Fee Schedule (PX 7).

L– T.T.D.

Based on the Arbitrator's findings regarding causal connection, the Arbitrator finds Petitioner to be temporarily and totally disabled and awards 128 5/7 weeks of T.T.D., from March 2, 2013 through August 19, 2015, the date of the Hearing.

K – PROSPECTIVE MEDICAL

Based on the Arbitrator's findings regarding causal connection and Petitioner's need and desire for the cervical fusion surgery prescribed by Dr. Lorenz, the Arbitrator orders Respondent to authorize and pay per the Fee Schedule for the costs of said surgery.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ronald R. Eglinton, Sr.,
Petitioner,

vs. No. 14 WC 8815

Durham School Services,
Respondent.

16IWCC0736

DECISION AND OPINION ON REVIEW PURSUANT TO §19(b) AND §8(a)

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident (arising out of), causal connection, medical expenses, marital status, temporary total disability, prospective medical care and penalties and attorney's fees, and being advised of the facts and law, reverses the §19(b) 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 the remaining issues.

At the January 20, 2015 arbitration hearing, Petitioner, 63, testified that on February 10, 2014 he was employed by Respondent as a bus aide. In addition to his morning bus route, his duties included rudimentary maintenance of the school bus fleet in the bus yard: checking the engine oil, antifreeze and transmission fluid levels.

On February 10, 2014 there were two lines of buses facing each other in the bus lot, separated by a 1-foot high pile of snow in a long row. He testified that while performing his duties, he was walking and wearing cleats on his shoes. After checking fluids in buses on one side of the snow pile, Petitioner needed to check the buses on the other side. His options were to either step over the snow, or walk to the end of the row to go around it, coming back on the other side. Petitioner chose to step over the snow pile, and started with his left foot. As his foot stepped down on the other side of the snow pile, he slipped and fell, striking his right knee on the asphalt.

Initially, he thought he had sprained or twisted his knee, and he continued working. That evening his knee worsened, and he went to Sherman Hospital. The following day, he called his supervisor and reported the accident.

Following a course of unsuccessful conservative care, Petitioner underwent an MRI of his knee and saw Dr. Anthony Savino who recommended surgery for a torn right medial meniscus. Petitioner now desires this surgery. Dr. Savino gave Petitioner light duty restrictions, which Respondent accommodated until it terminated him on February 26, 2014 for reasons unrelated to this claim. Petitioner testified he never refused light duty whenever it was offered by Respondent. Since his termination he has not worked anywhere.

At arbitration, Petitioner had forgotten, until reminded by counsel, that he had previously fallen on May 19, 2012, after which he had x-rays taken of his right knee. He also failed to provide that history to doctors he saw. Those x-rays appear to have been taken more as a precaution than due to any serious injury or condition, and no records were offered to show any treatment to his knee following that incident. Petitioner testified he had not received any treatment for his right knee since May 2012, and he had no issues with his right knee prior to the subject accident.

On behalf of Petitioner, Dr. Anthony Savino, Petitioner's orthopedic surgeon, testified via evidence deposition that he first saw Petitioner on March 25, 2014. He testified that Petitioner's MRI revealed tears to his medial meniscus and lateral meniscus, required an arthroscopic partial meniscectomy to repair. Because Petitioner continued to walk after he tore his meniscus, he still requires restrictions and another knee evaluation to check for further damage. Dr. Savino testified that a video of Petitioner taken after his accident which showed him walking without a limp or facial grimace didn't mean too much because some meniscus tears are not painful for the first 24 to 48 hours. Dr. Savino also testified that even if Petitioner complained that his legs were sore, a few hours before his accident, that didn't mean much since he didn't specifically mention his knee. Of note, Petitioner is a diabetic and he testified that his feet and legs hurt all the time due to neuropathy.

Dr. Savino was certain Petitioner's meniscus tear was acute and not degenerative, because his right knee was asymptomatic prior to February 10, 2014 and because he went to the emergency room shortly after his accident. He found that Petitioner did have a pre-existing right knee condition which was aggravated by his accident.

Dr. Aaron Bare, Respondent's Section 12 expert, testified via evidence deposition that he conducted a records review and an independent medical evaluation of Petitioner on June 16, 2014. Dr. Bare believed Petitioner's right knee looked normal, "with a little pain inside." Petitioner's right knee MRI showed arthritic changes in addition to a torn meniscus. Dr. Bare testified, contrary to Dr. Savino, that in virtually all cases of acute meniscus tears, patients have immediate pain and limping.

Initially, Dr. Bare gave his opinion in a report dated June 16, 2014 that Petitioner "possibility" injured his right meniscus in his work accident, although Dr. Bare had some concern regarding Petitioner's history. Petitioner had "forgotten" various facts regarding his treatment, his prior right knee x-rays in 2012, and even his Application for Adjustment of Claim in this matter, until his recollection was "refreshed" by questions from counsel.

Dr. Bare was subsequently asked by Respondent's claims examiner to provide updated opinions after she sent him additional medical records and 3 short video clips depicting Petitioner at work shortly before and after his accident. After Dr. Bare reviewed these items, he authored an addendum report dated September 26, 2014 in which he somewhat changed his causation opinion based upon Petitioner's "inaccurate history" and the videos which, Dr. Bare believed, showed Petitioner not limping or displaying any distress shortly after his accident. Dr. Bare then opined it was "unlikely" that Petitioner's need for surgery was causally related to his reported injury, though he still agreed that it could have been. Dr. Bare admitted that if Petitioner fell as he described, he could have aggravated a previous condition in his knee, if not sustained a meniscus tear. Dr. Bare admitted that Respondent's claims examiner, in seeking his updated opinions, incorrectly reported to him that prior to Petitioner's accident, Petitioner had complained of his "knees" (not "legs"). Dr. Bare also admitted the claims examiner provided him with *her* opinion that in the post-accident videos, Petitioner did not appear to be in distress.

The Arbitrator found that, although Petitioner proved he sustained an injury on February 10, 2014 while in the course of his employment, he did not prove his accident arose out of his employment, relying upon *Dodson v. Indus. Comm'n, 308 Ill.App.3d 572 (5th Dist. 1999),* and *Hatfill v. Indus. Comm'n, 560 N.E.2d 369 (4th Dist., 1990).* In both of those cases, claimants had finished their work and were walking to their cars when they slipped (*Dodson*) and jumped over an accumulation of water at the base of an incline (*Hatfill*). In both cases, the appellate court found the claimants had voluntarily exposed themselves to unnecessary personal risks, solely for their own convenience.

The Commission finds that Petitioner Eglinton's accident *did* arise out of his employment, and that he did not "take an unnecessary personal risk solely for his own convenience," by stepping over a 1-foot pile of snow. The facts in the *Dodson* and *Hatfill* cases are distinguishable; in the instant claim, Petitioner Eglinton *was* engaged in an activity which benefitted his employer at the time he slipped. Although Petitioner's act of stepping over the snow may have been personally convenient to him, it was not solely for his own convenience. He was performing work assigned to him by Respondent at that time. Further distinguishing the instant case from *Hatfill* is the fact that Petitioner Eglinton was stepping, not jumping, over the snow pile. Petitioner was not running or acting in an unsafe manner. Respondent offered no evidence to suggest that Petitioner's actions took him out of the sphere of his employment at the time of his fall. The height of the snow pile he was stepping over was not so high as to be an unreasonable hazard. The fact that an alternate route around the snow pile was available does not lead to the conclusion that Petitioner deviated from his employment by not taking it.

The Arbitrator found moot all other issues placed in dispute at Arbitration, and made no findings thereon. However, pursuant to §19(e) of the Act, the Commission has jurisdiction to review all questions of law and fact which appear from the transcript of evidence.

16IWCC0736

On the issue of causation, the Commission finds that Petitioner has proven that his current condition of ill-being, his treatment to his right knee since February 10, 2014 and his need for prospective care including knee surgery, are causally related to his accident. Although Respondent attempted to show that Petitioner's torn meniscus and need for surgery were caused by a preexisting condition or injury, it offered insufficient medical evidence to prove this.

The Commission finds Dr. Savino's causation opinion more persuasive than Dr. Bare's. Dr. Savino opined that Petitioner's February 10, 2014 fall caused an acute medial meniscus tear, and possibly a lateral meniscus tear (PX8). Although Dr. Bare thought that unlikely, he admitted that if Petitioner fell at work on that date, he possibly could have torn his meniscus or at least aggravated his knee. The uncontradicted evidence establishes that Petitioner did fall while working on February 10, 2014, and the Arbitrator likewise found Petitioner did prove that he was in the course of his employment when he sustained his injury.

The Commission acknowledges that Petitioner gave some inaccurate or inconsistent answers at trial. However, in finding his testimony credible regarding his fall, his treatment received thereafter and the condition of his right knee prior to his accident, the Commission finds there is sufficient evidence to corroborate his testimony. Petitioner sought and received emergency room treatment less than 15 hours later. He called his employer to report his accident the day after it occurred. He plausibly explained why he did not do so immediately; he believed he sustained only a minor injury. Petitioner's subsequent medical histories consistently related his knee problem to his February 2014 fall at work. No records were offered to show that Petitioner was treated for any significant right knee issues prior to his accident.

On the issue of marital status, the Commission finds Petitioner proved he was married on the date of his accident, and thus had one dependent. Evidence supporting this finding includes Petitioner's testimony that he was married; his Application for Adjustment of Claim stating that he was married; a March 25, 2014 medical intake form showing his status as "married" (PX5), and the lack of any evidence to the contrary.

On the issue of medical expenses and prospective medical care, the Commission finds Petitioner has proven his right knee treatment from February 10, 2014 through January 20, 2015 (date of arbitration hearing) was medically reasonable and necessary, and his need for prospective medical care to his right knee, including surgery, is causally related. This is based on Dr. Savino's opinions. At arbitration, Petitioner sought payment of two bills: from Midwest Bone & Joint in the amount of $298.00 for date of service of 9/9/14, and from Northwest Suburban Imaging in the amount of $39.00, for date of service of 2/11/14. The Commission finds these bills causally related to Petitioner's accident.

On the issue of temporary total disability, the Commission finds Petitioner has proven entitlement to 46-2/7 weeks of TTD benefits, from February 27, 2014 through March 9, 2014 and from March 14, 2014 through January 20, 2015. (Petitioner was briefly released to unrestricted work between March 10, 2014 and March 13, 2014.) Petitioner's unrebutted testimony was that he last worked on February 26, 2014. Prior to that date, Respondent had been accommodating Petitioner's work restrictions. No evidence was offered to show Petitioner was capable of working without restrictions during this period.

16IWCC0736

On the issue of §19(k), §19(l), and §16 penalties and attorney's fees claimed by Petitioner, the Commission finds Petitioner has not proven entitlement to any. Respondent presented a good-faith defense to challenge its liability for Petitioner's medical expenses and temporary total disability.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 4, 2015, is hereby vacated, the Commission finding that Petitioner has proven he sustained an accident arising out of *and* in the course of his employment by Respondent on February 10, 2014, and that his condition of ill-being related to his right knee is causally related to that accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's average weekly wage is $254.70, as stipulated by the parties, and that his temporary total disability rate is $253.00 per week, that being the minimum rate on February 10, 2014 for Petitioners having one dependent.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $253.00 per week for a period of 46-2/7 weeks, from February 27, 2014 through March 9, 2014 and from March 14, 2014 through January 20, 2015, those being the periods of temporary total incapacity from work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the sum of $337.00, as reasonable and necessary medical expenses as provided in §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for prospective reasonable and related medical care to Petitioner's right knee, including surgery, as provided in §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for penalties and attorney's fees pursuant to §19(k), §19(l), and §16 of the Act, is denied.

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

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

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

16IWCC0736

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $12,200.00. 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: NOV 14 2016

o-09/13/16
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

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

EGLINTON JR, RONALD R
Employee/Petitioner

Case# **14WC008815**

16IWCC0736

DURHAM SCHOOL SERVICES
Employer/Respondent

On 8/4/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.16% 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:

4883 LAW OFFICE OF ROBERTO ACEVEDO
2303 RANDALL RD
SUITE 204
CARPENTERSVILLE, IL 60110

0000 GAIDO & FINTZEN
LUKE BEHNKE
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Ronald R. Eglinton, Sr.
Employee/Petitioner

v.

Durham School Services
Employer/Respondent

Case # **14** WC **08815**

Consolidated cases: ___

16IWCC0736

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian Cronin**, Arbitrator of the Commission, in the city of **Geneva**, on **January 20, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **February 10, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did not* sustain an accident that arose out of his employment. Petitioner *did* prove that he was in the course of his employment when he sustained the injury.

In the year preceding the injury, Petitioner earned **$11,971.24**; the average weekly wage was **$254.70**.

On the date of accident, Petitioner was **63** years of age.

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$1,907.20** for medical benefits, for a total credit of **$1,907.20**.

ORDER

As he finds that Petitioner has failed to prove he sustained an accident that arose out of his employment, the Arbitrator denies compensation. All other issues are 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

August 3, 2015
Date

ICArbDec19(b)

AUG 4 - 2015

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

RONALD R. EGLINGTON, SR.)
)
Petitioner,)
)
vs.) Case No. 14 WC 08815
)
DURHAM SCHOOL SERVICES,)
) 16IWCC0736
Respondent.)

DECISION OF ARBITRATOR

FINDINGS OF FACT:

On February 10, 2014, Petitioner worked for Respondent as a school bus aide. As a bus aide, Petitioner was responsible for keeping the pupils in line, take them to their seats and putting their seat belts on. Between his bus routes, Petitioner was responsible for checking the fluids, e.g., oil, transmission and anti-freeze, in the buses. In order to perform this task, Petitioner had to lift the hood of each bus (Tr. 9)[1]

On February 10, 2014, Petitioner started at 7:20 a.m. as a bus aide. (Tr. 10-11) After Petitioner dropped off the children at school, he returned to the yard at approximately 8:15 a.m. He then walked into the office or the dispatch room, reported that he had returned and waited in the break room until 9:00 a.m. At 9:00 a.m., Petitioner began checking the bus fluids. (Tr. 11-12) The buses are parked inside a fenced lot. (Tr. 12-13) Please see PX #2A-B, aerial views of the lot, which the Arbitrator admitted for demonstrative purposes only. On February 10, 2014, approximately 80 buses were lined up inside the lot. Petitioner was responsible for checking fluids on 22 buses. (Tr. 17)

[1] "Tr." refers to arbitration hearing's transcript page number.

At one point, Petitioner completed checking fluids on 17-18 buses. (Tr. 18) Petitioner then walked to the middle of the lot where the two rows of buses line up and face each other. (Tr. 18-20) Petitioner testified that there was approximately 1 foot of snow piled up in between the two rows of buses. (Tr. 20-21) Petitioner attempted to step over the pile of snow using his left foot. (Tr. 19-20) Petitioner's left foot slipped. Petitioner fell on his right knee and to the ground. (Tr. 21-22; RX #1) He did "the splits."

Petitioner yelled for help. (Tr. 22-23) Petitioner's co-workers', Renee Graham and Scott Hibbons, came to his aid. Mr. Hibbons helped Petitioner to his feet. Petitioner had pain, but not a lot. Petitioner finished checking fluids on his remaining buses. (Tr. 23) Petitioner thought he had a minor strain that was not a "big deal." (Tr. 27) Petitioner went home without reporting the incident. (Tr. 26)

Later that night, Petitioner felt a lot of pain and tightness in his right knee while relaxing. (Tr. 27) Petitioner called his grandson to take him to the hospital. (Tr. 28) Petitioner arrived at Advocate Sherman Hospital at 2:25 a.m., February 11, 2014. (PX #6, p. 4) Petitioner gave a history of slipping and falling at work one-day earlier. Petitioner stated he twisted his knee in the process. (PX #6, p. 32) On examination, Petitioner had mild medial swelling, medial tenderness and positive valgus stress test. Petitioner was diagnosed with right knee sprain. (PX #6, p. 24)

Petitioner did not go to work the next morning, February 11, 2014. (Tr. 28) Petitioner called Kathy Yurk, his supervisor. (Tr. 29) Petitioner told Ms. Yurk that he went to the hospital overnight. (Tr. 29-30) Petitioner told Ms. Yurk that he fell inside the bus lot the previous morning while checking fluids. (Tr. 30)

On February 14, 2014, Petitioner went to Presence St. Joseph Hospital – Occupational Health. Petitioner stated that he slipped and fell on ice at work on February 10, 2014. Petitioner

also stated that he twisted his knee in the process. On examination, Petitioner had right knee medial tenderness. Petitioner was diagnosed with a medial knee sprain and moderate effusion. Petitioner was given work restrictions of limited standing and walking. (PX #7, p. 18) Respondent accommodated Petitioner's restrictions. (Tr. 34)

On February 18, 2014, Petitioner returned to Occupational Health. Petitioner reported that his right knee gives out. Petitioner reported his pain as 3/10. On examination, Petitioner had mild swelling. Petitioner's previous work restrictions were continued. (PX #7, p. 15) Respondent accommodated Petitioner.

On February 21, 2014, Petitioner returned to Occupational Health. Petitioner stated that he gets medial pain when he stands a lot, walks or twists his knee. Petitioner also stated that his knee feels unstable. Petitioner had a trace amount of swelling. There was tenderness over the medial collateral ligament. Petitioner exhibited 30 degrees of knee flexion due to pain. (PX #7, p. 13) Petitioner's previous work restrictions were continued and accommodated by Respondent. (PX #7, p. 14)

On February 26, 2014, Respondent terminated Petitioner's employment. Respondent fired Petitioner for something unrelated to his work injury. (Tr. 34) Petitioner testified that he never refused light-duty work and he never refused medical treatment. (Tr. 35)

On February 28, 2014, Petitioner returned to Occupational Health. On examination, Petitioner had medial right knee swelling and tenderness. Petitioner's light-duty restrictions were continued. (PX #7, p. 11)

On March 5, 2014, Petitioner returned to Occupational Health. Petitioner complained of knee pain, 3/10. Petitioner was allowed to resume full-duty work on March 10, 2014. (PX #7, p. 9)

On March 14, 2014, Petitioner returned to Occupational Health. Petitioner complained of persistent right knee medial tenderness and pain. Petitioner rated his pain as 5/10. On examination, Petitioner was tender to palpation. (PX #7, p. 7) Occupational Health ordered an MRI to rule out internal derangement. Petitioner was given work restrictions of ground-level work only and no climbing. (PX #7, p. 8)

On March 19, 2014, Petitioner's attorney mailed and e-mailed Ms. Katie Zemovich, Respondent's workers' compensation adjuster, a letter in which he requested temporary total disability benefits pursuant to the court's holding in Interstate Scaffolding v. Illinois Workers' Compensation Commission, 236 Ill.2d 132 (2010). (PX #1)

On March 24, 2014, Petitioner returned to Occupational Health. The MRI revealed medial and lateral meniscus tears. (PX #7, p. 4) Petitioner was ordered to consult with an orthopedic surgeon. Petitioner's work restrictions were continued. (PX #7, p. 5)

On March 25, 2014, Petitioner saw Dr. Anthony Savino at Midwest Bone & Joint Institute. (PX #5) Petitioner gave a history of falling on ice on February 10, 2014. (PX #5, pp. 4, 6) Petitioner reported being married. (PX #5, p. 4) On examination, Petitioner was tender over his medial joint line and had some swelling. Dr. Savino recommended arthroscopic surgery. (PX #5, p. 6)

On June 16, 2014, at Respondent's request, Petitioner saw Dr. Aaron Bare. After examining Petitioner and reviewing records, Dr. Bare authored a Section 12 report. (RX #7, Dep. Ex. 2) Dr. Bare opined that Petitioner sustained a traumatic injury when he slipped and fell. In Dr. Bare's opinion, Petitioner's meniscus tear could have been injured or created by his fall. Dr. Bare also opined that Dr. Savino's surgical recommendation was within the standard of care. (RX #7)

On September 9, 2014, Petitioner followed up with Dr. Savino. Dr. Savino continued to recommend arthroscopic surgery. Dr. Savino kept Petitioner on light duty. (PX #5, p. 12)

On September 26, 2014, Dr. Bare wrote an addendum to his June 16, 2014 Section 12 report. (RX #7, Dep. Ex. 3) Dr. Bare stated that he reviewed Petitioner's right knee MRI images from March 21, 2014. Dr. Bare noted a moderate sized medial meniscus tear. Dr. Bare also noted a small degenerative lateral meniscus tear. Dr. Bare also reviewed a video disc that contained three video clips of Petitioner on February 10, 2014. After reviewing the video, Dr. Bare opined that it is unlikely that Petitioner's condition is causally related to the reported injury. (RX #7, Dep. Ex. 3)

Finally, Petitioner testified that he lives with his wife of 37 years, Virginia Eglinton. (Tr. 7-8) Petitioner testified that he was not wearing his wedding ring at the trial because he lost it. In Respondent's own accident report (Form 45), which Lynn Kennedy completed, she indicated that Petitioner is married. (RX #1)

Petitioner also testified he did not have any right knee symptoms before his fall.

Dr. Anthony Savino (Treating Orthopedic Surgeon) Deposition Testimony:

Dr. Savino reviewed records from Sherman Hospital, Presence St. Joseph Hospital and Dr. Bare prior to his deposition. (PX #8, pp. 6-7)

Dr. Savino is an orthopedic surgeon who devotes 40-50% of his practice on knees. (PX #8, pp. 5, 33) In 1981, Dr. Savino started the first sports medicine clinic in Illinois. PX #8, p. 33)

On March 25, 2014, Dr. Savino examined Petitioner. Dr. Savino testified that swelling indicates trauma. (PX #8, p. 9) Dr. Savino also testified there will be tenderness when a person

stresses the medial aspect of the knee. (PX #8, p. 10) Dr. Savino's examination revealed swelling and tenderness over his Petitioner's medial joint line. (PX #8, p. 16)

Dr. Savino reviewed Petitioner's MRI from March 21, 2014. Dr. Savino agreed with the radiologist's interpretation. (PX #8, p. 15) Dr. Savino ordered surgery due to failed conservative treatment. (PX #8, p. 17) Dr. Savino agreed with Occupational Health's work restrictions. (PX #8, pp. 12, 15)

On September 9, 2014, Dr. Savino re-examined Petitioner. Dr. Savino continued to recommend surgery. Dr. Savino continued Petitioner's previous work restrictions. (PX #8, p. 18)

Dr. Savino was told that Petitioner complained of sore "legs" earlier in the morning on the day of his slip and fall. (PX #8, pp. 19-20) Dr. Savino did not find Petitioner's statement significant. (PX #8, p. 20) Petitioner's sore "legs" could have been due to his back, hip or ankle. If Petitioner had complained of pain in his knee earlier that day, then it would have been a big deal. (PX #8, pp. 20, 42-43)

Dr. Savino was also informed of a video showing Petitioner nearly 4 hours after falling. (RX #6) Specifically, the video did not show Petitioner limping. (PX #8, p. 20-21) Dr. Savino did not find that lone fact significant. (PX #8, p. 21) Dr. Savino testified that a torn meniscus sometimes does not cause pain for 24-48 hours. (PX #8, p. 22) For that reason, limping may not appear in a meniscus tear within the first 24 hours. (PX #8, p. 23)

Dr. Savino testified that a meniscus does not have any nerve supply and does not have any blood supply. He opined that one experiences pain from a meniscal injury from the swelling or the locking or the feeling of it giving out. (PX #8, p. 46)

Testifying from personal experience, Dr. Savino stated that he did not limp when he tore his meniscus playing tennis. Furthermore, Dr. Savino testified that his own knee did not swell

until the next day. (PX #8, p. 45) Dr. Savino also testified that he (Dr. Savino) did not experience pain until 24 hours later when swelling developed. (PX #8, p. 47)

Dr. Savino testified that Petitioner's torn right medial meniscus was due to his fall on February 10, 2014. (PX #8, pp. 28-29) Additionally, Dr. Savino testified that it's possible that Petitioner's fall on February 10, 2014 caused the right lateral meniscus tear. He further testified that Petitioner had pre-existing conditions and that the fall of February 10, 2014 aggravated the right medial meniscus and it possibly aggravated the right lateral meniscus. (PX #8, pp. 51-52)

Finally, Dr. Savino testified that all of Petitioner's treatment has been reasonable and necessary. In addition, Dr. Savino testified that the arthroscopic surgery he has recommended is reasonable and necessary. (PX #8, p. 25)

Dr. Aaron Bare (Section 12 Examining Orthopedic Surgeon) Deposition Testimony:

On June 16, 2014, at Respondent's request, Dr. Bare examined Petitioner. (RX #7, p. 7) Petitioner stated he slipped and fell on February 10, 2014. (RX #7, p. 9) Petitioner complained of right knee pain. (RX #7, p. 11) On examination, Petitioner had some tenderness to palpation over the inside of his knee. Petitioner's tenderness could suggest an injured meniscus. (RX #7, p. 12)

On June 10, 2014, six days before examining Petitioner, Dr. Bare received a faxed letter from Katie Zemovich, Respondent's workers' compensation adjuster. (RX #7, p. 29) Ms. Zemovich's letter stated that a co-worker did see Petitioner on the ground and helped Petitioner up. (RX #7, pp. 29-30)

Dr. Bare testified that he received another letter from Ms. Zemovich dated August 14, 2014. (RX #7, p. 32) Ms. Zemovich stated in her letter that a video showed Petitioner complaining of his "knees" the morning before falling. (Id.) Dr. Bare agreed that there nowhere

in the video is there a complaint of "knee" pain. (Id.) Dr. Bare testified that Ms. Zemovich's statement was incorrect. (RX #7, pp. 32-33)

Dr. Bare testified that Petitioner suffered trauma to his right knee on February 10, 2014. In addition, Dr. Bare testified that a fall can cause enough trauma to tear a meniscus. (RX #7, p. 44) Dr. Bare testified there is no evidence that Petitioner complained of, or treated for, right knee pain within one-year of falling on February 10, 2014. (RX #7, pp. 42-44)

Dr. Bare testified that Petitioner was evaluated for knee problems in [May] 2012. However, Dr. Bare could not comment on Petitioner's knee issue in 2012 because he (Dr. Bare) had no records to review from that period. (RX #7, p. 17) Dr. Bare testified that there is a good chance he did not review Petitioner's May 2012 x-rays images or report. (RX #7, p. 38) Dr. Bare testified that he did not request copies of Petitioner's x-ray images from May 2012 because they had zero impact on his opinion. (RX #7, p. 39)

Dr. Bare did testify that, in general, his own patients are not 100% accurate when they providing medical histories that are over two-years old. Dr. Bare testified that it is possible Petitioner simply forgot about his x-ray from May 2012, rather than lied. (RX #7, p. 41)

Dr. Bare testified that after someone definitively tears his meniscus, it hurts. Dr. Bare refuted Dr. Savino's statement that the meniscus does not have neurological supply and vascular supply. (RX #7, p. 47) Most of the time, people with substantial knee pain will exhibit physiological responses to pain, which may include limping, grimacing and walking abnormally. (RX #7, p. 48) Dr. Bare cited evidence-based medicine rather than someone's testimony on what they had done 5 to 10 to 20 years ago. (RX #7, pp. 53-54)

CONCLUSION OF LAW:

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

Petitioner testified that he slipped and fell on ice in Respondent's bus lot thereby injuring his right knee.

Petitioner testified that one of his work duties included checking the fluids in 22 buses. Petitioner testified that he had checked the fluids in approximately 18 buses and was attempting to cross over to the other row of buses. Petitioner testified that there were two rows of buses that were lined up and facing each other. Petitioner testified that between the two bus rows, there was a pile of snow that was approximately 1-foot high. There is no evidence as to the width or precise length of the snow pile. Petitioner attempted to step over the pile of snow with his left foot. Petitioner's left foot landed on ice, he slipped, he struck his right knee and he did "the splits."

Petitioner provided unrebutted testimony that he then called for help, that two co-workers, Renee Graham and Scott Hibbons, came to his aid, and that Mr. Hibbons helped him get up.

Petitioner's account of the accident is contained in the Sherman Hospital emergency room records, Presence St. Joseph – Occupational Health records, Dr. Anthony Savino's records and Dr. Aaron Bare's records.

Petitioner has proved that his right knee injury occurred in the course of his employment by Respondent.

Respondent argues that Petitioner took an unreasonable or unnecessary risk by attempting to step over the 1-foot pile of snow and therefore his injury did not arise out of his employment. In support of his argument, Respondent cited case law, which includes the following two cases:

In Dodson v. Indus. Comm'n, 308 Ill.App.3d 572 (5th Dist. 1999), the Appellate Court held that an injury does not arise out of the employment for workers' compensation purposes where an employee voluntarily exposes himself to an unnecessary personal danger solely for his own convenience. In Dodson, the claimant sustained an injury when she walked across a grassy slope, which was wet and icy, to her car in the employee parking lot rather than use the unobstructed stairs and sidewalk. The Appellate Court held that the accident did not arise out of her employment, despite the claimant's contention that the employer was aware of the practice and never attempted to stop it. By taking a shortcut, the Appellate Court held, the claimant voluntarily exposed herself to unnecessary personal risk solely for her own convenience.

In Hatfill v. Indus. Comm'n, 560 N.E.2d 369 (4th Dist. 1990), the Appellate Court held that "where the injury has resulted from a personal deviation by an employee or where the injury resulted from a risk personal to the employee and not incidental to the employment, the injury is not compensable." In Hatfill, the claimant injured himself when he attempted to jump over an accumulation of water at the base of an incline in the employer's parking lot. There were alternate walkways the claimant could have used within 50 feet in either direction from where the claimant had jumped the water onto the incline. In the weekly safety newsletters, all employees, including the claimant, were prohibited from taking shortcuts on numerous occasions. There was no reason for the claimant to jump over the accumulated water onto the incline when other routes were available.

In both of the above cases, the claimants finished work and were walking to their cars. In Dodson, the claimant was walking toward the employee parking lot while in Hatfill, the claimant was within the employee parking garage. In Dodson and Hatfill, the claimant deviated from the unobstructed and suggested route, respectively.

In the instant case, when he was not on the bus or in the break room/office/dispatch room, Petitioner worked *in* the parking lot. He testified that he was instructed to check the fluids in 22 buses from 9:00-11:00 a.m. Petitioner was required to open the hood of each bus to check the fluids. Petitioner testified that between the two bus rows, there was a pile of snow that was approximately 1-foot high. The pile of snow would have been in front of the hoods of the buses and behind Petitioner when he was checking fluids.

There is no evidence that Respondent instructed Petitioner to follow a particular route or footpath in carrying out his fluid-checking activity.

Yet, Petitioner *did* testify that he could have walked around the pile of snow. The Arbitrator draws the reasonable inference that Petitioner could have finished checking the fluids in each of his assigned buses in one row and then walked around the back of the buses and around the pile of snow to access the other row. Instead, he took a shortcut.

The Arbitrator notes that this was not a situation in which Petitioner slipped and fell on icy, snowy or wet pavement. The 1-foot high pile of snow was clearly an obstacle. Once again, there was no evidence to indicate the width or precise length of the snow pile.

As in Dodson and Hatfill, the Arbitrator finds that Petitioner, by attempting to step over the 1-foot high pile of snow, exposed himself to unnecessary personal risk solely for his own convenience. Therefore, Petitioner's knee injury did not arise out of his employment.

Compensation is hereby denied. All other issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tina Kosicek,

Petitioner,

vs.

NO: 03 WC 37076

East Aurora High School,

16IWCC0737

Respondent.

DECISION AND OPINION ON SECOND REMAND

This matter had previously been heard and the Decision of the Commission had been filed October 18, 2007. The Commission Decision affirmed the Arbitrator's Decision filed on January 18, 2007. Petitioner was awarded 28-6/7 weeks of temporary total disability benefits at a rate of $611.07 per week under §8(b) of the Act, $1,500.00 for reasonable and necessary medical expenses provided by Hinsdale Orthopedic Services and $1,971.35 for other medical expenses under §8(a) of the Act, and permanent partial disability (PPD) benefits for 137.5 weeks at $542.17 per week = $74,548.38 total PPD due to a 27.5% loss of use of her person as a whole under §8(d)(2) of the Act. This award stemmed from a May 28, 2003 work-related back injury.

Petitioner filed a §19(h)/8(a) Petition on June 12, 2009. Petitioner argued that her condition of ill-being in 2009 was causally related to her condition at Arbitration on January 4, 2007, which was found by the Commission to be causally related to her May 28, 2003 accident. Petitioner also argued that her disability had recurred or increased since the entry of the Commission's Decision, and that she was entitled to payment for outstanding medical bills, temporary partial disability (TPD) benefits, temporary total disability (TTD) benefits, and wage differential benefits pursuant to §19(h)/8(a) of the Act and that Respondent shall be liable for penalties and fees.

On October 4, 2012 the Commission denied Petitioner's §19(h)/8(a) Petition, finding credible the opinion of Dr. Goldberg, who opined that Petitioner's current condition was

16IWCC0737

subjective in nature, and seemed to lack credibility, and were thus unrelated to her May 2003 accident, given that she went over 4 years without seeking any medical treatment subsequent to 2004. Historically Petitioner has treated for back pain, dating back as far as 1992. Moreover, Petitioner's 2004 pain complaints were addressed during her initial trial in January of 2007, and there has been no increase in her disability. Her professional life today is the same as it was in February 2008 when she ***chose*** to work part time as an adjunct professor at Joliet Junior College. Although Petitioner left two full time positions in 2007 and 2008, at Lockport and Reed Custer High Schools, there is no evidence indicating she left either position due to back pain.

Additionally the Commission found that the March 2011 Functional Capacity Evaluation (FCE) was not sufficient proof that Petitioner's level of disability has increased, as Petitioner had not undergone work hardening. There is no way of knowing if any restrictions would have remained had work hardening been completed.

Lastly, the Commission noted that an August 18, 2010 medical record revealed that Petitioner had an immediate increase in low back pain following a car accident 6 days earlier. Curiously, Petitioner's treating physician, Dr. Lorenz, never addressed whether this car accident impacted Petitioner's permanent restrictions or her current condition.

Petitioner appealed this denial to the Circuit Court, and on May 11, 2015 the case was remanded to the Commission for a determination of temporary total disability, temporary partial disability, permanent partial disability and medical benefits, if any. The Circuit Court noted that the Commission went out of its way to prejudice Petitioner by viewing her 2007 testimony in a different light in 2012 than it did in 2007. The Circuit Court also noted that both Drs. Lorenz and Goldberg found causal connection in 2007, which corroborates Petitioner's testimony of continuity of complaints. Thus, Petitioner's increase in complaints and 2010 surgery are sufficient to satisfy her burden under §19(h).

On August 25, 2015 the Commission issued a Decision on Remand, in which it calculated temporary total disability and temporary partial disability benefits to be awarded to Petitioner, in accordance with the Circuit Court Order.

Petitioner then filed a Motion to Set Aside the August 2015 Commission Decision, citing failure to determine a permanent partial disability award, as well as an itemization of medical benefits payable. The Circuit Court granted this Motion on July 1, 2016 and remanded the case to the Commission once again.

FACTUAL BACKROUND

During the Arbitration hearing in January of 2007 Petitioner was teaching at Lockport High School full time. From August 2007 through February 2008 she taught Conceptual Chemistry at Reed Custer High School. During this time she testified that her back pain became more severe. She also testified that she resigned in February 2008, due to her back pain and her resistance to administrations push to change a student's grade.

Between July 2004 and December 2008 Petitioner sought no medical treatment for her back. However she testified that her back pain gradually progressed from 2007 to 2008. She began teaching part time as an Adjunct faculty member at Joliet Junior College in January of 2008. Shortly thereafter, she underwent a lumbar MRI with Dr. Lorenz. On January 7, 2009 she was prescribed pain medication, started on physical therapy and was taken off work. She decided to continue teaching 2 days a week for that semester, however. She also worked the 2009-10 school year, earning $4,354.00.

Respondent's Independent Medical Examiner, Dr. Goldberg, examined Petitioner in August 2009 and recommended back surgery, which Petitioner eventually underwent June 25, 2010. Dr. Goldberg noted that Petitioner's 2008 MRI did not reveal any herniation. It only revealed a degenerative disc at L5-S1 along with modic changes, which are changes within bone marrow on either side of a disc that are consistent with a degenerative process. He opined that a posterior fusion at L5-S1 (eventually performed in June 2010) would be an appropriate treatment. However he did not believe Petitioner's condition was causally related to the 2003 accident. Petitioner had improvement in her radicular pain after undergoing a discectomy subsequent to the accident, and she did not receive any treatment between July 2004 and December of 2008. Dr. Goldberg opined that a causal relationship would require ongoing symptomatology and, most commonly, additional medical treatment. Dr. Goldberg noted that the fusion was not necessary, but it was a quality of life option for Petitioner.

In August 2010 Petitioner was in an automobile accident, but claims that she did not injure her back in it. She also claimed that Dr. Lorenz's records are incorrect if they reflect that she suffered a low back strain as a result of the accident. She testified that she only presented to Dr. Lorenz after the car accident in order to make sure everything was ok. However, an August 18, 2010 medical record reveals that Petitioner complained of an immediate increase in low back pain following the car accident. In fact, she was diagnosed with an acute lumbar strain on that date. (Dr. Lorenz never addressed whether or not this car accident impacted Petitioner's permanent restrictions or her current condition).

Petitioner underwent a Functional Capacity Evaluation (FCE) in the Spring of 2011. Dr. Lorenz imposed permanent restrictions of 15 pounds lifting, 4-5 hours of work per day if a standing or sitting job, with intermittent breaks every 35-40 minutes. If it were a walking job, Petitioner could only work 3 hours per day. Petitioner took off work from June 21, 2010 through August of 2011, when she was re-hired by Joliet College, earning $3,315.00 per semester.

Had Petitioner been employed by Respondent in the 2008-09 school year, she would have been a step 11 and earned $50,359.00. In 2009-10, Petitioner would have earned $52,373.00. In the 2011-12 school year, Petitioner would have earned $56,623.00.

Petitioner reiterated that her back and leg pain improved significantly after her 2010 fusion. She still has intermittent right leg pain, however.

Petitioner's Exhibit #20 reveals unpaid medical expenses of $385,789.28 from December 4, 2008 through September 21, 2011. Pursuant to the fee schedule the unpaid total for these expenses equals $213,423.64.

16IWCC0737

ORDER ON REMAND

The Commission finds that there is no objective evidence supporting Petitioner's §19(h)/8(a) claim. Although the 2011 FCE indicates a worsening of her symptoms, it was not reliable, as Petitioner had not undergone work hardening. Thus, an accurate determination of her disability level could not be found. Additionally, Dr. Goldberg did not agree with the opinion of Dr. Lorenz regarding causation, and in fact noted that there was a lack of continuity in Petitioner's complaints, indicated by Petitioner's 4-and-a-half year period without treatment from 2004 to 2008.

While the Commission finds no basis in the record, facts or law, to alter its Decision, it does so in accordance with the Circuit Court Order.

At the time of the Arbitration Decision on January 18, 2007, Petitioner was working full time and was not seeking any medical treatment related to the back injury in question. This held true until Petitioner sought treatment on December 4, 2008.

Regarding temporary partial disability (TPD), Petitioner was taken off work by Dr. Lorenz on January 7, 2009, however she went back to work January 13, 2009 and continued working 2 days a week for the remainder of the 2008-09 school year as well as the entire 2009-10 school year up until May 6, 2010. In August 2011 Petitioner resumed working 2 days a week for a total of 4 hours and 20 minutes per week.

From January 13, 2009 through May 5, 2009 Petitioner earned $4,020.00 or $249.07 per week working part time for Joliet. She would have earned $1,207.36 per week during the same period if employed by Respondent. Thus, she sustained a wage loss of $958.29 per week and is due TPD benefits of $638.86 per week for the period of 16-1/7 weeks, or $10,311.20.

From August 25, 2009 through December 10, 2009, Petitioner earned $282.18 per week at Joliet, whereas she would have earned $1,281.77 per week at East Aurora. This is a wage loss of $999.59, which equates to TPD benefits of $666.39 per week for 15-3/7 weeks, or $10,282.40. From January 12, 2010 through May 6, 2010 Petitioner claims TPD benefits of $11,137.08.

Regarding TTD, Petitioner was off of work from January 7, 2009 through January 12, 2009, as well as the entire 2010-11 school year.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's current condition of ill-being is causally related to the accident in question

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to all reasonable and necessary medical expenses related to her back injury in the amount of $213,423.64.

16IWCC0737

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to 52-6/7 weeks of TTD benefits at a rate of $611.07 per week (January 7, 2009 through January 12, 2009; and 52 weeks for the 2010-11 school year).

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to TPD benefits in the amount of $31,730.68.

IT IS FURTHER ORDERE BY THE COMMISSION that Respondent pay to Petitioner the sum of $542.17 per week for a period of 150 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused a 30% loss of use of her person as a whole.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall receive 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.

NOV 15 2016

DATED:
DLG/wde
O: 10/20/16 (Discussion)
45

David L. Gore

Mario Basurto

Stephen Mathis

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Petra Garcia,

Petitioner,

vs.

NO: 08 WC 36678

16IWCC0738

Marriott Chicago O'Hare,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner/Respondent herein and notice given to all parties, the Commission, after considering the issues of permanent partial disability (PPD)/nature and extent only (Petitioner), causal connection, temporary total disability (TTD), OTHER-questions of law or fact which appear from transcript of evidence, and is Respondent entitled to credit for TTD overpayment (Respondent), and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner is a 55 year old employee of Respondent, who described her job as a housekeeper. Petitioner testified that she had worked for Respondent for 40 years. Petitioner agreed her job was to clean guest rooms at the hotel. On the date of accident, February 19, 2006, Petitioner testified that while she was leaving a bathroom after cleaning it she tripped over a wastepaper basket and hit her right knee. Petitioner testified to having pain and swelling in her knee. Prior to that date she never had pain or swelling in her right knee; before her fall her knee was normal. Petitioner completed her workday and went home. Petitioner testified that she told her husband she had fallen at work and that her right knee was still hurting and swollen that evening. Petitioner testified that she did not go on vacation shortly after her accident; she had continued to work doing her

housekeeping duties. Petitioner testified that she had more pain and she was not able to work well because of the pain when she would clean the bathtubs. Petitioner testified she sought treatment when Respondent sent her to Concentra where she saw Dr. Mercier. Petitioner noted that she had two small surgeries that did not come out well and she was sent for therapy but still had pain. Petitioner stated that she first had arthroscopic surgery. Petitioner testified that the second surgery was an open surgery in 2010 where Dr. Sclamberg replaced her knee. Petitioner stated that after the knee replacement she could work better but it was never quite the same as having it fine and normal. Petitioner stated that she saw Dr. Chmell at her attorney's request and Dr. Cole at Respondent's IME request. Petitioner stated that she returned to see Dr. Sclamberg in 2013 because she was still having pain; by the end of her work days she felt pain and her knee was tired. Petitioner stated that in 2013, Dr. Sclamberg had given her injections to her knee and in 2014 the he ordered additional therapy.

- Petitioner testified that she was still working for Respondent as a housekeeper and her knee bothers her after a day of housekeeping. She stated that housekeeping is hard work and her knee hurt at the end of the day. Petitioner testified that cleaning bathtubs was normal with housekeeping and her knee has to get pushed up against the bathtub. Petitioner stated that that is when she feels pain and afterwards her right knee still hurts. Petitioner testified a full day of work is cleaning 16 rooms and it now takes her longer to complete a day of work than it did before her accident. She noted sometimes she does not even stop for lunch because she does not have a chance to finish her rooms. Petitioner stated that at home she does not do very much and her husband helps her as she comes home tired. Her husband does the cooking and he did not have to do that before her accident. She stated he helps her because he sees that she is very tired. Petitioner testified that when she is walking sometimes her knee will pop and when she goes to turn her knee will hurt. She stated sometimes her knee feels very tense, a very strong pain and she will stop what she is doing to see if the pain will go away. She stated the pain always continues and she cannot stay stopped for too long when it is cold outside, so she has to then keep walking. Petitioner testified that at church she does not kneel because it hurts; Petitioner stated that she did kneel at church before the accident. Petitioner stated that she takes medication depending on how strong the pain is; sometimes two per day. Petitioner testified that her knee does click; it depends how often. Petitioner stated on work days it will click a lot after she works and has to walk home. Petitioner testified when her knee clicks it hurts. Petitioner testified that Dr. Chmell had recommended a revision knee surgery but she did not want that at this point. Petitioner testified she has not been pain free since her February 19, 2007 accident; she has pain the entire time.

The Commission finds that Respondent indicated causal connection as an issue on their Petition for Review but does not argue the issue, per se, it is therefore deemed as waived. Respondent stated in their Statement of Exceptions that the sole issue raised on Review by Respondent concerns Respondent's entitlement to §8(j) credit, otherwise Respondent submitted the Arbitrator's decision was correct and reserved the right to respond to issues raised by Petitioner. Regardless, Petitioner's testimony is unrebutted and supported in the records of an unbroken causal connection between her accident and her current condition of ill-being. There is even

Respondent's §12 examiner Dr. Cole, who opined a causal connection, albeit, opining Petitioner did not require the revision total knee replacement. Petitioner met her burden of proving an ongoing causal connection. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to causal connection.

The Commission finds that as the parties stipulated to the periods of lost time and amounts paid, the issue cannot be argued here, other than via causal connection, which Respondent did not argue, again the period of lost time and amounts paid were stipulated to. Respondent indicated nothing else as to credit at hearing and the Arbitrator specifically noted the issues in dispute were only causal connection and nature and extent of her permanent partial disability. The evidence and testimony (and stipulation sheet) finds Petitioner met the burden of proving entitlement to the stipulated lost time period which has been satisfied by Respondent; Respondent receiving the stipulated credit for amounts paid. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to total temporary disability and amounts of benefits paid.

The Commission finds Petitioner clearly evidenced accident and a causal relationship to her current condition of ill-being. Petitioner testified that she was still working for Respondent as a housekeeper and her knee bothers her after a day of housekeeping. She stated that housekeeping is hard work and her knee hurts at the end of the day. She testified that cleaning bathtubs was normal with housekeeping and her knee has to get pushed up against the bathtub. Petitioner stated that that is when she feels pain and afterwards her right knee still hurts. Petitioner testified a full day of work is cleaning 16 rooms and it now takes her longer to complete a day of work than it did before her accident. She noted sometimes she does not even stop for lunch because she does not have a chance to finish her rooms. Petitioner stated that at home she does not do very much and her husband helps her as she comes home tired. Her husband does the cooking which he did not have to do before her accident. Petitioner stated that he helps her because he sees that she is very tired. Petitioner testified that when she is walking sometimes her knee will pop and when she goes to turn her knee will hurt. She stated sometimes her knee feels very tense, a very strong pain and she will stop what she is doing to see if the pain will go away. She stated the pain always continues and she cannot stay stopped for too long when it is cold outside, so she has to then keep walking. Petitioner testified that at church she does not kneel because it hurts; Petitioner stated that she did kneel at church before the accident. She takes medication depending on how strong the pain is, sometimes two per day. Petitioner testified that her knee does click; it depends how often. Petitioner stated on work days it will click a lot after she works and has to walk home. Petitioner testified when her knee clicks it hurts. Petitioner testified that Dr. Chmell recommended a revision knee surgery but she did not want that at this point. Petitioner testified that she has not been pain free since her February 19, 2007 accident; she has had pain the entire time. Petitioner had the arthroscopic surgery and the total knee arthroplasty and her ongoing complaints are well documented and supported in the evidence. Petitioner's arguments to increase permanency to 70% of her leg are partially based on speculation and conjecture of what may occur in the future and any possible future revision of the total knee replacement. Petitioner does continue to perform her job duties despite her ongoing subjective complaints and even Respondent's §12 examiner, Dr. Cole, noted the causal connection and ongoing problems, albeit, he did not opine that Petitioner was in need of a revision surgery. Petitioner is older, works as a

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non-skilled laborer, and apparently has limited English speaking skills, but she can perform her work duties, albeit slower and maybe fewer rooms per day due to her condition. The Commission finds the Arbitrators PPD award is insufficient given the evidence and unrebutted testimony. The evidence and testimony supports a higher PPD award, but not to the extent Petitioner suggests. The Commission finds the evidence and testimony to support that Petitioner met the burden of proving entitlement to a permanent partial disability (PPD) award of 47.5% loss of her right leg. The Commission finds the decision of the Arbitrator as contrary to the weight of the evidence to warrant this modification, and, herein, modifies the award to find a 47.5% loss of Petitioner's right leg.

The Commission finds, as to Respondent's issue, --OTHER-Any questions of law or fact which appear from the transcript of evidence--, that Respondent did not address anything specific as to questions of law or fact they viewed as Arbitrator error (other than indicating that Dr. Chmell's deposition and opinions in evidence should not be considered credible as the deposition is not complete); Respondent agreed with the Arbitrator's decision with the PPD award and only requested the Commission find a TTD/8(j) credit which was not even at issue at hearing. Regardless, the question of the completeness of Dr. Chmell's deposition transcript (i.e. missing pages of deposition transcript) if that is what Respondent considers a question of law or fact, does not really affect the award as found by the Commission.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $287.17 per week for a period of 102.125 weeks ($29,327.24 total PPD), as provided in §8(e)(12) of the Act, for the reason that the injuries sustained caused the 47.5% loss of use of Petitioner's right leg.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $29,500.00. 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: NOV 15 2016
o-9/22/16
DLG/jsf
045

David L. Gore

Stephen J. Mathis

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GARCIA, PETRA
Employee/Petitioner

Case# **08WC036678**

16IWCC0738

MARRIOTT CHICAGO O'HARE
Employer/Respondent

On 3/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% 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:

0786 BRUSTIN & LUNDBALD LTD
CHARLES E WEBSTER
10 N DEARBORN ST 7TH FL
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY
CHRISTINE M JAGODZINSKI
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

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STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

PETRA GARCIA,
Employee/Petitioner

Case #08 WC 36678

v.

Consolidated cases:

MARRIOTT CHICAGO O'HARE,
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 **MARIA BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **January 12, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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FINDINGS

On **2/19/2006**, 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*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $24,888.24; the average weekly wage was $478.62.

On the date of accident, Petitioner was 55 years of age, ***married*** with 0 dependent children.

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

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

Respondent shall be given a credit of $12,781.60 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $12,781.60. Respondent is entitled to a credit of $0 under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$287.17/week** for **86** weeks, because the injuries sustained caused the **40%** loss of the **right leg**, as provided in Section **8(e)12** 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

3-7-2016
Date

MAR 7 - 2016

BACKGROUND

Petra Garcia ("Petitioner") filed her application for adjustment of claim against her employer, Marriott Chicago O'Hare ("Respondent"), seeking benefits under the Illinois Workers' Compensation Act ("the Act") alleging that on 2/19/06 she sustained injuries as the result of an accident arising out and in the course of her employment.

The claim proceeded to an arbitration hearing on 1/16/16 in Chicago, Illinois before Arbitrator Maria S. Bocanegra. Ax1. At issue were causal connection and nature and extent of the injury. Subsequent to the initial hearing, by agreement of both parties proofs were re-opened on 2/2/16 for the limited purpose of clarifying the issue of liability for medical bills. On the record, the parties agreed that nothing was due and owing to Petitioner for any alleged out of pocket expenses incurred as a result of the work accident, thereby removing the issue of liability for unpaid medical bills from contention. The request for hearing form was amended and proofs were once again closed.

FINDINGS OF FACT

The following is a recitation of the facts adduced at trial. Petra Garcia ("Petitioner") testified, via Spanish interpreter/translator Susan Schweigert, that she is a 65-year-old housekeeper employed by Marriott Chicago O'Hare ("Respondent") since April 1976. She works at the Marriott Hotel located at Cumberland and Higgins.

Petitioner testified she was involved in a work accident on 2/19/06 with Respondent when she tripped over a wastepaper basket and hit her knee. She noticed pain and swelling in her right knee after she fell. Petitioner denied any prior injuries to her right knee before this date. She completed her workday, went home and told her husband she fell. She noticed swelling around her knee and pain.

When asked whether she waited to present for treatment until she returned from a vacation after her injury, Petitioner denied going on vacation after this incident. She testified she continued to work, but she was not able to work well. She felt pain after cleaning bathtubs.

On 5/15/06, Concentra records confirm Petitioner first presented for treatment. Px8. Concentra noted a right knee injury on 3/8/06 when Petitioner tripped on a garbage can. She continued to work her usual routine, treated with Anacin and took her scheduled vacation. When she returned from vacation, the swelling and pain in her right knee was severe. She denied any previous injury to her right knee. Dr. Mary Capelli recommended Ibuprofen 600 mg, physical therapy three times a week and a follow-up visit in 2 days. That same day, she was evaluated by physical therapists. At trial, Petitioner denied taking any vacation.

On 5/17/06, Dr. George Bridgeforth examined Petitioner. Px8. She reported improvement. Upon examination, she had mild soreness along the medial joint line. There was no redness or swelling and no focal tenderness to palpation. She continued to work modified duty and attend physical therapy.

On 5/24/06, Petitioner was re-examined by Dr. Bridgeforth at Concentra. Px8. There was mild limp favoring the right. On exam, Petitioner's symptoms and signs were consistent with patellofemoral pain. Petitioner related a history of longstanding knee pain for several months before the accident. Dr. Bridgeforth referred her for MRI studies and returned her to work with a 10 room cleaning restriction. Px5.

On 6/2/06, records of Swedish Covenant Hospital document an unrelated injury to the left shoulder after Petitioner was hit by a car and fell. The car was backing up. She denied injury to her head. Px3. At trial, Petitioner denied this incident occurred and disagreed with the medical notation.

On 6/17/06, Petitioner followed up with Dr. Bridgeforth. Px8. She denied improvement and reported moderate pain and soreness affecting the right knee. Dr. Bridgeforth restricted her to cleaning 10 rooms and noted that MRI studies were pending. He diagnosed her with chondromalacia of the patella and planned to rule out a meniscal tear. The MRI showed knee joint effusion and mild osteoarthritic changes with a small degenerative tear of the posterior horn of the medial meniscus. There was evidence of a partially extruded lateral meniscus as well as subchondral bone marrow swelling within the lateral tibial plateau.

On 6/23/06, Dr. Charles Carlton examined Petitioner at Concentra. Px5, Px8. Petitioner related ongoing symptoms, that she was working within the restrictions and taking her medications, all without improvement. Her pain was located in the lateral aspect of the right knee, moderate in nature and exacerbated with bending, walking, squatting, kneeling, pivoting and standing. Dr. Carlton found the MRI positive for meniscal tear and referred her to an orthopedic surgeon, Dr. Charles Mercier. Light duty restrictions were continued.

On 6/26/06, Dr. Mercier examined Petitioner. She related she injured her right knee at work after tripping and that she had no prior history of this problem. He found the MRI positive and recommended surgery. He restricted her to modified duty. Px8.

On 7/10/06, Dr. Mercier continued light duty along with a 10 room cleaning limit. He requested that the employee be allowed to sit as need for comfort. Px5, Px8. On 7/24/06, the same restrictions were continued and Dr. Mercier noted surgery approval was still pending. On 8/7/06, 8/23/06, 9/6/06 and 9/20/06, the same restrictions were continued. On 10/4/06, Dr. Mercier restricted duty further to an 8 room cleaning limit. Px5, Px8. On 10/18/06, 10/26/06, 11/15/06, 12/6/06, 12/20/06 and 1/3/07, Dr. Mercier released Petitioner to regular duty pursuant to Petitioner's request to try same. Px5, Px8.

Dr. Brian Cole examined Petitioner on 11/1/06 for a Section 12 examination at Respondent's request. Rx3. She continued to work full duty with pain and swelling of the anterolateral aspect of her knee. Dr. Cole reviewed her MRI studies and noted a lateral meniscal cyst with a possible tear of the mid body and anterior horn. A posterior horn tear was noted on the medial side with significant effusion. Dr. Cole examined her and diagnosed her with low grade osteoarthritis and meniscal pathology. He recommended she continue to work full duty and proceed with a cortisone injection. If no improvement was noted following the injection, surgery would be indicated. On 11/15/06, Dr. Mercier administered a cortisone injection. Px8. Dr. Mercier noted that Petitioner planned to go out of town and he would see her during the first week of December.

On 12/6/06, Dr. Mercier examined Petitioner, noting she returned from an extended vacation and felt much better. Px8. The injection helped her. She continued to work her regular job duties. Dr. Mercier instructed her to follow-up in two weeks to see if she still had issues. On 12/28/06, she reported lateral knee pain with constant clicking and patellar crepitation. As the hotel was not very busy, she was not working as much. Dr. Mercier recommended surgery.

On 2/10/07, Petitioner underwent and Dr. Mercier performed arthroscopic surgery with a partial lateral meniscectomy and synovectomy. Px4, Px7. Dr. Mercier noted significant degenerative changes in the lateral tibial plateau located somewhat anterior and extending posteriorly. These changes were Grade 4. He also noted anterior lateral meniscal tear and significant degenerative changes of the lateral compartment. On 2/14/07, Petitioner was removed from work by Dr. Mercier and was ordered to start physical therapy. Px5, Px8. This off

work status continued through 5/1/07. Px5. Petitioner attended physical therapy at Concentra following surgery through 4/25/07. Px8.

On 4/25/07, Dr. Mercier noted she was much improved. Px8. There was no swelling. She exhibited full range of motion. She had sub patellar crepitation and anterior medial joint line pain. She wanted to return to her regular duties. Dr. Mercier released her to clean 10 rooms and noted she would slowly resume her full duties. He noted therapists indicated she did not require any additional therapy.

On 5/2/07, Dr. Mercier released Petitioner to work with an increased clearance to clean 12-13 rooms per day. Px5, 8. On 5/16/07, Petitioner reported medial joint line pain which he noted was consistent with her pre-existing degenerative arthritis. Dr. Mercier recommended that she take Motrin and work full duty. Px7, 8. On 5/30/07, Petitioner confirmed she returned back to work without restrictions. She had increased pain and swelling at the end of the day. Px7, 8. Dr. Mercier administered a cortisone injection. Full duty was continued. Px5. On 6/13/07, Petitioner had anterior knee pain associated with her patellofemoral degenerative changes. There was no swelling, ligaments were stable and there was full range of motion. He placed her at maximum medical improvement and should continue her full duties. Px5, 7, 8.

On 8/31/07, Petitioner returned to Concentra stating that she picked up some linen and hit her right knee on a door on that date. Px8. On exam, there was gross arthritic deformity of both knees. The doctor diagnosed her with a knee contusion. Full duty work was continued. Px5, 8. On 9/1/07, Dr. Fairbrother prescribed light duty on and 9/7/07, Petitioner was released to full duty and from medical care. Px5.

On 12/13/07, Petitioner began treating with Dr. Edward Sclamburg. Px1. She complained of low back pain to the right buttock. There was no mention of right knee pain. On 2/4/08, she presented to Dr. Sclamburg with complaints of pain in her right knee. Px1. Dr. Sclamburg referred her for right knee MRI studies. On 2/7/08, MRI of the right knee revealed mild to moderate residual deformity of the subchondral portion of the lateral tibial plateau suggesting an old osteochondral fracture. Px1. Degenerative joint changes were noted as well as an old tear of the anterior horn of the lateral meniscus.

On 5/15/08, Petitioner returned to Dr. Mercier. Px7, 8. She reported increased pain and swelling in the right knee from doing her normal job duties. Exam showed anterolateral joint line pain and some mild swelling. She had full range of motion, ligaments were intact and Lachman's was negative. She walked normally without limp. Dr. Mercier administered a cortisone injection. He noted that her knee will have flare ups from time to time. Petitioner returned to Dr. Mercier on 5/29/08 complaining of problems with stairs and kneeling. Px7, 8. She did not receive relief from the cortisone injection. She had lateral joint line pain. On exam, she had anterolateral joint line painful motion, some sub patellar crepitation and noticeable swelling in the suprapatellar pouch. He informed Petitioner she had some arthritis and it may something she has to learn to live with.

On 6/19/08, Petitioner saw Dr. Mercier, who noted she continued to complain of bilateral knee swelling and some pain. He reviewed the MRI from 2/7/08 which revealed postop changes of the lateral meniscus. There was a suggestion of an old osteochondral fracture of the lateral meniscus. There were also moderate arthritic changes. Dr. Mercier felt the majority of her problems were related to mild arthritis. He prescribed Motrin and Darvocet. He noted some of her job duties were bothering her but noted she did not want to lose her job and was willing to do what was necessary. Full duty continued and follow up was ordered.

On 7/1/08, Dr. Sclamburg recommended arthroscopic surgery. Px1. On 7/25/08, Petitioner underwent and Dr. Edward Sclamburg performed arthroscopic surgery consisting of a partial lateral meniscectomy of the right knee, debridement and synovectomy. Px1, Px6. Chondromalacia of the patellofemoral joint was noted at

the tibial surface of the femur and patella. He also identified tears at the anterior horn of the medial meniscus and lateral meniscus.

On 8/7/08, Dr. Sclamburg recommended physical therapy for the right knee. On 8/12/08, Petitioner presented for initial physical therapy evaluation at Swedish Covenant Hospital. Px3. Her functional limitations included pain with stairs, as well as pain with walking, sleeping and driving. On 9/5/08, therapists noted she continued to complain of increased pain mainly laterally and posteriorly in the right knee. Follow up was ordered. On 9/8/08, Petitioner told Dr. Sclamburg the therapy was not helping any longer. He instructed her to discontinue therapy and Petitioner was removed from work. On 10/7/08, Dr. Sclamburg released her to return to work. As of 9/6/08, a total knee replacement was discussed. Px1.

At the request of Respondent, Dr. Cole examined Petitioner a second time on 7/6/09. Rx4. Dr. Cole agreed she needed a total knee replacement. He causally related her condition of ill-being to the work accident and noted she was not yet at maximum medical improvement. On 7/29/10, Dr. Sclamburg noted Petitioner reported pain with increased symptoms over the past several months. Dr. Sclamburg discussed proceeding with a total knee replacement. Px1.

On 8/25/10, Petitioner underwent a total knee replacement/arthroplasty. Px1, Px9. Dr. Sclamburg documented progressive valgus deformity with degenerative arthritic changes primarily along the lateral joint line. She was hospitalized for four days and referred to a rehabilitation facility. Discharge diagnosis was right knee osteoarthritis. Px9. Post operatively, Dr. Sclamburg prescribed Vicodin, a walker, therapy and off work restrictions. Px1.

On 10/7/10, Dr. Sclamburg noted Petitioner was in physical therapy and stated she may need a functional capacity evaluation. She was continued off of work. Px1. That same month, Petitioner saw Dr. Steven Sclamburg for an unrelated right shoulder impingement syndrome. Px1.

On 1/3/11, Dr. Sclamburg noted progress in therapy and he injected the right knee with Kenalog. On 2/3/11 another Kenalog injection was administered. On 3/3/11, Petitioner denied pain in her knee and walked normally. On 3/7/11, Petitioner was released to regular duty. Px1.

On 4/4/11, Petitioner returned to Dr. Sclamburg reporting soreness after cleaning 16 rooms. Dr. Sclamburg suggested that she clean 14 rooms instead of 16. On 5/2/11, she reported improvement after reducing the number of rooms. On 7/13/11, Petitioner's knee exam was normal and she was cleared to full duty. Medications were renewed. On 11/1/11, she saw Dr. Sclamburg, who noted no further treatment was indicated except yearly x-rays.

On 7/2/12, Petitioner sought a second opinion with Dr. Chmell at the request of her attorney. Dr. Chmell thought she had loosening of the arthroplasty components in her knee and a possible infection. She underwent a bone scan and blood work as recommended by Dr. Chmell. The bone scan was abnormal and revealed post-surgical changes rather than loosening of the prosthesis. Rx5. She returned to Dr. Chmell on 7/12/12, who noted that she had good placement of the prosthesis and he referred her for physical therapy. There was no mention of another knee surgery in his records.

On 10/29/12, Dr. Chmell authored a letter addressed to Petitioner's counsel stating she will require a revision total knee replacement based on a concern for loosening of tibial prosthesis and for a bone cement allergy. Px10, Rx5.

On 12/17/12, Dr. Cole examined Petitioner for a third Section 12 exam at the request of Respondent. Rx5. Dr. Cole documented range of motion from 0-120 degrees. She reported tenderness around the pes anserine and medial hamstring tendons. Dr. Cole noted iliotibial band tenderness laterally and tenderness into the lateral hamstrings as well. Dr. Cole recommended a single cortisone injection for pain relief. If she declined the injection, she would be at maximum medical improvement. He also recommended permanent restrictions of limited squatting, kneeling and climbing, if she insisted she could not do her full duty job. He felt it was safe for her to try to work full duty and recognized she may have some discomfort doing so but it would not be orthopedically unsafe. He noted that if she had any difficulty, then she should be restricted to a job with limited squat, knee and climb. His diagnosis was persistent right knee pain post arthroplasty, causally related to her work accident but did not see any indications for a future revision total knee replacement was not necessary.

The parties proceeded with Dr. Chmell's evidence deposition on 2/7/13. Px10[1]. He testified that the bone scan came back abnormal, which to him indicated evidence of loosening of the tibial compartment. Dr. Chmell testified he recommended a revision knee replacement as Petitioner's best chance of reducing pain.

On 7/8/13, Petitioner again followed up with Dr. Sclamburg. Px11. He noted she was 3 years status post right knee arthroplasty/replacement. For the last 2 years, she had pain over the posterior aspect of the medial and lateral sides. She continued working with discomfort. He found the arthroplasty in excellent alignment with no evidence of loosening or any other abnormalities. He injected the joint with Kenalog. If she did not experience improvement from the injection, he planned to refer her for therapy. Dr. Sclamburg did not impose any work restrictions.

On 8/12/13, Petitioner returned to Dr. Sclamburg. Px11. She testified she returned because she still had pain in her right knee after she finished her workday. She stated Dr. Sclamburg administered injections and recommended additional physical therapy in 2014. She had some improvement with the cortisone injection. Dr. Sclamburg administered another injection and recommended she continue regular activity. He prescribed anti-inflammatory medication. She returned to Dr. Sclamburg on 9/26/13. Px11. She complained of lateral pain. There was no instability, near full range of motion, no effusion and no swelling. He recommended physical therapy three times a week for 4-6 weeks. She also planned to take Tramadol which he prescribed at her last visit. She had not filled that prescription.

On 12/19/13, Petitioner eventually presented to physical therapy at Total Rehab. Px11. Moderate swelling and tightness in the posterolateral portion of the right knee were noted along with severe tenderness in the medial infero portion. On 2/4/14, Dr. Sclamburg last saw Petitioner. Px11. He recommended additional physical therapy and noted that she stated she did not need any medications. He instructed her to continue her current work schedule. His diagnosis was degenerative joint disease of the right knee. There is no record of physical therapy or follow up being undertaken after this visit. Physical therapies continued until 4/4/14. In March 2014, she asked the therapist to discharge her as she did not have any more pain in her knee. She attended a total of 40 visits with three missed visits.

Petitioner continues to work as a housekeeper. Her right knee bothers her at the end of each day. She also feels pain when cleaning a bathtub as her knee is up against the bottom of the bathtub. Her full work schedule includes cleaning 16 rooms. Petitioner admitted she works full duty up to 6 days a week if the hotel is busy.

With regard to activities of daily living, Petitioner testified that her husband has to do the cooking in her

[1] The Arbitrator notes multiple pages are missing throughout the exhibit as tendered by Petitioner. The original reports and opinions pre-dating the October 2012 opinion were not admitted into evidence.

house as he helps her out when he sees she is tired. When she walks, her knee pops. She testified she has pain in her knee when she turns to the left or right. The pain is tense and very strong. She will stop to see if the pain will go away. When she attends church, she does not kneel down. She takes pain medications up to two times a day, but the amount she takes depends on her pain. She testified Dr. Chmell mentioned she may need a revision total knee replacement at some point. Petitioner testified she has had pain in her right knee for the entire time since her accident. She testified she takes Naprosyn which is prescribed by her primary care doctor, Dr. Campos. She could not recall the last time she sought treatment with Dr. Campos.

Petitioner testified that she takes a bus from her home and then gets on a train to travel to work. The bus stop is five blocks from her house. She then gets off the bus and takes a train. She has to walk two blocks from the train to the hotel. She agreed she walks approximately 14 blocks each day when she works. Petitioner also agreed that she cleans bathtubs while kneeling, even though she testified on direct examination that she was unable to kneel at church. Petitioner admitted she saw Dr. Cole at the request of Marriott, but she could not recall the dates. She denied having any hobbies outside work and noted she does not travel to Mexico frequently. She last went to Mexico in the fall of 2015 when her mother-in-law passed away.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

The Arbitrator finds Petitioner was credible in her recollection of her work accident, treatment history for the work accident and was somewhat credible in her describing her current symptoms as they relate to her right knee. The Arbitrator did not find Petitioner credible in denying her vacation time and in denying her being struck by a car injuring her shoulder but notes this information does not ultimately bear on any of the disputed issues.

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

The Arbitrator adopts and incorporates the above findings of fact as though fully set forth herein. Having considered all evidence, the Arbitrator concludes that Petitioner's right knee/leg condition is causally related to her undisputed work accident.

Petitioner sustained a right knee injury at work on 2/19/06. Despite the delay in treatment, initial records from Concentra in May 2006 document longstanding history right knee pain for a few months *before* the accident. At trial, Petitioner denied having prior right knee problems before her accident. At trial, Petitioner denied telling Concentra that she had knee pain before the work accident. The Arbitrator believes Petitioner in this regard, noting Concentra's incorrectly listed date of accident as 3/8/06 supports that Petitioner had pain before that date, namely on the correct date of her accident on 2/19/06.

The Arbitrator resolves any delay in treatment in favor of Petitioner, noting that she credibly testified she immediately reported her injury and that she attempted to self-treated prior to entering formal treatment. Other than a minor right knee contusion which occurred at work on 8/31/07, the medical records do not document any intervening accidents involving her right knee.

Records show Petitioner attempted conservative treatment to the right knee consisting of medication, physical therapy, cortisone injection and light duty. When that failed, on 2/10/07, Petitioner underwent her first arthroscopic surgery with a partial lateral meniscectomy and synovectomy. She was eventually released and placed at maximum medical improvement on 6/13/07. Petitioner re-entered treatment briefly for hitting her right knee but was returned to full duty. In February of 2008, Petitioner began treatment with Dr. Sclamburg,

complaining of ongoing right knee pain. In the following months, Petitioner continued to treat, noting difficulty with her normal job duties. On 7/25/08, Dr. Sclamburg performed a second arthroscopic surgery consisting of a partial lateral meniscectomy of the right knee, debridement and synovectomy. Chondromalacia of the patellofemoral joint was noted at the tibial surface of the femur and patella along with tears at the anterior horn of the medial meniscus and lateral meniscus were identified. Petitioner undertook usual post-operative care and when that failed, Dr. Sclamburg recommended a total knee replacement. Dr. Cole, Respondent's examining physician, examined Petitioner a second time on 7/6/09. He agreed she needed a total knee replacement causally related her condition of ill-being to the work accident and noted she was not yet at maximum medical improvement. Medical records reflect that her last office visit occurred in February, 2014 with Dr. Sclamburg and she finished physical therapy in April, 2014 at Total Rehab. There is no medical evidence reflecting ongoing treatment since 2014 for her right knee.

In light of the foregoing, the Arbitrator finds that Petitioner's right knee condition is causally related to her work accident on 2/19/06.

ISSUE (L) What is the nature and extent of the injury?

Petitioner underwent two arthroscopic surgeries on 2/10/07 and 7/25/08, consisting of a partial lateral meniscectomy and synovectomy and a second partial lateral meniscectomy, debridement and resection of a torn portion of the lateral meniscus as well as debridement of a torn portion of the anterior horn of the medial meniscus, respectively. Dr. Sclamburg eventually performed a total knee replacement on 8/25/10.

Petitioner resumed her full duties as a housekeeper and she continues to work full duty. She admitted she is able to walk 14 blocks when she commutes to work each day. She takes medication when needed for pain. Petitioner testified she has difficulty kneeling and stated she has not had a day free of right knee pain since the date of her accident. However, the Arbitrator notes there are various medical records that document instances where Petitioner denied having any right knee pain.

Petitioner has not returned to see Dr. Sclamburg for her right knee since 2/4/14. At the time she was released, she was allowed to resume full duty work in the same occupation as before the injury. She testified she has treated with her primary care doctor, Dr. Campos, but there are no records documenting any treatment for her right knee with Dr. Campos. Petitioner is now 65 years of age. She was 56 years old at the time of her injury. She testified when the hotel is busier, she sometimes must work 6 days per week rather than her usual 5 days per week. There is no evidence her accident had any impact upon her future earning capacity.

The Arbitrator finds that Petitioner continues to work full duty since she returned to work in March 2011 following her total knee replacement. When the hotel is busy, she sometimes works 6 days a week. Petitioner also admitted she walks 14 blocks when she commutes to work and she has not had significant treatment for her right knee since the spring of 2014. Based on the above, as well as the record as a whole, the Arbitrator finds that Respondent shall pay Petitioner permanent partial disability benefits of **$287.17/week** for **86** weeks, because the injuries sustained caused the **40%** loss of the **right leg**, as provided in Section **8(e)12** of the Act.

Signature of Arbitrator **Date** 3-7-2016

3-7-16 Boca Negra 16IWCC0738

ILLINOIS WORKERS' COMPENSATION COMMISSION
PETITION FOR REVIEW OF ARBITRATION DECISION

To appeal an arbitration decision, file two copies of this form within 30 days of receipt of the decision.

Petra Garcia
Employee/Petitioner

v.

Marriott Chicago O'Hare
Employer/Respondent

Case # **08** WC **36678**

Chicago

The petitioner ☒ respondent ☐ requests the Commission to review the arbitration decision for this case, filed on **March 7, 2016** and received on **March 17, 2016** , and to take the following steps:

1. Furnish a transcript of the arbitration hearings, including all exhibits, to be presented to the Commission.
   I guarantee to pay for the cost to prepare the transcript within 30 days from the court reporter's written request, even if I later withdraw this appeal, and enter myself as surety therefor. *Note:* The first party to file a petition will be charged for the cost to prepare the transcript (original rate).
   Provide **1** copy/copies of the transcript. I similarly guarantee payment at the copy rate.
2. Extend the time allowed to file the transcript or the agreed statement of facts by 30 days past the time allowed by statute or stipulation.
3. Consider the issues checked below to which I take exception:

ACCIDENT
- ☐ Did it occur?
- ☐ Did it arise out of employment?
- ☐ Was it in the course of employment?
- ☐ Is the date correct?

BENEFIT RATES
- ☐ Are the benefit rates correct?
- ☐ Are the wage calculations correct?

EMPLOYMENT
- ☐ Was there an employer-employee relationship?

JURISDICTION
- ☐ Does the Commission have jurisdiction?

MEDICAL EXPENSES
- ☐ Is there a causal connection?
- ☐ Is the charge reasonable?
- ☐ Was the treatment reasonably necessary?
- ☐ Is prospective medical care necessary?

NOTICE
- ☐ Was the respondent given proper notice?

OCCUPATIONAL DISEASE
- ☐ Was there an exposure?
- ☐ Was there a disease?
- ☐ Did it arise out of employment?
- ☐ Was it in the course of employment?
- ☐ What was the last date of exposure?

OTHER (explain) ____

PENALTIES AND FEES
- ☐ Section 16
- ☐ Section 19(k)
- ☐ Section 19(l)

PERMANENT DISABILITY
- ☐ Is there a causal connection?
- ☒ What is the nature and extent of the disability?

STATUTE OF LIMITATIONS
- ☐ Was the case filed within the statute of limitations?

TEMPORARY DISABILITY
- ☐ Is there a causal connection?
- ☐ Is the duration of the disability correct?

4. Oral argument: Requested ☒ Waived ☐

Chris Ewan
Signature

312-263-1250
Telephone number

10 N. Dearborn, 7th Fl.
Street address

FILED
16 APR 13 PM 12:56
ILLINOIS WORKERS' COMPENSATION COMMISSION-TR

16IWCC0738

Charles E. Webster, Brustin & Lundblad, Ltd.
Name (please print; attorneys, include IC attorney code#)

Chicago, IL 60602
City, State, Zip code

IC11 12/04 100 W. Randolph Street #8-200 Chicago, IL 60601 312/814-6611 Toll-free line 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

PROOF OF SERVICE

If the person who signed the *Proof of Service* is not an attorney, this form must be notarized.

I, **Rena Maritote**, affirm that I delivered ☐ mailed with proper postage ☒

in the city of **Chicago** a copy of this form

at **5:00** PM on **March 31, 2016** to each party at the address(es) listed below.

William Lowry
Nyhan Bambrick Kinzie & Lowry
20 N. Clark St., Ste 1000
Chicago, IL 60602
P – 312-629-9800
F-312-629-8518

Signature of person completing *Proof of Service*

Signed and sworn to before me on 3/31/16

Notary Public

OFFICIAL SEAL
IESHA GILMORE SMITH
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/01/20

FILED
16 APR 13 PM 12: 56
ILLINOIS WORKERS' COMPENSATION COMMISSION-TR

Cross review

ILLINOIS WORKERS' COMPENSATION COMMISSION
PETITION FOR REVIEW OF ARBITRATION DECISION

16IWCC0738

To appeal an arbitration decision, file two copies of this form within 30 days of receipt of the decision.

RECEIVED
2016 APR -6 PM 3:48
ILLINOIS WORKERS' COMPENSATION COMMISSION

PETRA GARCIA,
Employee/Petitioner

v.

MARRIOTT CHICAGO O'HARE,
Employer/Respondent

Case #**08 WC 36678**

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- ☐ Was there an employer-employee relationship?

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- ☐ Does the Commission have jurisdiction?

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- ☐ Is there a causal connection?
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- ☐ Was the treatment reasonably necessary?
- ☐ Is prospective medical care necessary?

NOTICE
- ☐ Was the respondent given proper notice?

OCCUPATIONAL DISEASE
- ☐ Was there an exposure?
- ☐ Was there a disease?
- ☐ Did it arise out of employment?
- ☐ Was it in the course of employment?
- ☐ What was the last date of exposure?

☒ OTHER (explain) **Any questions of law or fact which appear from the transcript of evidence; Is Respondent entitled to a credit for the TTD overpayment?**

PENALTIES AND FEES
- ☐ Section 16
- ☐ Section 19(k)
- ☐ Section 19(l)

PERMANENT DISABILITY
- ☐ Is there a causal connection?
- ☐ What is the nature and extent of the disability?

STATUTE OF LIMITATIONS
- ☐ Was the case filed within the statute of limitations?

TEMPORARY DISABILITY
- ☒ Is there a causal connection?
- ☒ Is the duration of the disability correct?

4. Oral argument: Requested ☒ Waived ☐

FILED
16 APR 3 PM 4:3
ILLINOIS WORKERS' COMPENSATION COMMISSION-TR

Signature

Christine M. Jagodzinski, #2461
Name (please print; attorneys, include IC attorney code#)

(312) 629-9800
Telephone number

Nyhan, Bambrick, Kinzie, & Lowry, P.C.
20 North Clark Street, Suite 1000
Street address

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City, State, Zip code

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WWW.IWCC.IL.GOV
(312) 814-6500 TDD (312) 814-2959 TOLL FREE (866) 352-3033

MAIL TO:
MARVIN A BRUSTIN LTD
10 N. DEARBORN
7TH FLOOR
CHICAGO IL 60602

NOTICE DATE:
04/21/2016
CASE NUMBER:
08 WC 036678

16IWCC0738

NOTICE OF RETURN DATE ON REVIEW

NOTICE TYPE: INITIAL

==========

PETITIONER:
GARCIA, PETRA

RESPONDENT:
MARRIOTT CHICAGO O'HARE

RETURN DATE ON REVIEW: 06/17/2016 COMMISSIONER: GORE, DAVID

IN PERSON:
THE REVIEWING PARTY SHALL **APPEAR BEFORE 5:00 P.M. ON THE RETURN DATE ON REVIEW** AND PRESENT THE AUTHENTICATED TRANSCRIPT AT ANY OF THE FOLLOWING WORKERS' COMPENSATION COMMISSION OFFICES:

SPRINGFIELD	ROCKFORD	COLLINSVILLE
4500 SOUTH 6TH 62703	200 S. WYMAN 61101	1014 EASTPORT PLAZA DR 62234
(217) 785-7087	(815) 987-7292	(618) 346-3450
PEORIA	CHICAGO	
202 N.E. MADISON 61602	100 W. RANDOLPH 60601	
SUITE 201	SUITE 8-200	
(309) 671-3019	(312) 814-6611	

BY MAIL (CHICAGO OFFICE ONLY) :
THE REVIEWING PARTY MAY ELECT TO SUBMIT THE AUTHENTICATED TRANSCRIPT **BY MAIL TO THE REVIEW DEPARTMENT OF THE COMMISSION AT ITS OFFICES AT 100 WEST RANDOLPH STREET, 8TH FLOOR, CHICAGO, IL., 60601, ON OR BEFORE THE RETURN DATE ON REVIEW IN ACCORDANCE WITH RULE 7040.10(D)(2). THE AUTHENTICATED TRANSCRIPT SHALL BE ACCOMPANIED BY A COVER LETTER INDICATING THE CASE CAPTION, CASE NUMBER, COMMISSIONER, AND THE RETURN DATE ON REVIEW.**

==========

BRIEFING SCHEDULE:
UNDER RULE 7040.70(F) OF THE RULES GOVERNING PRACTICE BEFORE THE WORKERS' COMPENSATION COMMISSION, THE APPELLANTS STATEMENT OF EXCEPTIONS AND/OR ADDITIONS AND SUPPORTING BRIEF MUST BE FILED WITH THE COMMISSION AND SERVED ON ALL PARTIES NOT LATER THAN 30 DAYS FROM THE RETURN DATE ON REVIEW. THE APPELLEES RESPONSE MUST BE FILED WITH THE COMMISSION AND SERVED ON ALL PARTIES WITHIN 15 DAYS FROM THE LAST DAY ALLOWED FOR THE FILING OF APPELLANTS STATEMENT OF EXCEPTIONS AND/OR ADDITIONS AND SUPPORTING BRIEF.

IMPORTANT INFORMATION:
ALL PERSONS ACCESSING WORKERS' COMPENSATION HEARING SITES MUST PRESENT VALID IDENTIFICATION AT SECURITY CHECK POINTS.
(I.C. 3A, 12/2004)

ILLINOIS WORKERS' COMPENSATION COMMISSION
REQUEST FOR HEARING

#2

ATTENTION. Please give this form to the Arbitrator after you obtain a trial date.

PETRA GARCIA
Employee/Petitioner
v.
MARRIOTT CHICAGO O'HARE
Employer/Respondent

Case # 08 WC 36618 16IWCC0738

Consolidated cases: __

Setting **CHICAGO**

Petitioner and Respondent are prepared to try this matter to completion on **January 12, 2016**, unless the Arbitrator approves other arrangements. ~~1-12-2016~~ 2-2-2016

1. Petitioner claims that, on **2/19/2006**, Petitioner and Respondent were operating under the Illinois Workers' Compensation or Occupational Diseases Act, and their relationship was one of employee and employer.

   Respondent agrees ☒ disputes ☐ .

2. Petitioner claims that, on the above date, he or she sustained accidental injuries or was last exposed to an occupational disease that arose out of and in the course of employment.

   Respondent agrees ☒ disputes ☐ .

3. Petitioner claims Respondent was given notice of the accident within the time limits stated in the Act.

   Respondent agrees ☒ disputes ☐ . If in dispute, Petitioner states that on _____, notice was given to _____, with the job title _____.

4. Petitioner claims his or her current condition of ill-being is causally connected to this injury or exposure.

   Respondent agrees ☐ disputes ☒ . **Subject to Strict Proof: Factual, Medical and Legal**

5. Petitioner claims his or her earnings during the year preceding the injury were $ 24,888.24, and the average weekly wage, calculated pursuant to Section 10 of the Act, was $ 478.62.

   Respondent agrees ☒ disputes ☐ and claims __

6. At the time of injury, Petitioner was **55** years old; married ☒ single ☐; with **0** dependent children.

   Respondent agrees ☒ disputes ☐ and claims __.

7. Petitioner claims Respondent is liable for the following unpaid medical bills: *Attach a list, if necessary.* CJ

   ~~Reimbursement to Ms. Cogan for out of pocket payment to Swedish Covenant in the amount of $125.75~~ No additional bills are owed by Respondent. CW

   Respondent agrees ☒ disputes ☐ and claims $ _____

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

Petitioner agrees ☒ disputes ☐ and claims $_____

AXI

ILLINOIS WORKERS' COMPENSATION COMMISSION (IWCC)
100 WEST RANDOLPH STREET, SUITE 8-200, CHICAGO, IL 60601
WWW.IWCC.IL.GOV
(312) 814-6500 TDD (312) 814-2959 TOLL FREE (866) 352-3033

MAIL TO:
NYHAN BAMBRICK KINZIE & LOWRY
20 N CLARK ST
SUITE 1000
CHICAGO IL 60602

NOTICE DATE: 04/21/2016
CASE NUMBER: 08 WC 036678

16IWCC0738

NOTICE OF RETURN DATE ON REVIEW

NOTICE TYPE: INITIAL

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PETITIONER:
GARCIA, PETRA

RESPONDENT:
MARRIOTT CHICAGO O'HARE

RETURN DATE ON REVIEW: 06/17/2016 COMMISSIONER: GORE, DAVID

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PEORIA 202 N.E. MADISON 61602 SUITE 201 (309) 671-3019	CHICAGO 100 W. RANDOLPH 60601 SUITE 8-200 (312) 814-6611	

BY MAIL (CHICAGO OFFICE ONLY) :
THE REVIEWING PARTY MAY ELECT TO SUBMIT THE AUTHENTICATED TRANSCRIPT **BY MAIL TO THE REVIEW DEPARTMENT OF THE COMMISSION AT ITS OFFICES AT 100 WEST RANDOLPH STREET, 8TH FLOOR, CHICAGO, IL., 60601, ON OR BEFORE THE RETURN DATE ON REVIEW IN ACCORDANCE WITH RULE 7040.10(D)(2). THE AUTHENTICATED TRANSCRIPT SHALL BE ACCOMPANIED BY A COVER LETTER INDICATING THE CASE CAPTION, CASE NUMBER, COMMISSIONER, AND THE RETURN DATE ON REVIEW.**

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BRIEFING SCHEDULE:
UNDER RULE 7040.70(F) OF THE RULES GOVERNING PRACTICE BEFORE THE WORKERS' COMPENSATION COMMISSION, THE APPELLANTS STATEMENT OF EXCEPTIONS AND/OR ADDITIONS AND SUPPORTING BRIEF MUST BE FILED WITH THE COMMISSION AND SERVED ON ALL PARTIES NOT LATER THAN 30 DAYS FROM THE RETURN DATE ON REVIEW. THE APPELLEES RESPONSE MUST BE FILED WITH THE COMMISSION AND SERVED ON ALL PARTIES WITHIN 15 DAYS FROM THE LAST DAY ALLOWED FOR THE FILING OF APPELLANTS STATEMENT OF EXCEPTIONS AND/OR ADDITIONS AND SUPPORTING BRIEF.

IMPORTANT INFORMATION:
ALL PERSONS ACCESSING WORKERS' COMPENSATION HEARING SITES MUST PRESENT VALID IDENTIFICATION AT SECURITY CHECK POINTS.
(I.C. 3A, 12/2004)

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CARL LIBRIZZI,

Petitioner,

vs.

NO: 14 WC 13688

16IWCC0739

DTZ, UNICO,

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 and prospective medical care, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner is an Electrician for Respondent. On March 31, 2014 he was working on a sign when he poked his right middle finger with a wire. His finger became infected. He underwent surgery to drain the infection, and was then released to one handed light duty work in May 2014.

2. Light duty was accommodated by Respondent.

3. Petitioner was released from care by Dr. Ellis on September 22, 2014.

4. On November 25, 2014 Petitioner reported to Dr. Baylis that he had been having a hard time with his finger since September 2014. Additional surgery was recommended to insert a metal plate on both sides of the finger. However, once the surgery commenced, Dr. Baylis realized that the damage was much worse. A fusion surgery was scheduled for February 2015.

5. Subsequent to the surgery, Petitioner's finger was in a cast for 2 months and was immobilized with the index finger.

6. After the cast was removed Petitioner noticed that he could not move his right index finger. This was not an issue prior to the fusion surgery. Dr. Fernandez opined that the index finger process was a typical reaction to an infectious process.

7. Petitioner also complained of pain everywhere in his hand and his knuckles.

8. On November 10, 2015 Dr. Baylis noted stiffness, pain and decreased motion in the index finger secondary to mobilization.

9. Petitioner had been taken off work due to the surgery, but has never been released back to work since. He now receives social security benefits.

10. Petitioner testified that his right hand is more like a claw now, as he no longer has use of his middle or index fingers. He has difficulty holding glasses, turning door knobs and using hand tools. He can also no longer work as an Electrician.

The Commission affirms the Arbitrator's causal connection ruling with respect to Petitioner's right middle finger condition, and also affirms the denial of causal connection with respect to Petitioner's right hand condition. However, the Commission reverses the Arbitrator's causal connection ruling regarding the right index finger condition.

The Commission notes that Respondent's §12 Physician, Dr. Fernandez, found causal connection between the work accident and the fusion surgery to the middle finger. Subsequent to the fusion, Petitioner's middle finger was bound and cast together with his index finger. Once the cast was removed, Petitioner immediately noticed immobility with his index finger. The contemporaneous relationship between treatment of the middle finger and the start of the index finger issues, along with the aforementioned

causal connection opinion of Dr. Fernandez, indicates there is a causal relationship between the accident and Petitioner's index finger condition.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses related to treatment for his right middle and index fingers under §8(a) of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 15 2016
O: 9/29/16
DLG/wde
45

David L. Gore

Mario Basurto

Stephen Mathis

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

LIBRIZZI, CARL
Employee/Petitioner

Case# **14WC013688**

DTZ, UNICO
Employer/Respondent

16IWCC0739

On 1/21/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.37% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0659 BRILL & FISHEL PC
FRANCINE R FISHEL
180 N LASALLE ST SUITE 3700
CHICAGO, IL 60601

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

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

CARL LIBRIZZI
Employee/Petitioner

Case #14 WC 13688

v.

16IWCC0739

DTZ, UNICO
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on December 21, 2015. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

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

M. ☐ Is the respondent due any credit?

N. ☐ Prospective medical care?

FINDINGS

- On March 31, 2014, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $88,880.00; the average weekly wage was $1,709.23.
- At the time of injury, the petitioner was 57 years of age, married with three children under 18.
- The petitioner agreed that there are no unpaid bills for his medical services.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $1,139.49/week for 6 weeks, from November 10, 2015, through December 21, 2015, which is the period of temporary total disability for which compensation is payable.
- The petitioner is entitled to have from the respondent the reasonable and necessary cost for the right hand therapy recommended by Dr. Baylis on November 10, 2015.
- In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of temporary total disability, medical benefits, or compensation for a permanent disability, if any.

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

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

below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Robert E. Williams

Signature of Arbitrator

January 19, 2016
Date

JAN 21 2016

FINDINGS OF FACTS:

On March 31, 2014, the petitioner, an electrician, injured his right third finger while working on an electrical box. The petitioner testified that he sought emergency care on April 1st at Bolingbrook Hospital. The emergency treatment records for April 1st are not in evidence. On April 2nd, Dr. Samir Shah noted right hand swelling more dorsally, erythema, an area of induration over the long finger metacarpophalangeal area (MCP) and a history of rheumatoid arthritis treated with methotrexate. He reported that x-rays revealed joint space destruction and narrowing. His assessment was right hand swelling with questionable underlying osteo versus inflammatory arthritis. Dr. Nabil Barakat's findings on April 3rd were definite but slow improvement and persistent but moderate edema and erythema. He opined that the right finger MCP appeared mobile without much tenderness and no crepitus. He also noted that the petitioner's finger had passive range of motion and that the cellulitis was improving. An MRI on April 6th revealed prominent dorsal soft tissue swelling with a small 1.1 cm rim-enhancing collection along the dorsal, lateral aspect of the third MCP joint suggestive of a small abscess, significant marrow changes and enhancement at the third MCP and minimal diffuse extensor digitorum tenosynovitis. On April 9th, the petitioner's right long finger abscess was drained by Dr. Ramsey Ellis. On April 17th, the petitioner complained to Dr. Ellis of extreme pain and the inability to move his hand. Dr. Ellis recommended occupational therapy and left hand/office work.

On April 29th, the petitioner saw Dr. William Baylis at Parkview Orthopaedic Group and reported severe pain in his right long MCP joint and the inability to write. Dr. Baylis noted past treatment for noninsulin-dependent diabetes and degenerative arthritis

in his right long and index MCP joints. Dr. Baylis recommended that he return to Dr. Ellis for the abscess and follow up with his infectious disease doctor.

On May 1st, the petitioner reported continued pain and swelling to Dr. Ellis. Dr. Ellis noted a healed wound, reactive erythema over the dorsum of the petitioner's hand consistent with his previous infection and no fluctuance, drainage, lymphangitic streaking or fluid collection. Continued antibiotics and occupational therapy were recommended. On May 12th, Dr. Ellis noted that the petitioner was able to extend his fingers except for a slight lag at the MP joint of his long finger, stiffness in flexion and reduced erythema and edema. On June 2nd, Dr. Ellis found a normal sensation in the petitioner's median ulnar and radial nerve distributions, an increased range of motion of his long finger and reduced erythema. He increased the petitioner's lifting to 25 pounds. Minimal erythema at his scar, an increased range of motion and residual stiffness at the MP joint was noted on June 30th. The petitioner was released to full-duty work. On September 22nd, Dr. Ellis noted a complete resolution of the petitioner's infection, continued stiffness and some soft tissue swelling of his right long finger. The doctor opined that the petitioner was at MMI.

On November 25th, the petitioner returned to Dr. Baylis and reported significant pain with any type of axial load/gripping over his right long MCP joint and decreased motion of his index and ring fingers. The petitioner reported that he was laid off in October. Dr. Baylis opined that x-rays showed degenerative changes to the MCP joints of the right index, long and ring fingers. Dr. Baylis' impression was degenerative joint disease of the right long fingers, for which he recommended a fusion.

On February 27, 2015, the petitioner had an arthrodesis of his right long MCP joint by Dr. Baylis. On March 17th, the petitioner's splint and stitches were removed and it was noted that by x-ray there was a good fusion. The immobilization of his hand was discontinued on April 28th. On May 26th, the petitioner reported pain everywhere in his hand and knuckles. Pursuant to the request of the respondent on July 22nd, the petitioner was evaluated by Dr. Fernandez. On October 16th and November 10th, the petitioner reported stiffness in his right index finger and no pain in his long finger. Dr. Fernandez re-evaluated the petitioner on November 5th.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that his current condition of ill-being with his right long MCP joint is causally related to the work injury. The petitioner failed to prove that his current condition of ill-being with his right hand and his right index finger is causally related to the work injury. The petitioner's work injury involved only his right long finger. The evidence is insufficient to establish that the pre-existing degenerative changes in his right index finger or the rheumatoid arthritis and/or osteoarthritis in his hands and other fingers were aggravated by his work injury on March 31, 2014.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

On November 10, 2015, Dr. Baylis recommended some therapy to improve the petitioner's hand range of motion and strength, which he attributed to stiffness and weakness caused by the cast immobilization and restricted the petitioner from working until a recheck after two months. The respondent shall pay the petitioner temporary total

disability benefits of $1,139.49/week for 6 weeks, from November 10, 2015, through December 21, 2015, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

FINDING REGARDING PROSPECTIVE MEDICAL:

The petitioner proved that the right hand therapy recommended by Dr. Baylis is reasonable medical care necessary to relieve the effects of the work injury. Dr. Baylis believed the petitioner's reduced hand range of motion and strength was due to stiffness and weakness from wearing a cast. The doctor's opinion is reasonable and credible. The petitioner is entitled to have from the respondent the reasonable and necessary cost for the right hand therapy recommended by Dr. Baylis on November 10, 2015.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Aaron A. Brookins,

Petitioner,

vs. NO: 09 WC 31240

American Steel,

16IWCC0740

Respondent.

DECISION AND OPINION ON §19(h) AND §8(a) PETITION

This case comes before the Commission on Petitioner's §19(h) and §8(a) Petition, alleging a material increase in his disability since the Commission's previous Decision and Opinion on Review (14 IWCC 234) dated March 31, 2014. A hearing on the petition was held before Commissioner Ruth White on March 14, 2016 in Collinsville, Illinois and a record was made. The Commission, having considered the entire record, finds that Petitioner failed to prove a material increase in disability and that as a result Petitioner's §19(h) and §8(a) Petition is denied, for the reasons set forth below.

I. HISTORY OF THE CASE

In a Corrected Decision at Arbitration filed 4/10/13, following a hearing on 12/21/12, Arbitrator Lee found that Petitioner was permanently and totally disabled for life commencing 6/10/11 pursuant to §8(f) of the Act. (Arb.Dec., pp.2,5).

On review, the Commission in a decision filed 3/31/14 reversed the Arbitrator's determination that Petitioner was permanently and totally disabled and found that Petitioner failed to prove that he fell into the odd lot category. Instead, the Commission awarded 45% loss of the person-as-a-whole. (Com.Dec., pp.1-4). In a dissenting opinion, Commissioner Tyrrell argued that Petitioner demonstrated he was permanently and totally disabled and that Respondent failed to show that Petitioner was employable or that a stable labor market existed for his

services. (Com.Dec., pp.5-6).

On appeal, the Circuit Court confirmed the Commission decision in an order dated 10/15/14.

Petitioner subsequently appealed the matter to the appellate court and subsequently sought a dismissal of said appeal, which was granted on 3/13/15. (RX4). The appellate court eventually issued its mandate affirming the circuit court's award on 4/24/15. (RX5).

Petitioner filed the present §§19(h)/8(a) Petition on 2/18/15.

II. FINDINGS OF FACT

A) Arbitration Hearing

At the arbitration hearing held on 12/21/12, Petitioner testified that he takes "[m]aybe eight to ten" non-narcotic pills a day and that he is to have maintenance checks once a year indefinitely with Dr. Boutwell, his pain management physician, and Dr. Gornet, his treating orthopedic surgeon. (RX1, pp.39-40). He noted that because of his physical limitations and pain he can no longer lift weights as well as run or play basketball with his 12 year old son. (RX1, p.41). He also indicated that he got a divorce which he attributed "... to all the back injury and surgeries and everything." (RX1, p.41). He stated that his son lives with him and that he is responsible for taking care of him and seeing him off to school. (RX1, p.42).

Petitioner testified that during the day he takes his medicine and a shower and does little things around the house, noting that his "... life has just changed tremendously to being active and doing things to really not doing much of anything worse." (RX1, p.42). He went on to state that he "... sit[s] in a chair. [He] lay[s] down. [He] ha[s] to usually lay down in a fetal position to try to alleviate the pressure and pain off [his] back as much as [he] can." (RX1, pp.42-43). He also noted that he usually has to switch between sitting, standing and lying down "... maybe about 15, 20 times a day or more." (RX1, p.43). Petitioner explained that "[i]f [he] sit[s] too long, [he] get[s] pain and discomfort. [He] ha[s] to constantly switch positions in order to try to just be comfortable." (RX1, p.43). He stated that "... if [he] sit[s] or stand[s] too long, [he] ha[s] to lay down because it feel[s] like – like pressure is like building up in [his] neck and [he] ha[s] to lay down to like alleviate that pressure like in a fetal position on [his] side", and that he has to do this "quite often" or as many times as he needs to. (RX1, pp.43-44).

On cross examination, Petitioner agreed that from 6/9/11, when he was given permanent restrictions and found to be at MMI by Dr. Gornet, he had not attempted to return to work anywhere or applied for any jobs. (RX1, p.50). He also agreed that he told both vocational rehabilitation consultants, June Blaine for Respondent and Steve Dolan for Petitioner, that he did not feel that he was capable of working or engaging in additional training/education because of his back pain, and that he was still of that opinion on the date of his testimony at arbitration. (RX1, p.52). Petitioner also acknowledged that he can and does drive an automobile, that he drove to the hearing site and that he drives to his son's school and sports activities. (RX1, p.62).

Dr. David Lange examined Petitioner at the request of Respondent prior to the original arbitration hearing. Dr. Lange has since retired, effective 12/31/14. (RX16). In a report dated 7/7/11, Dr. Lange opined that "[b]arring further evaluations and surgery, Mr. Brookins has reached maximal medical improvement." (RX14). He noted that since Petitioner stated that "... he would not contemplate any further surgical procedures because of the failure of the first two... further diagnostic imaging likely would not be indicated." (RX14). Dr. Lange went on to opine that Petitioner "... will require permanent restrictions consistent with the sedentary to light physical demand levels. He would also need to have intermittent activity with respect to sitting, standing, and walking. It would be advisable for him to be cautious with forward bending and avoid awkward positions of the low back. These restrictions obviously would not allow him to return to his premorbid occupation. Mr. Brookins likely will require medications on a permanent basis..." (RX14).

In a report dated 6/26/12, Dr. Lange once again noted that "Mr. Brookins has reached maximal medical improvement. He probably is not employable. He will need medications on a permanent basis." (RX15).

Vocational rehabilitation consultant J. Stephen Dolan was retained at the request of Petitioner. In a report dated 11/28/11, Mr. Dolan noted that Petitioner did not have the academic skills for a four-year college and would be better suited for a community college. (RX17). He also noted that based on his restrictions he would need a job with very little physical work and where he can change position as needed for pain control. (RX17). Mr. Dolan indicated that "[v]ery few such jobs exist for workers who do not have training for sedentary types of jobs ...[and] [i]t is not clear why an employer would hire Mr. Brookins, with such restrictions. Potential employers are going to see Mr. Brookins as potential liability in their workplace, not as an answer to their staffing needs. Based on Mr. Brookins' education, work experience, academic skills, work skills, and the restrictions from either Dr. Lange or Dr. Gornet, Mr. Brookins is not able to maintain employment in the open labor market with his current level of education." (RX17).

Vocational rehabilitation consultant June Blaine was retained at the request of Respondent. In a report dated 12/30/11, Ms. Blaine noted that "[g]iven the current functional capacities, we do not believe it is feasible for him to perform any of the jobs he completed previously. Therefore, the focus needs to be upon jobs which would fall in the sedentary level work demand level... We believe additional training would need to be complete for his [sic] to be employable. However, he is forty years old, has more than two years of college and demonstrated his ability to learn new information... We believe training could include a focus upon the development of more clerk/clerical skills acquired through vocational training program that would enable him to work in support role for jobs with pay in the $8.50 to $10.00 an hour, which is less than Mr. Brookins[] was earning at the time of his injury...We also believe it is feasible to look at more advanced training using his college education upon which to build a career... [However,] [w]hile we would be able to offer vocational services to help Mr. Brookins with the development of a vocational plan which focuses upon training, we question whether he would be interested in a plan..." (RX18).

B) §§19(h)/8(a) Hearing

At the review hearing held on 3/14/16, Petitioner testified that following his surgeries he received treatment and pain management care until sometime in 2011. (T.14). He noted that when he was released with permanent restrictions in June of 2011 his pain had gotten somewhat better and "was stabilized." (T.14-15). He indicated that he has had to consistently be on medication and has followed up with Dr. Boutwell on a periodic basis since, or about once a year now to check on his medication levels. (T.16-17). Petitioner testified that as a result of the pain he "... had to alternate between sitting and standing and [he] had to, like, lay down periodically throughout the day and [he] couldn't repetitively bend. It was a life change..." (T.18). He noted that since then the pain has increased, beginning in late 2014. (T.19). He indicated that it concerned him so he asked to see Drs. Gornet and Boutwell. (T.19). He stated that he "... noticed [him]self laying around more, having more difficulty doing things ..." (T.20). He noted that he was then placed on different medication, which provided a bit more comfort. (T.21). He also testified that if he skipped his medication he would be in a great deal of pain. (T.22).

Petitioner testified that in late 2014 his pain level gradually increased from a base of about 5/6 on the pain scale to 7/8. (T.22). He noted that his body "probably got used to" the medication he had been taking, Arthrotec, and that it "... wore off or stopped doing the same thing that it was doing, stopped having the same effect so then they changed that." (T.23). He indicated that his medication was then changed to Daypro, which had "a different effect", but that he was told it was "causing damage to [him]" so he was placed back on Arthrotec. (T.23-25). Petitioner testified that when he went back on Arthrotec "[his] pain stayed the same as it was before [he] was on the Daypro." (T.26).

Petitioner testified that given his increased pain he lies down more during the day, explaining that "... it takes the pressure off [his] spine because it's [his] understanding that standing up ... was causing more pain so [he] would have to lay down to alleviate some of that pain in the fetal position." (T.26-27). He noted that before his pain increased he would have to lie down four or five times a day but that since then he has had to lie down "[p]robably double that", like eight to ten times a day. (T.27-28).

When asked his understanding as to his current restrictions, Petitioner noted that he has to "... alternate between sitting and standing, not to lift over ten pounds, no repetitive bending and [he] ha[s] to lay down periodically throughout the day." (T.29). He indicated that he attempted to find work within these restrictions starting on 11/3/14, or once the appeal process ended, without success. (T.30-34). He stated that prior to that time he had not conducted a job search. (T.32).

On cross examination, Petitioner agreed that Arthrotec and Daypro are nonsteroidal anti-inflammatories, and that he has been taking the same class of drugs since 2010. (T.39-40). He also agreed that he started looking for work on 11/3/14 because his workers' compensation partial disability benefits had stopped in May and he was "in financial despair." (T.45-46). He indicated that at that time he was willing to try to do a sit-down job if they were willing to give him a chance. (T.48). However, he admitted that none of the jobs he applied for were within Dr. Gornet's restrictions. (T.54).

On re-direct examination, he testified that the biggest change in his typical day is that he

lies down more. (T.62).

Board certified orthopedic surgeon Dr. Mathew Gornet testified by way of evidence deposition on 7/23/15. Dr. Gornet indicated that he performed surgery on Petitioner on 1/26/10 involving removal of the L5-S1 disc and replacement with an artificial disc called ProDisc-L as well as an anterior decompression. (PX1, p.8). He noted that Petitioner subsequently had some sliding of replacement disc material necessitating fusion surgery at L5-S1 on 6/2/10. (PX1, pp.8-9). Dr. Gornet noted that this procedure was done posteriorly given that "[i]t's very difficult to get the disc replacement out anteriorly once it[']s placed..." (PX1, p.9). He indicated that the complication Petitioner experienced with the disc replacement was rare, and that he's probably "... had it one or two times out of a thousand..." (PX1, p.10).

Dr. Gornet testified that he treated Petitioner for approximately another year before releasing him at MMI on 6/9/11 with permanent restrictions of "[n]o lifting greater than 10 pounds, alternate sitting and standing, no repetitive bending, no repetitive lifting, no pushing/pulling. Essentially sedentary work." (PX1, pp.10-11,13-14). He noted that leading up to that date Petitioner "[b]asically went through rehabilitation, still had some persistent pain. And again, we had a long discussion with him trying to manage him, and my belief was his best option was to move forward with his life, have some permanent restrictions, and hopefully go into vocational rehab or something of that nature." (PX1, p.10). He also noted that the fusion took a long time to heal given that the artificial disc in the front of his spine is designed to move and the fusion in the back is designed to stop motion "... so you have two conflicting hardware constructs ... and it makes fusion much more difficult." (PX1, p.11).

Dr. Gornet indicated that Petitioner returned for follow up on 1/9/12 at which time Petitioner was "... functioning better, he's off his narcotics, he's still on some nonnarcotic medicines." (PX1, p.11). He indicated that at that time he told Petitioner to "... pace himself. And we talked about worrying about his symptoms, and my note states he understands that this may preclude him ultimately from gainful employment, but he's trying to cope [the] best he can." (PX1, p.12). Dr. Gornet noted that at the time of this visit Petitioner was still having pain and that "[h]is main problem is with any prolonged activity he develops increasing pain and symptoms to the point that the only way to relieve his pain is to lie down in the fetal position." (PX1, p.14).

Dr. Gornet stated that Petitioner returned for follow up on 12/1/14 at which time the former noted that Mr. Brookins "... felt he was getting worse. His radiographs showed good position of his implants with no other obvious problems. I felt he – he continued to have significant back pain which affects his quality of life, most aspects of his life." (PX1, p.15). Dr. Gornet recommended a new MRI and a CT myelogram which were performed in 2015. (PX1, pp.15-16). Dr. Gornet noted that "... the MRI did not show any significant adjacent-level pathology, meaning we're looking at the discs. I didn't feel there was significant disc failure at any of the adjacent levels; I felt it was fairly stable. I felt the CT myelogram did show widening of his facet joints at L4-5, what I believe is increasing lateral recess stenosis consistent with widening of the joints, especially comparing this to the L3-4 level where the joints appear fairly tight." (PX1, p.17). Dr. Gornet explained that "... facet sign is the earliest indicator of an instability pattern developing at the adjacent segment. So that is known to be a reliable predictor of a structural

problem that is seen oftentimes potentially on the MRI as fluid in the joints, but, unfortunately, he has implants that are close by, so there is artifact that you can't detect that, but you see widening of the facet joints, and that widening is an indicator that that segment is starting to fail." (PX1, p.18). He noted that "[i]t's a known sequela of adjacent-level failure that develops, that we see this all the time and it's predictable." (PX1, p.18). He also stated "...we feel that this is isolated to the adjacent segment just at L4-5." (PX1, p.19).

Dr. Gornet testified that he believed "... it will continue to deteriorate over time and ... that that deterioration will cause further issues in [Petitioner's] spine." (PX1, p.19). In addition, Dr. Gornet "... believe[d] [Petitioner's] increased pain is related to the objective findings seen on CT scan." (PX1, p.20). As a result, Dr. Gornet expected Petitioner's pain to get progressively worse as the condition progresses. (PX1, p.20).

When asked if there were any new restrictions, based on these findings, Dr. Gornet noted that "[t]he only new restriction [he] placed [on Petitioner] was ... [that] [he] felt it was reasonable for [Petitioner] to lie down on occasion for his back ... Remember back in 2012, even before all this, that was something that relieved his pain and symptoms, and he discussed that with [Dr. Gornet] over three years ago, and [Dr. Gornet] felt that that was reasonable given the objective findings [Dr. Gornet] was seeing on CT scan." (PX1, p.20). He noted that by lying down and unloading the spine his "... hope is that that will gradually, over time, allow him to manage this without necessitating further surgery." (PX1, p.21). However, Dr. Gornet indicated that he believed Petitioner will require future treatment, including continuing medications and/or injections. (PX1, p.21).

In addition, Dr. Gornet testified that "... what has caused his condition is – his current condition of widening of the facet joints and an instability pattern at L4-5 is his previous fusion surgery, and his previous fusion surgery was necessitated by his original work-related injury." (PX1, p.22). He went on to state that "... the chain of medical care has all been necessitated by his 2009 injury..." (PX1, p.22). Finally, he agreed that the need for Petitioner's current permanent restrictions is related to the injury on 6/16/09. (T.22-23).

On cross examination, Dr. Gornet agreed that at the time of Petitioner's visit on 10/14/10, as well as a subsequent visit on 12/9/10, he did not think Petitioner would ever go back to work and thus saw no reason to invest in significant physical therapy. (PX1, pp.27-29). He also agreed that he imposed restrictions at that time, even though he believed Petitioner was not going to be able to work, including no lifting greater than 10 pounds, no repetitive bending or lifting, alternate between sitting and standing positions, no pushing or pulling, and he was not able to work a full eight-hour day. (PX1, p.29). In addition, Dr. Gornet indicated that at the time of his subsequent visit on 6/9/11 he did not "... believe [he] necessarily changed [his] belief that [Petitioner] was capable of functioning in an eight-hour day at that point, although he was functioning better ..." (PX1, p.30). He also noted that the restrictions he had previously imposed were made permanent at that time and that Petitioner was MMI as of 6/9/11. (PX1, p.31).

Furthermore, Dr. Gornet agreed that as of his subsequent visit with Dr. Boutwell on 1/6/12 Petitioner was still complaining of pain of 8/10 with bending, standing, sitting and walking too long, and that he had the same complaints when he visited Dr. Gornet three days later on 1/9/12.

(PX1, pp.33-34). Dr. Gornet also agreed that Petitioner told him at that time that he had to lie in a fetal position to relieve his pain, and that he told Mr. Brookins that having to lie down was likely to preclude him from gainful employment. (PX1, p.34). However, Dr. Gornet noted that while he believed Petitioner when he said that lying down helped him, "... there was no objective information at that point in time why [Dr. Gornet] needed to place that restriction on him. [Petitioner] felt that way, but there was no objective data to support that at that point in time." (PX1, p.35).

Dr. Gornet also agreed that when he saw Petitioner on 12/1/14, after having last seen him on 8/16/12, a repeat CT scan performed at that time showed a solid L5-S1 fusion and no change from the prior CT study that he had ordered. (PX1, pp.39-40). Likewise, he acknowledged that his "... opinions regarding [Petitioner's] ability to work or [his] interpretation of those current studies [on 12/1/14] had not dramatically changed based on the information [he] had at that point ..." (PX1, pp.41-42). When asked whether Petitioner's condition had really changed since he put him MMI on 6/9/11, Dr. Gornet noted that "... subjectively [Petitioner] feels he's slowly getting worse... [and] [Dr. Gornet] did not see any reason why it was getting worse at that point in time, but [he] told [Mr. Brookins] that if it continued to be a problem, we would get an MRI as well as a CT myelogram..." (PX1, pp.42-43). Dr. Gornet also indicated that he still did not think Petitioner was going to be able to return to gainful employment when he saw him on 12/1/14. (PX1, p.43). He likewise acknowledged that Petitioner's objective physical examination and his interpretation of the plain CT had not changed as of 12/1/14. (PX1, p.44).

Furthermore, with respect to his 3/16/15 visit, Dr. Gornet testified that "[t]here is no official documentation that I changed his restrictions at that point, but that was not my intent. My intent was, at least in the body of the note that I can see, was that – that in the same sense increasing pain will probably require him to lay down at times ... [but] [t]here is no written note that says I changed his restrictions, I agree with you." (PX1, p.50). In addition, Dr. Gornet testified that he had "... no plans to operate on him at [the time of the 3/16/15 visit], but [he] believe[d] that given the fact that [Mr. Brookins] [is] already developing adjacent-level changes he understands that it becomes more probable than not that over his lifetime, given his young age, he will require further surgery." (PX1, p.52).

Also on cross, Dr. Gornet acknowledged that following his last visit on 3/16/15, Petitioner was seen by Dr. Boutwell on 5/22/15 at which time he related that Mr. Brookins was "... now improved subjectively and he attributed the addition of Daypro in his medication regimen for the improvement..." (PX1, pp.54-55). Dr. Gornet noted that "... the facet failure that we see developing is a[n] inflammatory condition. If [Dr. Boutwell] changed his anti-inflammatories, that may change some of his subjective symptoms, but it doesn't necessarily change the objective failure that's occurring." (PX1, pp.54-55).

On re-direct, Dr. Gornet agreed that on 6/9/11 he did not include in Petitioner's restrictions the need to lie down on occasion, but that following the March 2015 CT myelogram and his finding of widening facet joints he felt adding such a restriction would be appropriate, although he admittedly has not provided Petitioner with a work slip setting forth such a restriction. (PX1, pp.63-65).

At the request of Respondent, Petitioner visited board certified orthopedic surgeon Dr. Frank O. Petkovich on 8/5/15 for purposes of a §12 examination. (RX19, p.9). Dr. Petkovich testified by way of evidence deposition on 10/29/15. (RX19). Dr. Petkovich noted that his review of the 3/16/15 postmyelogram CT revealed "... good structural alignment with the prior posterior fusion at the L5-S1, the disc replacement anteriorly at the L5-S1 level. The fusion appeared to be solid... [and] there were the hardware findings which I discussed at the L5-S1 level but overall, this CT was essentially unchanged from the prior CT in December 2014. (RX19, p.21). Dr. Petkovich also indicated that he did not observe any widening of the facet joints at L4-5 in this study. (RX19, p.21). Instead, Dr. Petkovich noted mild degenerative changes at L4-5 consistent with someone with a spine fusion. (PX19, p.22). He later agreed that the degenerative changes he noted were age-related. (RX19, p.67).

Dr. Petkovich noted that his diagnosis was 1) status post lumber disc replacement L5-S1 on 1/26/10; 2) status post posterior lumbar spine fusion L5-S1 with instrumentation using pedicle screws and rods on 6/2/10. (RX19, p.27). Dr. Petkovich was of the opinion that Petitioner had reached MMI with respect to the 6/16/08 work injury when he was released from care by Dr. Gornet in June of 2011. (RX19, p.27). Dr. Petkovich also believed that Petitioner's claims of increasing pain in December of 2014 through May of 2015 "... can be consistent with ... a chronic condition in his lower back ... and I think that could very well be – probably was due to the Arthrotec losing its efficiency and simply he was just placed on a different medication. I don't think there was any change in his underlying status. There was no advance of any of his – the pathology in his spine..." (RX19, p.31).

Furthermore, Dr. Petkovich opined that "... Mr. Brookins could work with a 40-pound lifting restriction... I would limit him to a 40-pound lifting restriction because of those subjective complaints... [H]e doesn't have any neurologic deficit in either one of his lower extremities. Radiographically, the fusion at the L5-S1 level is solid, so based upon his exam and his radiographic findings, my opinion is that he should be able to go back to the regular job he was doing prior to June 16, 2009; however, ...because of his subjective complaints, I would place him with restrictions that he not lift more than 40 pounds." (RX19, p.36). Dr. Petkovich also felt that Petitioner "... should not need to lie down. There would be no reason for that." (RX19, p.36).

When asked whether there had been a material change in Petitioner's disability since his MMI date of 6/9/11, Dr. Petkovich testified that "[t]here's been no change. Mr. Brookins told me that his situation has not changed during his entire scope. As I've testified to, he does not feel he's improved with the surgical procedures and his condition has not changed during this entire time period." (RX19, pp.36-37).

In a letter dated 10/15/15, Petitioner's vocational rehabilitation consultant, J. Stephen Dolan reiterated his previously stated position that "... Mr. Brookins no longer has reasonable access to a stable labor market and is a poor candidate for addition[al] education or training because of a pain problem." (PX2).

III. CONCLUSIONS OF LAW

Section 19(h) of the Act provides, in pertinent part, that

> ". . . as to accidents occurring subsequent to July 1, 1955, which are covered by any agreement or award under this Act providing for compensation in installments made as a result of such accident, such agreement may at any time within 30 months, or 60 months in the case of an award under Section 8(d)1, after such agreement or award be reviewed by the Commission at the request of either the employer or the employee on the ground that the disability of the employee has subsequently recurred, increased, diminished or ended."

In the present case, Petitioner filed the current §§19(h)/8(a) on 2/18/15, or less than eleven (11) months after the Commission's award on 3/31/14.

As to the merits of Petitioner's §§19(h)/8(a) Petition , the Commission notes that prior to the Commission's previous award Dr. Gornet had released Petitioner at MMI on 6/9/11 with permanent restrictions of "[n]o lifting greater than 10 pounds, alternate sitting and standing, no repetitive bending, no repetitive lifting, no pushing/pulling. Essentially sedentary work." (PX1, pp.10-11,13-14). In addition, Dr. Gornet agreed that as early as 1/9/12, or eleven (11) prior to arbitration, he discussed with Petitioner the possibility that his ongoing symptoms "... may preclude him ultimately from gainful employment ..." (PX1, p.12).

Following the Commission decision on review, Petitioner returned to Dr. Gornet on 12/1/14 at which time it was noted that Mr. Brookins "... felt he was getting worse. His radiographs showed good position of his implants with no other obvious problems. I felt he – he continued to have significant back pain which affects his quality of life, most aspects of his life." (PX1, p.15). Dr. Gornet recommended a new MRI and a CT myelogram which were performed in 2015. (PX1, pp.15-16). Dr. Gornet noted that "... the MRI did not show any significant adjacent-level pathology, meaning we're looking at the discs. I didn't feel there was significant disc failure at any of the adjacent levels; I felt it was fairly stable. I felt the CT myelogram did show widening of his facet joints at L4-5, what I believe is increasing lateral recess stenosis consistent with widening of the joints, especially comparing this to the L3-4 level where the joints appear fairly tight." (PX1, p.17). Dr. Gornet testified that he believed "... it will continue to deteriorate over time and [he] believe[d] that that deterioration will cause further issues in [Petitioner's] spine." (PX1, p.19). In addition, Dr. Gornet "... believe[d] [Petitioner's] increased pain is related to the objective findings seen on CT scan." (PX1, p.20). As a result, Dr. Gornet expected Petitioner's pain to get progressively worse as the condition progresses. (PX1, p.20).

On cross examination, Dr. Gornet agreed that at the time of Petitioner's visit on 10/14/10, as well as a subsequent visit on 12/9/10, he did not think Petitioner would ever go back to work and thus saw no reason to invest in significant physical therapy. (PX1, pp.27-29). He also agreed that he imposed restrictions at that time, even though he believed Petitioner was not going to be able to work, including no lifting greater 10 pounds, no repetitive bending or lifting, alternate between sitting and standing positions, no pushing or pulling, and he was not able to work a full eight-hour day. (PX1, p.29). In addition, Dr. Gornet indicated that at the time of his subsequent visit on 6/9/11 he did not "... believe [he] necessarily changed [his] belief that [Petitioner] was capable of functioning in an eight-hour day at that point, although he was functioning better ..."

(PX1, p.30). He also noted that the restrictions he had previously imposed were made permanent at that time and that Petitioner was MMI as of 6/9/11. (PX1, p.31).

When asked whether Petitioner's condition had really changed since he put him MMI on 6/9/11, Dr. Gornet noted that "... subjectively [Petitioner] feels he's slowly getting worse... [and] [Dr. Gornet] did not see any reason why it was getting worse at that point in time, but [he] told [Mr. Brookins] that if it continued to be a problem, we would get an MRI as well as a CT myelogram, and that brings us up to the last visit." (PX1, pp.42-43). He also indicated that he still did not think Petitioner was going to be able to return to gainful employment when he saw him on 12/1/14. (PX1, p.43). He likewise acknowledged that Petitioner's objective physical examination and his interpretation of the plain CT had not changed as of 12/1/14. (PX1, p.44).

Respondent's §12 examining physician, Dr. Petkovich opined that his review of the 3/16/15 postmyelogram CT revealed "... good structural alignment with the prior posterior fusion at the L5-S1, the disc replacement anteriorly at the L5-S1 level. The fusion appeared to be solid... there were the hardware findings which I discussed at the L5-S1 level but overall, this CT was essentially unchanged from the prior CT in December 2014. (RX19, p.21). Dr. Petkovich also indicated that he did not observe any widening of the facet joints at L4-5 in this study. (RX19, p.21). Instead, Dr. Petkovich noted mild degenerative changes at L4-5 consistent with someone with a spine fusion. (PX19, p.22). He later testified that the degenerative changes he noted were age related. (RX19, p.67).

Dr. Petkovich's diagnosis was 1) status post lumber disc replacement L5-S1 on 1/26/10; 2) status post posterior lumbar spine fusion L5-S1 with instrumentation using pedicle screws and rods on 6/2/10. (RX19, p.27). Dr. Petkovich was of the opinion that Petitioner had reached MMI with respect to the 6/16/08 work injury when he was released from care by Dr. Gornet in June of 2011. (RX19, p.27). Dr. Petkovich also believed that Petitioner's claims of increasing pain in December of 2014 through May of 2015 "... can be consistent with ... a chronic condition in his lower back ... and I think that could very well be – probably was due to the Arthrotec losing its efficiency and simply he was just placed on a different medication. I don't think there was any change in his underlying status. There was no advance of any of his – the pathology in his spine..." (RX19, p.31).

When asked whether there had been a material change in Petitioner's disability since his MMI date of 6/9/11, Dr. Petkovich testified that "[t]here's been no change. Mr. Brookins told me that his situation has not changed during his entire scope. As I've testified to, he does not feel he's improved with the surgical procedures and his condition has not changed during this entire time period." (RX19, pp.36-37).

Based on the above, and the record taken as a whole, the Commission finds that Petitioner failed to prove by a preponderance of the credible evidence that his disability has materially increased since the prior decision. Indeed, it would appear that the evidence submitted as part of the present Petition differs little from the evidence submitted at the time of arbitration. More to the point, aside from his claim that his subjective pain complaints have worsened, Petitioner points to little more than Dr. Gornet's opinion that recent studies show a widening of the facet joints at L4-5, which Dr. Petkovich disputed, as well as Dr. Gornet's testimony that he would

16IWCC0740

add the ability to lie down to Petitioner's current list restrictions, even though Dr. Gornet has yet to memorialize such a restriction in his records and despite the fact that Petitioner had previously testified to his need to lie down in a "fetal position" at the time of arbitration. Furthermore, the opinion of Petitioner's vocational rehabilitation consultant, Mr. Dolan, to the effect that no stable labor market exits for Petitioner's services and that he's a poor candidate for additional training or education (PX2), would appear to differ little if any from the one he offered at the time of the prior proceedings.

As a result, the Commission finds that Petitioner failed to prove that his disability has materially increased since the prior Commission Decision and Opinion on Review. Thus, Petitioner's §19(h) and §8(a) Petition is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition under §19(h) and §8(a) is hereby denied.

The party commencing 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: NOV 17 2016
o: 9/19/16
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lori Timmons,

Petitioner,

vs.

NO: 15 WC 13809

16IWCC0741

State of Illinois Department of Childern and Family Services,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 1, 2016, is hereby affirmed and adopted.

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

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

DATED: NOV 17 2016
TJT:yl
o 11/1/16
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TIMMONS, LORI
Employee/Petitioner

Case# **15WC013809**

STATE OF ILLINOIS/DCFS
Employer/Respondent

16IWCC0741

On 6/1/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0969 THOMAS C RICH PC
6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9204

4948 ASSISTANT ATTORNEY GENERAL
WILLIAM PHILLIPS
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

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

JUN 1 ⁿ 2016

Ronald A. Piasia

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

16IWCC0741

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Lori Timmons
Employee/Petitioner

v.

State of Illinois/DCFS
Employer/Respondent

Case # **15** WC **13809**

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 **Mt. Vernon**, on **April 6, 2016**. By stipulation, the parties agree:

On the date of accident, **November 25, 2014**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$103,974.00**, and the average weekly wage was **$1,999.50**.

At the time of injury, Petitioner was **53** 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 **$10,851.75** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$10,851.75**.

Respondent is entitled to a credit for **all amounts paid under group health plan** 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 **$735.37**/week for a further period of **50** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **10% loss of use of the person-as-a-whole.**

Respondent shall be given a credit of **$10,851.75** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$10,851.75**.

Respondent is entitled to a credit for **all amounts paid under group health plan** under Section 8(j) of the Act.

RULES REGARDING APPEALS Unless a 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

5/26/16

Date

16IWCC0741

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Lori Timmons
Employee/Petitioner

Case # **15** WC **13809**

v.

Consolidated cases: **N/A**

State of Illinois/DCFS
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that she is employed by Respondent and has worked there for 21 years. She testified that she is an administrative case reviewer. She testified that on November 25, 2014, she sustained accidental injuries at work. She testified that she was taking her work files and her work computer and putting them in the back seat of her vehicle, and that she heard a pop and had pain in her left shoulder.

Petitioner testified that following the accident of November 25, 2014, she ultimately came under the care of Dr. George Paletta. She testified that after Dr. Paletta ordered some diagnostic testing, he recommended surgery. She testified that prior to undergoing surgery, she had several injections in the left shoulder which relieved the pain for maybe a day or two, and that she also underwent physical therapy.

Petitioner testified that in the week or two before surgery, the symptoms in her left shoulder included a lot of popping, pain and that she could not sleep on her left side. She testified that the surgery helped, and that following surgery she was still under the care of Dr. Paletta and had physical therapy. She testified that therapy further assisted her recovery, and that she ultimately returned to work. She agreed that she was paid while she was off work.

Petitioner testified that she still has soreness in her left shoulder, and that activities of daily living like getting dressed, bathing, and sleeping on the left side tended to bother her. She testified that her range of motion was improved, and that she has crackling and popping probably every single day. She testified that when she feels these symptoms or pain, she takes Tylenol a couple times per week. She testified that her job duties still remain the same, that she still has to travel to other offices and that she still has to transport files. She testified that she tries to only take into the office the files that she needs for the day, but that her employer has also made it so that she is in her home office at least once a week which helps tremendously.

Petitioner testified that she was just released from Dr. Paletta on March 30th, and that her last physical therapy appointment was March 31st so she was trying to get back into the routine of everyday life. She testified that she did not know yet if there were any real limitations. She testified, however, that whenever she reaches up to the side to reach her arm up, there is a little bit of a catch. She testified that she is doing exercises at home which Dr. Paletta and the physical therapist recommended. She testified that she has been placed at maximum medical improvement with no additional appointments scheduled.

On cross-examination, Petitioner agreed that she reported to Dr. Paletta at her last office visit that overall she felt like she was making good progress and that she felt like she had her range of motion back. She agreed that his record was consistent of her recollection of that conversation. She agreed that she recalled the conversation with Dr. Paletta where it was reported that overall she was doing extremely well and had excellent motion with minimal losses and good strength. She agreed that Dr. Paletta indicated that the subjective soreness and the occasional popping she had in the shoulder was not uncommon and may take anywhere from 6-12 months to resolve fully.

On cross-examination, Petitioner denied that in the intervening time between her last visit with Dr. Paletta and the time of arbitration that she had any kind of traumatic event or any change in her condition. She agreed that despite the accommodation allowing her to work from her home office more often, her job title and the general responsibilities she had remained unchanged.

The Application for Adjustment of Claim was entered into evidence at the time of arbitration as Arbitrator's Exhibit 2. The Application alleged that Petitioner was injured on November 25, 2014 while lifting, and that her left shoulder/body as a whole was affected. (AX1).

The Medical Bills List was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The parties stipulated on the record that Respondent either has or will pay related medical bills pursuant to the fee schedule. (T.5). The Medical Records List was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The medical records of Dr. Jha were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Petitioner was seen on December 9, 2014, at which time it was noted that she had been putting a file that was heavy in the back of her car along with her computer, and that she felt left shoulder and arm pain that was now going down to the hand. It was noted that Petitioner had pain with abduction in the left arm. The assessment was that of most likely a rotator cuff injury, and Petitioner was referred for physical therapy and an x-ray. (PX3).

The records of Dr. Jha reflect that Petitioner underwent x-rays of the left shoulder on December 9, 2014, which were interpreted as revealing no acute fracture, dislocation, or bone lesion of the left shoulder. (PX3).

The records of Dr. Jha reflect that Petitioner was seen on December 23, 2014, at which time she complained of left shoulder pain. It was noted that Petitioner did one physical therapy session, and that she was awaiting authorization for more. Petitioner was seen on February 12, 2015, at which time she was seen in follow-up for the left shoulder. It was noted that Petitioner was doing well, and that she had seen Dr. Ahn. It was also noted that physical therapy was helping as well as a steroid injection. Petitioner was assessed with shoulder pain. (PX3).

The records of Dr. Jha reflect that Petitioner was seen for pre-operative clearance on April 29, 2015, which was provided. Petitioner was seen on May 28, 2015, at which time it was noted that she had not yet had surgery. Petitioner was seen on June 25, 2015 for a physical examination. Petitioner was seen on July 23, 2015, at which time it was noted that Petitioner was awaiting surgery approval. (PX3).

The medical records of Orthopaedic Center of Southern Illinois/Dr. Ahn were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Petitioner was seen on January 12, 2015, at which time it was noted that she was complaining of left shoulder pain since November 25, 2014. It was noted that Petitioner was putting a heavy bag weighing approximately 25-30 pounds into the back seat of her car, and that she worked as a DCFS case manager. It was noted that Petitioner had been having

significant discomfort, and that overhead activity and reaching behind the back was difficult. The clinical impression was that of left shoulder rotator cuff tendinopathy and muscle strain of scapular stabilizer muscles. An injection of cortisone into the left shoulder subacromial space was recommended and performed. Petitioner was also recommended to undergo physical therapy. A Work/School Slip was issued on that date, allowing Petitioner to return to work with no overhead activity with the left arm and no more than 15 pounds lifting restriction through February 23, 2015. (PX4).

The records of Dr. Ahn reflect that Petitioner was seen on February 23, 2015, at which time it was noted that Petitioner had good relief of about 80% for about a week, but that her symptoms were back, quite sore and localized. It was noted that the pain was more at the posterior glenohumeral junction. Dr. Ahn recommended that Petitioner undergo an MRI as there was suspicion for a SLAP lesion and posterior labral tear. Petitioner was also recommended to continue physical therapy. (PX4).

Included within the records was the interpretive report for an MRI of the left shoulder performed on March 12, 2015, which was interpreted as revealing: (1) extensive labral tearing, comprised of a SLAP tear, tear of the posterior labrum and tear of the anteroinferior labrum; (2) area of high-grade chondral loss superomedial humeral head. (PX4).

The records of Dr. Ahn reflect that Petitioner was seen on March 30, 2015, at which time Petitioner was noted to have a probable SLAP lesion. Surgery was recommended, and it was noted that Petitioner wanted to take some time to think it over. It was noted that if Petitioner thought her symptoms were tolerable and she wanted to live with it for a little while, then Dr. Ahn would accommodate as she wished. A Work/School Slip was issued on that date, allowing Petitioner to return to work with no overhead activity with the left arm and no more than 15 pounds lifting restriction through April 13, 2015. (PX4).

The records of Dr. Ahn reflect that Petitioner was seen on April 13, 2015, at which time she stated that her pain was usually 2-3/10 activity-wise and with certain activity did go up quite a bit. It was noted that Petitioner was scheduled to undergo an IME, and that Petitioner would wait to see the results. It was also noted that in addition to the labral tear pain, Petitioner also had some tendinopathy symptoms on the lateral aspect of the shoulder that came and went also. Petitioner was instructed to return in one month to discuss further treatment options. A Work/School Slip was issued on that date, allowing Petitioner to return to work with no overhead activity with the left arm and no more than 15 pounds lifting restriction until the next visit on May 11, 2015. (PX4).

The medical records of Salem Township Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The medical records pertained to physical therapy performed during the timeframe of January 26, 2015 through April 20, 2015. The Discharge Summary dated April 20, 2015 indicated that Petitioner reported having more pain and stiffness on that date in the left shoulder, and that she also reported popping in the left shoulder. It was noted that Petitioner had undergone 20 visits with 0 cancellations and 0 "no-shows." (PX5).

The medical records of The Orthopedic Center of St. Louis/Dr. Paletta were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. Petitioner was seen on April 27, 2015, at which time she presented for evaluation of a chief complaint of a five-month history of left shoulder pain. It was noted that the onset of symptoms dated back to November 25, 2014, when Petitioner was lifting a bunch of files and was trying to either take them out or put them in her car. It was noted that she was also lifting a computer. Petitioner described lifting these up to about chest level and moving them from one side to the other. Petitioner stated that she was not sure of the exact weight but that it was four days' worth of files. Petitioner stated that she had pain in the left shoulder and, because of the Thanksgiving holiday, she was off for the next few days and did not report the incident until she got back to work after the holiday.

The impression was that of symptomatic extended labral tear left shoulder involving both the biceps anchor and the posteroinferior labrum. It was noted that the options would be to continue to treat it with observation and symptomatic use of anti-inflammatories versus consideration for arthroscopy, probable labral repair and subpectoralis tenodesis. A causation opinion was included within the note, and Petitioner was issued a Work Status Report allowing her to return to full duty effective April 27, 2015. (PX6).

The records of Dr. Paletta reflect that Petitioner was seen on October 30, 2015, at which time she returned having decided to go ahead with surgery. Petitioner stated that her shoulder was about the same, that she had pain with activities of daily living and that her pain was about 5/10. The impression was that of persistently symptomatic extended labral tear, left shoulder. Surgery was discussed, and Petitioner was recommended to continue to work full duty up until the time of surgery. A Work Status Report allowing Petitioner to return to full duty effective October 30, 2015 was issued on that date. (PX6).

The records of Dr. Paletta reflect that a Work Status Report was issued on November 10, 2015, taking Petitioner off work through November 16, 2015, and that as of November 16, 2015 she could return to work with restrictions of primarily one-handed work with injured hand assisting on light task; no reaching cross body; no reaching overhead/overhead work; clerical or sedentary work only; and no lifting. (PX6).

The records of Dr. Paletta reflect that Petitioner was seen on November 23, 2015, at which time she returned for an initial post-operative visit. It was noted that overall she was doing well, and that her pain had been reasonably well controlled. It was noted that Petitioner's main complaint was that of some lightheadedness and dizziness. Petitioner was instructed to undergo physical therapy, and it was noted that with regard to work, she was confined to primarily one-handed work with the left arm assisting on light tasks only; no reaching overhead; no lifting; and clerical or sedentary duty work only. (PX6).

The records of Dr. Paletta reflect that Petitioner was seen on December 30, 2015, at which time it was noted that she was doing relatively well although she stated that she still could not get her arm up over her head. Petitioner noted some tendency for the left thumb to feel like it wanted to catch on her. Petitioner was instructed to continue with physical therapy. A Work Status Report was issued on that date, allowing Petitioner to return to work with restrictions of no reaching overhead/overhead work and no push/pull greater than 10 pounds, no lifting above chest, and no lifting greater than 10 pounds from floor to chest. (PX6).

The records of Dr. Paletta reflect that Petitioner was seen on February 15, 2016, at which time it was noted that she was doing much better and that she felt she had made big gains in therapy. It was noted that her only real issues at that point were that she still felt like she had some difficulty abducting the arm out to the side and reaching up behind her back. Petitioner also noted some soreness on the back aspect of the deltoid extending down into the trapezius a little bit. The impress was that of mild residual motion losses and residual supraspinatus weakness status post arthroscopy with biceps tenodesis and labral debridement. Petitioner was recommended to undergo four additional weeks of physical therapy. (PX6).

The records of Dr. Paletta reflect that Petitioner was seen on March 30, 2016, at which time Petitioner felt like she had her range of motion back. It was noted that Petitioner also felt like she was making improvements in her strength, and that she felt she could probably continue with a home exercise program. It was noted that her only complaint was that she still had a sense of some tenderness mainly in the back of her shoulder that tracked down the triceps occasionally but did not go below the elbow and into the hand. The impression was that of doing well status post biceps tenodesis. Dr. Paletta noted that Petitioner had excellent motion with minimal losses, and that she had good strength. It was noted that

Petitioner could resume activities as tolerated without restriction or limitation, and that her subjective soreness and the occasional popping was not uncommon and may take anywhere from 6-12 months to fully resolve. (PX6).

The medical records of Frontenac Surgery & Spine Care Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The Operative Report dated November 10, 2015 indicated that the procedures performed included (1) left shoulder exam under anesthesia; (2) left shoulder diagnostic arthroscopy; (3) left shoulder arthroscopy with extensive debridement labrum including posterior, superior and anterior; (4) arthroscopic biceps tenodesis; (5) arthroscopic subacromial decompression, bursectomy and acromioplasty. The pre- and post-operative diagnoses were that of (1) left shoulder pain; (2) left shoulder labral tear; (3) left shoulder impingement syndrome. (PX7).

CONCLUSIONS OF LAW

The parties stipulated that Petitioner sustained an accident on November 25, 2014 that arose out of and in the course of her employment with Respondent, and that Petitioner's condition of ill-being was causally connected to this injury. (AX1).

With respect to the sole disputed issue at the time of hearing which was that of 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 in this matter. As a result thereof, the Arbitrator gives no weight to this factor.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner continues to work for Respondent and that despite the accommodation allowing her to work from her home office more often, her job title and the general responsibilities she had remained unchanged. The Arbitrator finds that the nature and demands of her position will likely have some affect on her permanent partial disability and, as such, the Arbitrator places some weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 53 years old on her date of accident. Given the age of Petitioner and the fact that her treating physician, Dr. Paletta, gave her a full duty/no restriction release, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that there was no evidence proffered at arbitration to demonstrate that this work accident has impaired or otherwise affected her future earnings capacity. The Arbitrator places no 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 she still has soreness in her left shoulder, and that activities of daily living like getting dressed, bathing, and sleeping on the left side tended to make her symptomatic. She testified that her range of motion was improved, and that she has crackling and popping probably every single day. She testified that when she

feels these symptoms or pain, she takes Tylenol a couple times per week. At her final office visit with Dr. Paletta on March 30, 2016, it was noted that Petitioner felt like she had her range of motion back. It was noted that Petitioner also felt like she was making improvements in her strength, and that she felt she could probably continue with a home exercise program. It was noted that her only complaint was that she still had a sense of some tenderness mainly in the back of her shoulder that tracked down the triceps occasionally but did not go below the elbow and into the hand. Dr. Paletta noted that Petitioner had excellent motion with minimal losses, and that she had good strength. It was noted that Petitioner could resume activities as tolerated without restriction or limitation, and that her subjective soreness and the occasional popping was not uncommon and may take anywhere from 6-12 months to fully resolve. (PX6). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely her continued complaints and purported limitations, were corroborated by his treating records at the conclusion of his treatment with Dr. Paletta. The Arbitrator accordingly places greater 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 10% loss of use of the person-as-a-whole under Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gina L. Skelton,

Petitioner,

vs. NO: 12 WC 02992

Kirkenmeier, Inc., d/b/a McDonalds,

16IWCC0742

Respondent.

DECISION AND OPINION ON REVIEW

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

For the reasons set forth below, the Commission modifies the Arbitrator's Decision by reducing the period of temporary total disability to January 19, 2012 through February 6, 2014.

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective. We have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent. One should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the Arbitrator's, it should not be presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

The Petitioner testified on direct examination that on December 1, 2011 she carried fifteen, thirty-six pound cases of French fries from her employer's freezer to her fry station area. Respondent was understaffed, and Petitioner was unable to obtain the usual assistance she would receive with the cases of French fries. On a typical day, the employees would utilize ten cases of French fries. The Petitioner loaded the fry hopper with the frozen French fries and prepared the fries utilizing baskets that she would have to extend from her body with her right hand and turn over. The Petitioner would normally work at the fry station from 11 or 11:30 a.m. to 5:00 p.m. The Petitioner testified that her arm and shoulder area felt tired and weak on December 1, 2011. (Tr. 17-40)

The Petitioner treated with Dr. Saadiq El Amin, an orthopedic surgeon, from February 23, 2012 until February 6, 2014. Dr. El Amin reported that the Petitioner's injury at work was due to lifting bags of French fries and in the performance of repetitive motions at work utilizing her right arm contributed to the Petitioner's shoulder condition. Dr. El Amin performed surgery on the Petitioner's right shoulder, which revealed that she had inflammation, a bone spur, fraying in her rotator cuff, and an anterior labral tear. Dr. El Amin repaired her anterior structures, the labrum, reduced the bone spur, and debrided her rotator cuff. (Tr. Px5, Px9, Px14).

The Petitioner subsequently underwent an electromyogram ("EMG") which revealed ulnar neuropathy at her right elbow/ cubital tunnel syndrome. Dr. El Amin performed an ulnar nerve transposition on Petitioner's right extremity on December 6, 2013. (Px11, Px14)

At the Petitioner's last appointment with Dr. El Amin, it was noted that the Petitioner was still having right shoulder symptoms and pain, with some mild impingement symptoms. The Petitioner was ordered to undergo a functional capacity examination ("FCE") of her upper extremity. She was also given an 'off-work until further notice' note. The Petitioner testified that she never completed the FCE because it was not approved for payment by insurance, and that she could not financially afford to undertake the FCE on her own. (Tr. Px5, 59-65).

On direct examination, the Petitioner testified that she thought that she was fired from Respondent around July 2012 when she received 401(k) related paperwork from Respondent. She ultimately found new employment in August of 2014 in the home health care field. (Tr. 54-59, 81-83)

Based upon the totality of the evidence and the factual findings above, the Commission finds that Petitioner's period of temporary total disability should be modified to reflect a period of temporary total disability from January 19, 2012 through February 6, 2014, as set forth below. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

After the Petitioner's last appointment with her treater, Dr. El Amin, on February 6, 2014, the Petitioner neither underwent an FCE nor had a subsequent appointment with her physician. Although the Petitioner was provided with an 'off-work until further notice' note at her last appointment on February 6, 2014, there was no follow-up to decipher an appropriate date for her to return to work. In fact, the Petitioner found new employment in August of 2014. Without evidence of a continued disability or her inability to work, the Commission finds that Petitioner's period of temporary total disability ended on February 6, 2014. Accordingly, the

16IWCC0742

period that the Petitioner is entitled to temporary total disability benefits is modified to reflect the period of January 19, 2012 through February 6, 2014.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision, filed on August 7, 2015, is hereby modified as to the period of temporary total disability awarded.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services of $51,093.45, as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner permanent partial disability benefits of $249.27 per week for 100.6 weeks because the injuries sustained caused the 10% loss of the person as a whole (50 weeks), as provided in Section 8(d)2, and 20% loss of use of the right arm (50.6 weeks), as provided in Section 8(e) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $249.27 per week for a period of 109 and 5/7 weeks (January 19, 2012 through February 6, 2014), 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 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: NOV 17 2016

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

TJT/gaf
O: 9/19/16
51

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SKELTON, GINA L
Employee/Petitioner

Case# **12WC002992**

KIRKENMEIER INC D/B/A McDONALDS
Employer/Respondent

16IWCC0742

On 8/7/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.16% 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:

0352 LaMARCA LAW OFFICE PC
WILLIAM LaMARCA
1118 S 6TH ST
SPRINGFIELD, IL 62703

0734 HEYL ROYSTER VOELKER & ALLEN
BRADFORD PETERSON
102 E MAIN ST SUITE 300
URBANA, IL 61801

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

16IWCC0742

☐ 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

Gina L. Skelton
Employee/Petitioner

v.

Kirkenmeier, Inc. d/b/a McDonalds
Employer/Respondent

Case # **12** WC **02992**

Consolidated cases: **None**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Peoria, Illinois** , on **June 16, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 1, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of 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 **$12,961.87**; the average weekly wage was **$249.27**.

On the date of accident, Petitioner was **53** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$1,320.00** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$1,320.00**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $249.27/week for 132-3/7 weeks, commencing 01/19/12 through 08/03/14, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $51,093.45, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $249.27/week for 100.6 weeks, because the injuries sustained caused the 10% loss of the person as a whole (50 weeks), as provided in Section 8(d)2, and 20% loss of use of the right arm (50.6 weeks), as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

8/6/15
Date

AUG 7 – 2015

With respect to issues (C.) and (F.)Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent and Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

Petitioner testified that she had been employed by Respondent since October 27, 2008. Petitioner testified that at the time of the alleged injury she was a "Prep Person." Petitioner testified as to her job duties as a Prep Person. Petitioner testified that during a typical shift she initially counted parfaits, made salads, washed breakfast dishes and then, "was on the floor." Petitioner testified that the prep work she performed normally occurred before 11:00am. The prep work involved physically lifting and carrying items. The average weight would be ten to twelve pounds, "some are heavier, some are lighter."

Petitioner testified that after performing the changeover duties between serving breakfast and lunch, the majority of her time was spent at the "fry station." Petitioner testified besides working on the fry station, she made coffee, took orders, bagged items and performed other duties involving orders. She also worked in the prep area where employees make salads. Petitioner testified that the salad prep area had a large table that had refrigerated sections underneath for perishable ingredients and an overhead area where supplies such as lids and napkins were kept.

Petitioner described in detail her job duties while "on fries." Generally the work involves maintaining overhead hoppers which feed the french fries into individual baskets which are dropped into grease. Petitioner testified that on December 1, 2011, the store was understaffed. As a result, she was unable to get help carrying cases of fries from the freezer. Petitioner estimated that a case of french fries to weighed approximately thirty-six (36) pounds. Petitioner testified she had to move the cases from the top of the stack which was stacked higher than her height (Petitioner testified she is five feet- two and a half inches tall). She then had to pick up the box of fries. She estimated that she had to carry approximately fifteen boxes of french fries. With respect to loading the hoppers with french fries, she testified, "Well, you have to open it and take out each bag and pour them into the hopper. It was a new hopper, and it was designed so that it was frozen at the top and it would keep the fries frozen, until you asked it to drop them down into the basket." She added, "So you would have to empty those bags into the hopper above my head (indicating)." Petitioner testified that after loading the fries and carrying the fries and performing the activities as described, she noticed that her arm and especially her shoulder area on the top of her shoulder "felt like [she] didn't have any strength left; felt like [it] was giving out." Petitioner testified that while on the fry station it is necessary to lift up the basket of fries with one hand. Petitioner testified she lifted the basket with one hand, normally her right hand. Petitioner confirmed that she would hook the fry baskets onto a mechanism that was approximately, "a little above shoulder level." Petitioner estimated that the weight of the basket filled with french fries was seven to eight pounds.

Petitioner was shown Petitioner's Exhibit 15 which depicted the area of the fry station. Petitioner confirmed that some of the photographs depicted the fry station and the area she was working on December 1, 2011. Petitioner was asked if she could identify the person in the picture. Petitioner testified that she could and that her name was Ryan Taliferno. Petitioner estimated that Ms. Taliferno was approximately six feet tall, "she is a tall girl." Petitioner testified that being shorter required more shoulder activity to operate the fry station. Petitioner testified that other activities involved in operating the fry station would also be affected by the employee's height, such as adding fresh oil.

Petitioner was asked approximately how long she estimated she worked at the fry station. Petitioner testified that other than her thirty minute lunch break she would work the fry station from 11:00am or 11:30am until 5:00pm. Petitioner believed she worked the fry station more than other employees because she was considered one of the most productive employees in the operation of the fry station.

Petitioner was asked if after she developed symptoms in her right arm on December 1, 2011 whether she mentioned them to anyone. Petitioner testified that she had a conversation with Mandy Shannon, her supervisor. Petitioner testified that she told Ms. Shannon that she, "was hurting and that [I] needed somebody to take my place, [and] she did not respond to me." Petitioner testified in addition to speaking to Ms. Shannon, she also completed an accident report the following week. Petitioner testified she gave the written statement to her morning manager, Ms. Wheeler the following morning which Ms. Wheeler signed and dated. The written note was marked and introduced as Petitioner's Exhibit 17. Petitioner testified that an accident report was also completed by Mandy Shannon. The report was marked and introduced at Petitioner's Exhibit 14. Petitioner testified she completed her shift on December 1st and worked the following day. At that time, she noticed her symptoms were worse.

Petitioner testified she ultimately sought medical care from Gretchen Fawcett, a Physician's Assistant, on December 8, 2011. Ms. Fawcett's office notes were marked and introduced as Petitioner's Exhibit 1. Ms. Fawcett recorded "[p]atient states she was injured at work. She does the fry position and many others at McDonalds. Last Thursday was very busy and then on Friday morning she was unable to pick up a cup of coffee or brush her hair due to severe pain in her right shoulder, elbow and outer wrist…She lifts baskets of fries-putting them in the frier and then dumping them into a pan over and over all day. She does this process with 4 baskets simultaneously-usually 200-300# of fries. Last Thursday she did this process from 11-4:30pm. Usually she is on fries for 3-4 hrs a day 5 days per week. She lifted a lot more fries/baskets that day…" Ms. Fawcett assessed right shoulder/elbow and wrist pain with weakness. Ms. Fawcett ordered x-rays of the right shoulder and elbow which when completed demonstrated degenerative changes about the AC joint. The elbow findings were negative. Also ordered was a MRI of the right shoulder which when completed demonstrated findings suggesting distal supraspinatus tendonitis and bursitis. There was no evidence of full-thickness rotator cuff tear. (PX 1, PX 2, PX 3)

Ms. Fawcett placed restrictions on Petitioner's activities of no lifting greater than five pounds and that she not work at the fry station. (PX 1) Petitioner testified once she provided her employer with this information, her employer was able to accommodate the restrictions. Petitioner testified and the records show she was taken off work completely on or about January 19, 2012. (PX 1)Petitioner testified she received temporary total disability benefits for approximately six to eight weeks. Petitioner testified she noticed that when she was not working, she felt better.

Regarding ongoing treatment, Petitioner testified that Ms. Fawcett referred her to physical therapy. Petitioner testified the physical therapy did not help her symptoms. Ultimately, Ms. Fawcett referred Petitioner to Dr. El-Amin for an orthopedic evaluation. Petitioner first presented to Dr. El-Amin on February 23, 2012 with complaints of right shoulder pain. The doctor recorded, "…she has had a couple of months with right shoulder pain which acutely became worse on December 1, 2011 after she had a long day "working the frier" at McDonald's. She states she did lots of heavy lifting including 36-pound bags of fries and this seem to aggravate her shoulder significantly…" The doctor reviewed the MRI performed indicating same demonstrated relatively mild rotator cuff tendinopathy and a slight amount of fluid around the biceps tendon which he felt could indicate biceps tendonitis. After performing an examination, Dr. El-Amin assessed right shoulder impingement, biceps tendinitis and partial rotator cuff tear. Dr. El-Amin prescribed continued physical therapy and a

subcromial injection. Dr. El-Amin also indicated Petitioner should be off work until her next appointment in six (6) weeks. (PX 5)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Lawrence Li on March 12, 2012. Dr. Li noted that Petitioner provided a history that she had discomfort and fatigue in her right shoulder for several months, but on December 1, 2012 (this appears to be a typographical error as same should read December 1, 2011) she had more pain than before. Dr. Li also noted initially she had some right elbow and wrist pain, but that had resolved. Dr. Li provided that in addition to performing an examination he reviewed the records of the Physician's Assistant, Ms. Fawcett, the diagnostic studies taken and the records of Dr. El-Amin. Dr. Li concluded that she had a diagnosis of right AC Joint arthritis and a right elbow strain that had resolved. Dr. Li opined that Petitioner had no actual injury on the job on December 1, 2011 indicating, "[s]he just reports a lot of pain after that day of work." The doctor opined that her complaints were a result of her underlying AC joint degenerative arthritis and not related to work injury. The doctor also opined that based on review of her job description, most of the weight that she would lift would be less than 10 pounds and therefore she should be able to return to work full duty. Lastly, the doctor stated that although Petitioner did not suffer an actual injury at work that caused the degenerative changes, he would recommend a cortisone injection to the AC joint. He provided that if her symptoms persist after the injection, he would recommend arthroscopic shoulder surgery. The doctor added that Petitioner did not require any further treatment for her right elbow strain. (RX1). Petitioner testified she did not recall Dr. Li palpating her right elbow. She also did not recall having an opportunity to discuss her work activities when her right arm symptoms developed on December 1, 2011 with Dr. Li.

Petitioner returned to Dr. El-Amin on April 5, 2012. The doctor noted that Petitioner's right shoulder injury was due to part repetitive motion as well as an acute injury. Dr. El-Amin recommended surgical intervention which was scheduled for May 18, 2012. The doctor also kept Petitioner off work until "approximately 6 weeks after surgery." (PX 5)

On May 18, 2012, Dr. El-Amin performed an intra-articular labral debridement with subacromial decompression and acromioplasty. During the operation, Dr. El-Amin noted the glenohumeral joint was in good condition. There was no SLAP tear and the biceps tendon was in good condition, with no tendinitis. The rotator cuff had no tears. There was significant bursitis and impingement signs. Subacomial decompression was completed, removing the bursa. A large subacromial anterior spur was visualized which was smoothed from the lateral aspect to the medial aspect of the acromion towards the AC joint. The post-operative diagnosis was right shoulder labral sprain and right shoulder subacromial impingement. (PX 7)

Post-operatively, Dr. El-Amin ordered physical therapy. On June 1, 2012, the doctor provided that Petitioner should not return to work for the next four (4) weeks. On July 16, 2012, Dr. El-Amin noted that Petitioner had not able to undergo physical therapy as her claim had been denied by Respondent. At that time, the doctor provided instructions on a home physical therapy program which included exercises twice a day for two (2) weeks. On August 30, 2012, Dr. El-Amin recorded that Petitioner provided that she works very hard everyday with her therapy. Her symptoms persisted which included pain and stiffness which caused a great deal of difficulty gaining range of motion. The doctor also noted that "...now she does admit to having whole arm numbness on the right side." Dr. El-Amin ordered an EMG of the upper extremity and kept Petitioner off work for an additional six weeks. The doctor also noted that since Petitioner was precluded from attending physical therapy, same had been very detrimental to her recovery. (PX 5)

At Respondent's request, Dr. Li performed a records review regarding treatment since his original evaluation of March 12, 2012. On September 28, 2012, Dr. Li authored a report indicating that based on the history provided

to him, "...there was actually no injury on the job the day she felt pain. She simply reports a lot of pain after that day at work. Her job was the fry station the majority of the time, and it does not require any over chest work. There are a few times during the day where she would actually have to use her arm over chest, but this very infrequent." The doctor opined that the rotator cuff muscle tear identified by Dr. El-Amin was most likely degenerative in nature. He again opined Petitioner's work would not have caused or contributed to her right shoulder condition. (RX2)

Petitioner returned to Dr. El-Amin on January 24, 2013. Dr. El-Amin reiterated his recommendation for an EMG. He continued her off work status through March 1, 2013. (PX 5) Petitioner ultimately underwent the EMG which was performed by Dr. Edward A. Trudeau on February 7, 2013. Dr. Trudeau interpreted same to show ulnar neuropathy at the right elbow (cubital tunnel syndrome). (PX 11) When Petitioner returned to Dr. El-Amin on March 12, 2013, she continued to complain of right shoulder symptoms. The doctor injected the shoulder under aseptic technique. The doctor also noted the EMG results which he indicated were consistent with cubital tunnel syndrome. At that time surgical release was discussed. Petitioner was kept of work until further notice. (PX 5)

Petitioner testified that the treatment with Dr. El-Amin helped relieve some of the pain with her shoulder. She indicated that once the shoulder "settled down," the issues with her elbow became more apparent. On November 7, 2013, Dr. El-Amin recorded, "I am concerned that due to the fact that her injury injured her whole right upper extremity, now that her shoulder is improving, her other symptoms from her initial injury are starting to unmask themselves. Therefore, I am recommending that she undergo a cubital tunnel release." Petitioner was kept off work. (PX 5)

On December 6, 2013, Dr. El-Amin performed a right cubital tunnel release and arm nerve transposition. (PX 13) On December 17, 2013, the doctor noted that Petitioner was better than she had been before the surgery, indicating she had regained feeling in her small and ringer finger. Continued therapy was recommended for both the shoulder and the elbow. (PX 5)

Records submitted show that Petitioner last saw Dr. El-Amin on February 6, 2014. The doctor related that Petitioner was doing extremely well, status post right cubital tunnel release. He also noted Petitioner was still having some mild impingement symptoms in the right shoulder. At that time, Dr.El-Amin recommended Petitioner undergo a FCE. (PX 5) Petitioner testified that the FCE was not completed as same was not authorized.

Petitioner testified she had a conversation with the owner of Respondent involving the Physical Demands Evaluation marked and introduced as Petitioner's Exhibit 19. Petitioner testified the Evaluation does not accurately describe her job duties at the time of her injury. Petitioner testified she ultimately found work with a different employer. The effective date of her employment was August 6, 2014.

Petitioner testified she had experienced some symptoms in her right arm prior to December 1, 2011; however, she was still able to perform her job duties.

On cross-examination Petitioner was asked if a specific incident had occurred at work on December 1, 2011. Petitioner referred to the activity of carrying boxes of french fries and placing them on her right shoulder. Petitioner confirmed that she may have spoken with Gretchen Fawcett about the amount of fries that she loaded in a typical day but she never told Ms. Fawcett that she fried and dumped french fries from four baskets simultaneously with usually two hundred to three hundred pounds of fries in them. She indicated the reference was meant to described two hundred to three hundred pounds of fries a day. Petitioner agreed the job duties she

performed for Respondent varied. Petitioner testified that she did not recall telling Mandy Shannon that she did not know how she injured her shoulder. Petitioner also confirmed on cross-examination that the symptoms in her right shoulder did in fact improve when she was taken off work entirely.

On redirect examination Petitioner confirmed the symptoms that she had described developed on December 1, 2011 while she was carrying supplies from the freezer and also while performing the activities at the fry station. Petitioner also confirmed she was assigned to the fry station for a better part of her shift and the other job duties she performed also involved some degree of lifting and overhead activity. With respect to any gaps in seeing Dr. El-Amin, Petitioner provided same were related to either scheduled follow-ups or due to waiting for treatment authorization.

Ms. Mandy Shannon testified via deposition on April 6, 2015. The transcript of Ms. Shannon's deposition was marked and introduced as Respondent's Exhibit 5. Ms. Shannon identified herself as one of Petitioner's supervisors. Ms. Shannon verified Petitioner's work duties during a normal shift and that Petitioner did work the fry station and that the cases of fries had to be taken from the freezer to the fry station weighing approximately thirty-six pounds. Ms. Shannon indicated that if the individual who was getting the fries did not open the box and carrying the bags individually, "then she would do so, by, you know, opening the box that was on the floor, rip open the bag, and dump them into the fry hopper." (Dep. at 8) Ms. Shannon confirmed the fries would be loaded into the hopper which would be above the area where the fries were cooked. Ms. Shannon's testimony as to how the hoppers were filled and how the fry baskets were handled was consistent with Petitioner's testimony. Ms. Shannon testified that the bags weight approximately six pounds and the baskets with fries weighted approximately three pounds.

Ms. Shannon's testimony was that Petitioner was having problems with her right shoulder the following day but that Petitioner provided that she did not recall doing anything to it. (Dep. at 12) Ms. Shannon stated Petitioner told her, "it just started hurting real bad and that the symptoms began after she got home on December 1, 2011."

On cross-examination Ms. Shannon testified the individual depicted in the photographs (PX 15) is taller than Petitioner. Ms. Shannon also confirmed loading the hoppers with fries at the fry station would involve overhead lifting. With respect to lifting the french fries out of the grease and flipping them, she indicated the level of activity would either be chest or above chest level depending on the height of the person. Ms. Shannon also described other activities involved lifting, including lifting trash bags out of the trash cans and getting ice. Ms. Shannon also confirmed it was her understanding Petitioner had alleged her injury involved not only her shoulder but also her elbow. (Dep. at 28)

Petitioner's Exhibit 17 is a hand written note dated January 2, 2012 signed by Petitioner and witnessed by Marta Wheeler which Petitioner states as follows:

> I hurt my right arm ~ i.e. shoulder, elbow and wrist working fry station and/or carrying a case of fries on Thursday, December 1, 2011.
> I reported this to Mandy and every other manager I worked with between December 1, 2011 and December 8, 2011.
> My work injury has by this letter been reported in writing as well as orally.
> Thank you,
> Gina Skelton.

Petitioner's Exhibit 18 is an Employer's First Report of Injury form dated December 30, 2011. The report refers to Petitioner's injury of December 1, 2011 involving injuries to her right elbow and right shoulder. The tasks

Petitioner was performing at the time of her injury was "fries." The report was prepared and signed by Mandy Shannon. Attached to the report is a hand written note dated December 30, 2011 signed by Mandy Shannon. The hand written note states in part:

> "On December 1, 2011 Gina came to work and was placed on fries, she worked this station from 11:30 a.m. until 5:00 p.m. She stated when she got home from work, her right shoulder was sore. When she woke the next morning her arm and shoulder were still sore. She asked to please not be placed on fries on Friday, December 2, 2011…"

Petitioner marked and introduced as Petitioner's Exhibit 8 a narrative report from Gretchen Fawcett dated May 23, 2012. Also contained in Petitioner's Exhibit 8 is a letter dated May 21, 2012 from Petitioner's attorney. In her narrative report, Ms. Fawcett describes Petitioner's work activities for Respondent, in particular her job duties at the fry station. Ms. Fawcett's job description is consistent with Petitioner's description of her job duties. It was Ms. Fawcett's opinion that, "I definitely believe her shoulder pain/injury and subsequent need for surgery was caused from the type of job she had been assigned while working at McDonalds."

Petitioner marked and introduced as Petitioner's Exhibit 10 the evidence deposition of Gretchen Fawcett. Ms. Fawcett identified herself as a Physician's Assistant to Dr. Townsend. Ms. Fawcett also described her training and education to be a Physician's Assistant. Ms. Fawcett's office notes were marked as Petitioner's Exhibit 1. Ms. Fawcett was asked about the history she obtained from Petitioner at the initial office visit on December 8, 2011. She was advised by Petitioner that her symptoms had begun on the Thursday before the appointment, which would have been December 1, 2011. Ms. Fawcett demonstrated the movement Petitioner described to her that she performs while operating the fry station involving an internal rotation of the right shoulder. "She had pain that day so then that night the pain worsened. The next day it was much worse." (Dep. at 10) Ms. Fawcett provided that based on her exam of Petitioner, she diagnosed Petitioner with tendonitis with possible rotator cuff tear. She ordered an x-ray of her shoulder and elbow because she had pain radiating to her elbow. Ms. Fawcett confirmed she placed restrictions on Petitioner's work activities, in particular, to get off the fry station and not to lift over five pounds.

Ms. Fawcett testified that Petitioner's symptoms seemed to improve after going on light duty. Ms. Fawcett testified she ordered an MRI which she indicated revealed that the findings were consistent with her assessment of Petitioner's shoulder problems which led to her referring Petitioner for an orthopedic evaluation to Dr. El-Amin. (Dep. at 15-16) Ms. Fawcett testified that based on her understanding of Petitioner's job duties at the fry station, including repetitive rotation of her shoulder while putting the fries in, taking the fries out, dumping them, loading overhead compartments with fries were activities that could cause impingement and tendinitis or inflammation of the rotator cuff leading to impingement syndrome. (Dep. at 25-26)

On cross-examination, Ms. Fawcett testified that she did not know how many times Petitioner would perform the task of cooking fries during the course of a normal shift; she did not know how many times an hour Petitioner would pick up the baskets of fries and turn it over; she did not know how many times a day Petitioner would load the fry basket nor how many times she would load the container (hopper) with French fries; and she did not know when Petitioner began her employment at McDonald's. (Dep. at 32 - 44)

On redirect examination Ms. Fawcett was asked if any of the questions that had been asked of her on cross-examination affected her opinion that Petitioner's work activities, in particular the increased activities that she performed on December 1, 2011 caused or contributed to the condition of her right shoulder. Ms. Fawcett stated that the questions did not change her opinion. Referring to questions on cross examination regarding whether she knew exactly how many times Petitioner performed the activities she described at the fry station, Ms.

Fawcett stated it was not necessary for her to know the exact number of times Petitioner performed these activities in order to render an opinion that the activities may have caused or contributed to the development of her condition. Ms. Fawcett was also asked about the presence of a bone spur that was revealed during shoulder surgery. It was Ms. Fawcett's opinion that the bone spur may have also been caused by the repetitive work activity Petitioner described that she performed for Respondent. (Dep. at 49-50)

On September 17, 2012, Dr. El-Amin authored a narrative report which was marked and introduced as Petitioner's Exhibit 9, Dr. El-Amin refers to Petitioner's repetitive work activities making french fries as well as lifting a thirty pound "bag" of french fries. Dr. El-Amin noted that Petitioner developed increased pain as a result of these activities. Dr. El-Amin refers to Petitioner's participation in physical therapy at the direction of Gretchen Fawcett and there was evidence Petitioner had failed conservative measures. Dr. El-Amin referred to x-ray and MRIs that had been taken as well as his physical examination. He noted the x-ray revealed no osteophytes and no fractures. Dr. El-Amin also referred to the MRI which he believed revealed a small tear along the anterior portion of the supraspinatus tendon with thinning but no full thickness tear. He indicated there was evidence of fraying and tendonopathy of the rotator cuff and inflammation of the bursa with thickening of the rotator cuff. Dr. El-Amin's noted his diagnosis was right shoulder partial rotator cuff tear and major shoulder impingement and bicep tendonitis for which he recommended surgery. Dr. El-Amin memorialized that Petitioner underwent surgery on May 18, 2012 which involved an arthroscopic debridement of rotator cuff as well as debridement of her labrum and a subacromial decompression. Petitioner remained under Dr. El-Amin's care subsequent to the surgery.

With respect to the relationship between her work activities at the fry station for Respondent, Dr. El-Amin stated, "In my assessment, I understand that Ms. Skelton's examination and operative findings associated with this specific injury at work where she did lift a 36 pound bag of fries and perform repetitive motion at work using her right arm contributed to her shoulder condition."

Dr. El-Amin testified via deposition on March 11, 2014 which is marked as Petitioner's Exhibit 14. Dr. El-Amin was asked questions about his course of treatment of Petitioner's right arm. Dr. El-Amin was asked if Petitioner had given him details about the work she was performing on December 1, 2011. Dr. El-Amin stated it was his understanding that on that date Petitioner was "working the fryer and doing a lot of turning and after that her shoulder was really very bothersome to her." He had also testified that the condition of impingement syndrome can usually cause symptoms when you raise your arm and do certain things above chest level and do repetitive turning. Dr. El-Amin commented that Petitioner had a type II acromion which along with a bone spur can increase the tendency for injury with repetitive motion. (Dep. at 13) The doctor also provided that although a type II acromion can increase the likelihood of developing impingement syndrome with repetitive activity, a person can have type II or type III acromion and not experience pain similar to what Petitioner experienced. When asked if Petitioner's symptoms were consistent with right shoulder impingement and a partial tear of the rotator cuff, Dr. El-Amin stated, "Well I think the symptoms that she described to me were very consistent with repetitive motion or an activity that could flare up either anterior labrum or the rotator cuff so they were consistent." (Dep. at 16)

Dr. El-Amin testified that when he saw Petitioner on April 5th he had offered her injections. There was further discussion about going forward with surgery which was then scheduled. The post-operative diagnosis, according to Dr. El-Amin was inflammation with a huge bone spur, fraying of her rotator cuff, an anterior labral tear. Dr. El-Amin testified that post-operatively Petitioner remained under his care and had not been released to return to work. Dr. El-Amin confirmed that there were some post-operative issues with getting medical bills paid and that the insurance coverage issues may have affected Petitioner's course of treatment. (Dep. at 22)

Dr. El-Amin also testified that post-operatively Petitioner began complaining of neck pain and had some concern as to whether Petitioner developed some symptoms radiating into her hand. Ultimately an EMG was performed on February 7, 2013. The EMG revealed ulnar neuropathy at the right elbow. Dr. El-Amin stated that with respect to the condition of Petitioner's right elbow, it was his impression that with her shoulder symptoms improving, her right elbow symptoms became more apparent. (Dep. at 27) In his office note dated November 7, 2013 Dr. El-Amin had stated that, "due to the fact that she injured her whole right upper extremity, now that her shoulder is improving her other symptoms from her initial injury are starting to unmask themselves." (Dep. at 28) Dr. El-Amin testified that it was very common for patients to focus on the problem that is causing the most symptoms and not discuss other symptoms that are not as bothersome. The doctor felt it significant that Petitioner had complained to Gretchen Fawcett on December 8, 2011 of right elbow and wrist pain. Dr. El-Amin believed that those initial complaints would be significant in terms of his assessment of the development of her right elbow condition. (Dep. at 30)

With respect to the condition of cubital tunnel syndrome, it was Dr. El-Amin's opinion that that condition can be a result of repetitive lifting and twisting with the arm. Petitioner underwent surgery on December 6, 2013. The procedure involved a right cubital tunnel release and ulnar nerve transposition. Dr. El-Amin testified that post-operatively Petitioner noticed improvement in the condition of her fingers and right hand and that she had regained feeling in her small and ring finger. (Dep. at 32-33) At that last office visit on February 6, 2014 Dr. El-Amin was recommending Petitioner undergo a Functional Capacity Evaluation.

Dr. El-Amin was asked about his narrative report dated September 17, 2012 marked as Petitioner's Exhibit 9 and a letter from Petitioner's attorney requesting the narrative report. At his deposition Dr. El-Amin was posed with a hypothetical regarding Petitioner's work activities and the development of the symptoms in her right arm. (Dep. at 37-38) Dr. El-Amin was asked, assuming the facts were accurate whether he had an opinion within a reasonable degree of medical certainty that those types of physical activity can lead to injuries that Petitioner had in her right shoulder. Dr. El-Amin's response was, "Well, absolutely." (Dep. at 39)

Dr. El-Amin was also asked about the condition of Petitioner's right elbow and whether the activity that was described to him that Petitioner was performing on December 1, 2011 may have also caused or contributed to the development of her right elbow symptoms. Dr. El-Amin stated that that type of repetitive activity can contribute to the development of right ulnar neuropathy. Dr. El-Amin stated that the weight of the fry baskets is not as important as the repetitive motion involved. Dr. El-Amin also stated that in order to render his opinion regarding the relationship between the activities on December 1, 2011 and the condition of Petitioner's right arm it was not necessary for him to know the exact number of times she was lifting objects or the exact amount of weight. (Dep. at 42-43)

On cross-examination, Dr. El-Amin was asked if the condition of Petitioner's shoulder is associated with repetitive activity and the person stops performing the repetitive activity, should that person get better. Dr. El-Amin stated, "[n]ot necessarily because if the repetitive motion has already done the damage, the damage is there. The question is are you dealing with - - are you dealing with the damage that's already occurred because of the repetitive motion which usually is the case and now you can't do the repetitive motion anymore and now you're suffering the consequence associated with that activity…" (Dep. at 46-47) Dr. El-Amin did not agree that the sole problem of Petitioner's shoulder condition was the presence of a spur. He indicated that "…if it was only because of the large shoulder bone spur then she would have contralateral pain as well. She would have contralateral issues. So clearly it's a combination of having a bone spur there. The repetitive motion, the inflammation that happens as result of that of having impingement." (Dep. at 47) Dr. El-Amin stated that he did not know whether she performed a single repetitive task during the entirety of her job shift; he did not know how many hours a day she worked during a normal shift at the fry station; did not know how many hours a day

she worked the cash register or performing salad preparation; did not know how many hours she worked during a normal shift, nor during a normal week; did not know how many times during a shift she would lift 36 pound boxes of French fries; did not know how many times she would remove bags of fries from boxes and place them into the fry hopper; and did not know how much the bags of French fries weighed. (Dep. at 48-51) Dr. El-Amin was also asked on cross-examination about the bone spur present in Petitioner's shoulder and whether or not it was caused by her work activities. Dr. El-Amin stated, "...her employment activities did not cause the bone spur?...I can't confirm that because a bone spur it causes itself over time it grows. She could have been born like that, but it's the repetitive motion or in a certain position that could have caused it to flare up or contribute to it." (Dep. at 57) Dr. El-Amin did not agree that the type of acromion Petitioner had necessarily made her likely to have shoulder symptoms with or without repetitive trauma. (Dep. at 59)

Based on the Arbitrator's review of Petitioner's testimony, the testimony of Mandy Shannon, the testimony of Gretchen Fawcett and Dr. El-Aim and the other exhibits, the Arbitrator finds that Petitioner sustained accidental injuries that arose out of and in the course of her employment for Respondent on December 1, 2011. Petitioner's unrebutted testimony shows that the restaurant was "slammed" with an unusually heavy volume of customers. Petitioner was assigned to the fry station after performing her usual morning prep work. By then end of the day she had developed increased symptoms in her right shoulder and elbow. Her symptoms got worse that evening and the following day. She finally sought medical care from Gretchen Fawcett, PA-C. She was ultimately sent to Dr. El-Amin for orthopedic evaluation. She then underwent surgery to her right shoulder on May 18, 2012 and to her right elbow on December 6, 2012. The evidence supports the finding that Petitioner's work activities on December 1, 2011 caused or contributed to the condition of Petitioner's right shoulder and right elbow. Although Petitioner may have had certain symptoms that had developed prior to December 1, 2011, the symptoms were mild in nature and not affecting her ability to perform her job duties for Respondent.

Following the Court's reasoning in *Peoria County Bellwood Nursing Home v. Industrial Commission,* 115 Il. 2d 524, 505 NE 2d 1026 (1987) Petitioner's condition manifested itself on December 1, 2011 when her symptoms became so severe while performing her work activities that she could no longer continue working. She then sought medical care and was placed on light duty and ultimately taken off work.

The Arbitrator is not persuaded by the opinion's Respondent's Section 12 examiner, Dr. Li. In his report dated March 12, 2012 Dr. Li concludes that Petitioner is suffering from right AC joint arthritis and right elbow strain. Dr. Li concludes that Petitioner's current complaints are not the result of her work activities on December 1, 2011. Dr. Li's report refers to a job description which he apparently based his opinion on in determining causal connection. In that regard Petitioner testified the job description that had been forwarded to Dr. Li is inconsistent with the work activities Petitioner testified she was performing on December 1, 2011. It is also inconsistent with the testimony of Mandy Shannon. Specifically, Petitioner further testified that Dr. Li did not ask her what her job duties were when her symptoms began. In his letter dated September 26, 2012, Dr. Li states, "Her job was the fry station a majority of the time and it does not require any over the chest work. There are a few times during the day when she would actually have to use her arm over her chest, but this is very infrequently." Dr. Li's understanding of Petitioner's job duties is inconsistent with Petitioner's testimony and the testimony of Mandy Shannon.

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

Petitioner was asked about Petitioner's Exhibit 16, a group exhibit containing medical bills and a medical bill summary. Petitioner testified the bills were incurred during the course of receiving medical treatment for her right arm associated with her accident of December 1, 2011. To her knowledge the bills remained unpaid.

The Arbitrator has reviewed the medical bills and a summary of medical bills contained in Petitioner's Exhibit 19. The Arbitrator has also reviewed the medical records associated with the unpaid bills. After reviewing the medical records the Arbitrator concludes that the bills are both reasonable and necessary and related to Petitioner's accident of December 1, 2011. Respondent is ordered to pay the medical bills as per the fee schedule.

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

Petitioner confirmed that the off work slips contained in Petitioner's Exhibit 20 had been issued by Ms. Fawcett and Dr. El-Amin and that Petitioner had provided Respondent with copies of the off work slips. Petitioner testified that sometime in July, 2012 she believed her employment status may have changed in that she received paperwork involving her 401(k) through her job at McDonalds.

Ms. Fawcett testified she initially placed restrictions on Petitioner's work activities and then took her off work completely as of January 19, 2012. (Dep. at 16) Dr. El-Amin confirmed that he took Petitioner off work on February 23, 2012 because of his concern that, "I was worried that, you know, she was saying she was in a lot of pain, she couldn't do her job." Dr. El-Amin took her off work because he was under the impression Petitioner had to go back to work full duty or was unable to come back at all. (Dep. at 16-17)

Dr. El-Amin confirmed that he did keep Petitioner off work and that she may have been able to work light duty other than during the immediate period after surgery but only under certain circumstances. (Dep. at 62-63) Dr. El-Amin reiterated that he had never released Petitioner to return to work and that one of the reasons he wanted her to have an FCE was to determine her "final deficits."

On redirect Dr. El-Amin reiterated that although he prefers a six week period between appointments, if there are larger gaps that does not mean that he would have released the individual to return to work. (Dep. at 68)

The Arbitrator has reviewed Petitioner's Exhibit 20. The Exhibit contains multiple off work slips. The early off work slips are from Gretchen Fawcett. Once Petitioner was referred to Dr. El-Amin, she received off work slips from his office, beginning on February 23, 2012. The last off work slip signed by Dr. El-Amin was dated February 6, 2014 stating that Petitioner at that time was unable to work because of illness or accident until further notice. Dr. El-Amin testified that at the last office visit with Petitioner on February 6, 2014 he recommended that Petitioner undergo a functional capacity evaluation. Petitioner testified she never had the FCE because it was never approved by Respondent. Petitioner was able to find employment on August 4, 2014. Petitioner testified that she was under the impression that her employment had been terminated by Respondent. There was no evidence Respondent offered Petitioner light duty work except from December 8, 2011 until January 18, 2012. Petitioner testified she received six weeks of temporary total disability.

Based on the above, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from January 19, 2012 through August 3, 2014.

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

Pursuant to Section 8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability, for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:
- (i) The reported level of impairment;
- (ii) The occupation of the injured employee;
- (iii) The age of the employee at the time of injury;
- (iv) The employee's future earning capacity; and
- (v) Evidence of disability corroborated by medical records.

With regards to paragraph (i) of Section 8.1(b) of the Act:

i. In this case, neither party submitted an AMA impairment rating.

With regards to paragraph (ii) of Section 8.1(b) of the Act:

ii. Petitioner changed occupations, but there is no testimony or indication that the change in occupation is due to her inability to perform in her previous occupation. Petitioner still engages in several activities, including cleaning homes, cooking and caring for residents as a home healthcare worker

With regards to paragraph (iii) of Section 8.1(b) of the Act:

iii. Petitioner was 53 at the time of injury. The Arbitrator finds that her period of disability is less than a younger worker.

With regards to paragraph (iv) of Section 8.1(b) of the Act:

iv. At the present time, there is no evidence that Petitioner's future earning capacity has diminished as a result of this injury.

With regards to paragraph (v) of Section 8.1(b) of the Act:

v. As a result of accident sustained Petitioner underwent subacromial decompression on May 8, 2012. Dr. El-Amin repaired Petitioner's labrum, took down a bone spur and debrided the rotator cuff. Dr. El-Amin also diagnosed Petitioner with cubital tunnel syndrome after which underwent an ulnar nerve transposition surgery on December 6, 2013. Petitioner last saw Dr. El-Amin on February 6, 2014. The doctor related that Petitioner was doing extremely well, status post right cubital tunnel release. He also

noted Petitioner was still having some mild impingement symptoms in the right shoulder. At that time, Dr.El-Amin recommended Petitioner undergo a FCE. The FCE was not completed as same was not authorized. Petitioner testified she still had pain in her right arm. Petitioner testified she notices weakness. With respect to her right elbow Petitioner testified it was doing relatively well with some sensitivity but no pain or tingling or numbness that had previously radiated into her right arm. Petitioner's testimony is consistent with her complaints and/or statements given to Dr. El-Amin at her last visit.

The determination of PPD is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of PPD, consideration is not given to any single enumerated factor as the sole determinant. Therefore, after applying Section 8.1b of the Act, 820 ILCS 305/8.1b and considering the relevance and weight of all these factors, the Arbitrator finds Petitioner is permanently disabled to the extent of 10% under Section 8(d)2 (right shoulder condition), and sustained 20% loss of use of the right arm under Section 8(e) of the Act (cubital tunnel syndrome).

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Leslie Kinder,
Petitioner,

vs.
State of Illinois/Choate Mental Health,
Respondent,

NO: 14 WC 36413

16IWCC0743

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 9, 2016 is hereby affirmed and adopted.

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

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

No bond or summons required for State of Illinois cases.

DATED: NOV 18 2016

MB/mam
o:11/3/16
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KINDER, LESLIE
Employee/Petitioner

Case# **14WC036413**

16IWCC0743

SOI/CHOATE MENTAL HEALTH
Employer/Respondent

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

If the Commission reviews this award, interest of 0.43% 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:

0969 THOMAS C RICH PC
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
NICOLE M WERNER
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

JUN 9 - 2016

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

16IWCC0743

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

Leslie Kinder
Employee/Petitioner

v.

State of Illinois/Choate Mental Health
Employer/Respondent

Case # **14** WC **36413**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **May 10, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 18, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$41,354.76**; the average weekly wage was **$795.28**.

On the date of accident, Petitioner was **37** years of age, ***married*** with **3** dependent children.

The parties stipulated at the time of hearing that Respondent paid **$39,991.42** in TTD, **$0** in TPD, **$0** in maintenance, **$0** in non-occupational indemnity disability benefits, and **$0** in other benefits, for which credit may be allowed under Section 8(j) of the Act.

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

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

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

ORDER

Respondent shall pay Petitioner the sum of **$477.17/week** for a period of **100 weeks**, as provided in Section 8(d)2 of the Act, because the injuries caused **20% loss of use of the person-as-a-whole.**

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

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

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

Melinda M. Pierce-Gillman

Signature of Arbitrator

6/7/16

Date

JUN 9 - 2016

16IWCC0743

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Leslie Kinder
Employee/Petitioner

Case # 14 WC 36413

v.

Consolidated cases: N/A

State of Illinois/Choate Mental Health Center
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that she is employed by Respondent as a support service worker in the dietary department. She testified that on April 18, 2014, she sustained accidental injuries at work when she was unloading a food cart off the back of a truck. She testified that the cart was falling over, and she bent over the top of it to lift it back up and pulled her lower back. She denied having any injuries, treatment or surgeries to her low back prior to April 18, 2014.

Petitioner testified that back in 2009 when she had treatment for an assault, she saw Dr. Gornet and went back to him as a result of this injury. She testified that a number of tests were performed, and that after those tests were finished, Dr. Gornet offered surgery. She testified that right before her surgery, she had lower back pain and pain down her leg that was constant. She testified that the surgery helped, as did the post-operative treatment and therapy. She testified that she was released to return to work, and that all the time that she was off she was paid benefits. She testified that when she went back to work, she went back to the same job in the same department performing the same duties. She testified that she has been employed with the State of Illinois for nearly eleven years, and has always worked at Choate Mental Health Center.

Petitioner testified that she noticed that when she is lifting heavy things, she gets pain in her back. She testified that on bad weather days, she notices that she gets achy when it rains. She testified that if she is lifting a lot of heavy things it occurs, but if she is not lifting it is not bad. She testified that she lifts heavy things five days a week. She testified that she works five days per week and that she occasionally works overtime. She testified that she is married with three kids.

Petitioner testified that she can sleep no longer than about six hours, and then has to get up and walk around because she has pain in her back. She testified that she takes over-the-counter Ibuprofen and sometimes Tramadol that is prescribed to her by Dr. Decoursey, her primary care physician. She testified that Dr. Gornet probably does not know that she is getting the Tramadol from her family physician. She denied that she asked Dr. Decoursey to prescribe it for any other ailment than her back.

Petitioner testified that she can lift, but it causes pain. She testified that she can drive, but if she drives an hour or so, she gets sore. She testified that she takes over-the-counter medication daily, usually once per day. She testified that she takes the Tramadol only when she needs it, perhaps a couple of times a week.

Petitioner testified that she no longer rides roller coasters because it hurts her back. She testified that she owns a home and is required to do things like lifting and bending around the house, and that she sometimes has help from her husband and children. She testified that not many things around the house bothered her, though, as she does not lift heavy things at home.

Petitioner testified that that lifting milk crates at work give her the most trouble, and that they are full of half gallons of milk. She testified that she is required as part of her job to lift these items, and that there are nine half gallons in a crate so it totaled 4.5 gallons of milk per crate.

On cross-examination, Petitioner agreed that she was back to work and returned on October 13, 2015. She agreed that she returned to full duty with no restrictions, and that she was still working full duty with no restrictions. She testified that she last saw Dr. Gornet a couple of weeks prior to arbitration, and agreed that he released her at maximum medical improvement. She agreed that she has not returned to Dr. Gornet since that time.

On cross-examination, Petitioner agreed that she was not currently undergoing any physical therapy, and she denied being required to wear any kind of brace or protective device. She agreed that she was able to perform her job satisfactorily. She denied having had any performance evaluations completed since she returned to work in October. She further denied having had any complaints by supervisors of her job performance since she returned. She testified that she was recently promoted at work on April 16th and that she was promoted to support service lead.

On cross-examination, Petitioner testified that she last obtained a prescription for Tramadol approximately three months ago. She further testified that she usually takes Ibuprofen on days that she works.

The Application for Adjustment of Claim was entered into evidence at the time of arbitration as Arbitrator's Exhibit 2. The Application alleged a date of accident of April 18, 2014, that Petitioner was catching a food cart and that Petitioner allegedly sustained injury to the back, body as a whole and left foot as a result thereof. (AX2).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Medical Records List was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The medical records of SIH Medical Group Prompt Care/Dr. E. Clay Travis were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Petitioner was seen on April 23, 2014, at which time she stated that she got hurt at work on Friday, and that a food cart fell over and landed on her left foot. It was noted that Petitioner worked in the kitchen at Choate Mental Health and that she helped take food carts from the kitchens to the other openings and while wheeling one of the carts off a truck, it tipped over onto her left foot. Petitioner noticed immediate pain and it was sore to the touch, and there was no bruising or swelling. Petitioner also indicated that she had back pain with an onset of the 18th, that the severity level was mild-moderate and that the problem was worsening. It was noted that Petitioner was bending forward and had a sudden movement trying to catch a falling food cart. It was noted that Petitioner's back did not start hurting at the time of the accident, but did so shortly thereafter and had progressively worsened. It was noted that Petitioner's pain was worse if she bent over or lifted anything. Petitioner denied any prior history of back problems, and further denied weakness or numbness of the extremities. Petitioner stated that her discomfort could go down the back of the right lower extremity to the foot. The assessment was that of a contusion of the left foot and low back pain radiating to the right leg. Petitioner was prescribed medications and given work restrictions, and she was also given some back stretching and strengthening exercises. (PX3).

The medical records of St. Joseph Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Petitioner underwent x-rays of the left foot on April 23, 2014, which were interpreted as normal. (PX4).

The medical records of Dr. Mark Austin/Work Care were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. Petitioner was seen on April 28, 2014 as a referral from Prompt Care for a lumbosacral strain (right and midline greater than left) and left foot contusion. It was noted that Petitioner's lumbosacral strain had not yet improved and that she was having radiculopathy symptoms into the left and right legs, right greater than left. Petitioner was issued work restrictions and a referral for physical therapy was given. (PX5).

The records of Dr. Mark Austin/Work Care reflect that Petitioner was seen on May 21, 2014, at which time it was noted that she stated that her back was the same and not any better. It was noted that Petitioner was not working due to her restrictions, and that she had not had much improvement with physical therapy. The impression was that of (1) follow-up of lumbosacral strain (not improved with physical therapy); (2) persistent right leg radiculopathic symptoms; (3) right sacroiliitis; (4) left foot contusion (resolved). Petitioner was given work restrictions, given prescriptions and ordered to undergo an MRI. (PX5).

The records of Dr. Mark Austin/Work Care reflect that Petitioner was seen on July 7, 2014 in follow up on the MRI. It was noted that Petitioner felt about the same with no improvement overall. The impression was that of (1) persistent lower lumbar pain; (2) persistent radiculopathic pain intermittent into both legs with possible nerve root impingement. Petitioner was referred to a neurosurgeon and placed under work restrictions. (PX5).

Included within the records of Dr. Mark Austin/Work Care was an interpretive report for x-rays performed at Herrin Hospital on April 28, 2014. The x-rays of the lumbar spine were interpreted as revealing alignment within normal limits; well-maintained disc spaces; no fractures, dislocations or other significant bony abnormalities. (PX5).

The medical records of Carbondale Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. Petitioner underwent outpatient physical therapy for the timeframe of May 6, 2014 through May 30, 2014. At the time of the visit on May 30, 2014, it was noted that Petitioner continued to have "irritating" pain on the right PSIS, that she had decreased posterior rotation of innominates than anterior rotation, and that she was discharged from therapy and needed to be re-checked for SI joint pain mainly on the right side. (PX6).

The medical records of Cape Imaging were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. Petitioner underwent an MRI of the lumbar spine on July 1, 2014, which was interpreted as revealing (1) degenerative disc disease at the L4-5 level with mild posterior disc bulging along with osseous degenerative hypertrophic change which results in mild central spinal canal stenosis with potential slight impingement of both the originating right and left L5 nerve roots as these nerve roots are positioned between the bulging disc and the hypertrophied facet joints; bilateral narrowing of the neural canals at the L4-5 level however the L4 nerve roots exit without impingement; (2) degenerative disc disease at the L3-4 level with mild posterior disc bulging; (3) clinical correlation is requested. (PX7).

The medical records of Dr. Gerson Criste/Brain & Spine Institute were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. Petitioner was seen on September 5, 2014 for low back pain that radiated to both legs, and it was noted that that her pain was stabbing and constant. It was noted

that the onset was one month ago, and that the severity level was moderate. It was noted that Petitioner tried to catch falling kitchen "stuff." The assessment was that of sacroiliac joint dysfunction and lumbago. An SI joint injection was recommended and Petitioner was instructed to continue physical therapy afterwards. (PX8).

The medical records of Dr. Mathew Gornet/The Orthopedic Center of St. Louis were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. Petitioner was seen on September 15, 2014, at which time it was noted that she had undergone previous cervical spine surgery in 2009 and that she had not been seen since April of 2013. It was noted that Petitioner's current symptoms related to an issue on April 28, 2014 while working at Choate, and that she was in the kitchen and there was a large food cart that began to tip over. It was noted that it was about three feet high and that Petitioner reached over the top to try and prevent it from falling, and that on extending her back outward she noticed pain that became progressively worse over the next three days. It was noted that Petitioner had tried physical therapy, had been on work restrictions and that her symptoms remained constant and really worse in the low back to both sides, right greater than left, and into her right leg. It was noted that Petitioner's symptoms were causally connected to her work injury of April 28, 2014 and that she was recommended to undergo an injection on the right at L4-5 for which she was referred to Dr. Granberg. It was noted that Petitioner could continue working light duty, and that if she was improved then consideration could be given to a trial of full duty with no restrictions. (PX9).

The records of Dr. Gornet reflect that Petitioner was seen on November 17, 2014, at which time it was noted that no light duty work was available. It was noted that Petitioner's main symptoms were predominantly low back, pain to both sides, particularly the right side, right buttock, right hip and right leg. It was noted that her MRI scan showed bilateral foraminal lateral recess stenosis at L4-5 with what appeared to be facet hypertrophy, but her scan was somewhat "fuzzy" and was not distinct. It was noted that Petitioner's treatment options may be as simple as a left-sided laminotomy at L4-5, but there was suggestion of a disc injury also and annular tear and she may require discography to adequately treat her. Work restrictions were also issued. (PX9).

The records of Dr. Gornet reflect that Petitioner was seen on November 15, 2015, at which time it was noted that her MRI showed an annular tear at L4-5 and a lateral disc herniation on the left at L4-5. It was noted that Petitioner may have a subtle central protrusion at L3-4 with some subtle change in disc hydration, but it appeared the majority of her problem came from the L4-5 level. It was noted that Petitioner's symptoms were more low back pain than leg pain and that Petitioner had some bilateral symptoms again, but the right side seemed to be worse than the left and was more consistent with discogenic structural pain as well as aggravation of her pre-existing stenosis. A recommendation was made for a CT discogram at L3-4 and L4-5. Petitioner was also instructed to remain on light duty restrictions. (PX9).

Included within the records of Dr. Gornet was the operative report dated January 30, 2015 for the discogram with x-ray interpretation at L3-4 and L4-5 with facet block left at L3-4 and L4-5. The pre- and post-operative diagnosis was that of evaluate discogenic low back pain. The summary noted non-provocative disc at L3-4 with anterior annular tear; provocative disc at L4-5 with posterior left annular tear. (PX9).

The records of Dr. Gornet reflect that Petitioner was seen on February 12, 2015, at which time it was recommended that she undergo lumbar disc replacement at L4-5. It was noted that approval would be sought, and that Dr. Gornet would expect Petitioner to be able to work full duty with no restrictions, assuming she went back to her previous job. At the time of the visit on March 26, 2015, it was noted that Petitioner had been approved for a single level lumbar disc replacement at L4-5. The risks and benefits of surgery were placed, and Petitioner indicated her desire to proceed. (PX9).

Included within the records of Dr. Gornet was the operative report dated April 8, 2015 at the St. Louis Spine and Orthopedic Surgery Center. The pre- and post-operative diagnosis was that of discogenic back pain. The procedures performed included (1) anterior decompression at L4-5; (2) disc replacement at L4-5 with ProDisc-L with the entire procedure with increased difficulty due to scar from previous surgery. (PX9).

The records of Dr. Gornet reflect that Petitioner was seen on May 4, 2015, at which time it was noted that she was doing well and was already improving in her back, buttock and leg pain. At the time of the June 4, 2015 visit, Petitioner was noted to continue to do well and was very pleased with her progress. Petitioner was asked to begin exercises on her own. At the time of the July 20, 2015 visit, Petitioner was noted to continue to do well and was very pleased. Physical therapy was recommended. At the time of the October 5, 2015 visit, Petitioner was noted to continue to do extremely well and was completing her therapy. Petitioner was recommended to return to work full duty with no restrictions. At the time of the January 7, 2016 visit, Petitioner was noted to continue to do well and was pleased with her progress. It was noted that the next follow-up would be in April with x-rays and a CT, and that if things looked good she would be placed at maximum medical improvement. Petitioner was instructed to continue working full duty. At the time of the April 14, 2016 visit, it was noted that Petitioner continued to do well. It was noted that Petitioner was at maximum medical improvement and if she desired, she could follow-up in one year but it was noted that she was very pleased with her result. (PX9).

The medical records of Dr. Steven Granberg/Millenium Pain Management were entered into evidence at the time of arbitration as Petitioner's Exhibit 10. Petitioner was seen on September 24, 2014, at which time it was noted that she caught a food cart that was falling over back in April which she related to her current symptoms of low back and right lower extremity pain. It was noted that Petitioner was being referred for trial injections by Dr. Gornet. The assessment was that of (1) thoracic or lumbosacral neuritis or radiculitis, unspecified; (2) degeneration of lumbar or lumbosacral intervertebral disc. Petitioner was recommended to proceed with an L4-L5 epidural steroid injection and to return for transforaminal approach at that level. (PX10).

The records of Dr. Steven Granberg/Millenium Pain Management reflect that Petitioner was seen on October 15, 2014, at which time she presented for her subsequent injection trial of a right L4-5 transforaminal approach. Petitioner was recommended to proceed with a right L4 selective nerve root injection. (PX10).

The medical records of CT Partners of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 11. Petitioner was seen on January 15, 2015 for a myelogram of the lumbar spine. The impression was that of (1) L4-5 disc protrusion; (2) CT myelogram of the lumbar spine to follow. The interpretive report for the CT lumbar spine post myelogram performed on January 15, 2015 was that of (1) L4-5 broad-based disc protrusion and left lateral disc herniation with facet arthropathy resulting in mild bilateral recess stenosis and left foraminal encroachment. The interpretive report for the CT lumbar spine post discogram performed on January 30, 2015 was that of (1) left foraminal annular tears at L3/4 and L4/5 with a large anterior full thickness annular tear at L3/4. The interpretive report for the CT lumbar spine performed on July 20, 2015 was that of (1) anterior decompression and disc replacement at L4-5 with ProDisc-L or similar type prosthesis in satisfactory position; (2) annular disc bulges at L2-3 and L3-4, stable in appearance; no new central canal or foraminal stenosis are detected; (3) bilateral renal caliceal stones; no obstructive nephropathy is detected. The interpretive report for the CT lumbar spine performed on April 14, 2016 was that of (1) anterior decompression and disc replacement at L4-5 with ProDisc-L or similar type prosthesis in stable satisfactory position; (2) minimal annular disc bulges at L2-3 and L3-4, unchanged in appearance with no new central canal or foraminal stenosis. (PX11).

The medical records of MRI Partners of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 12. Petitioner underwent an MRI of the lumbar spine on January 15, 2015, which was interpreted as revealing (1) L4-5 broad-based disc protrusion and left far lateral disc herniation with facet arthropathy resulting in mild bilateral recess stenosis and left foraminal encroachment; (2) L3-4 milder disc bulge without spinal canal stenosis or foraminal encroachment. (PX12).

The medical records of St. Louis Spine & Orthopedic Surgery Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 13. Included within the records were the operative reports dated January 30, 2015 and April 8, 2015 as contained in Petitioner's Exhibit 9. (PX13).

The medical records of West County Care Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 14. Petitioner was seen on April 8, 2015 after transport by facility van from the surgery center. Petitioner was discharged on April 9, 2015. (PX14).

The medical records of Union County Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 15. Petitioner underwent orthopedic aftercare/physical therapy for the timeframe of July 31, 2015 through September 21, 2015. It was noted that the total visits attended were that of 18, and that the total missed visits were that of 3. (PX15).

The IME Report of Dr. David Lange was entered into evidence at the time of arbitration as Petitioner's Exhibit 16. The report reflects that Petitioner was seen on December 9, 2014 for an independent spine evaluation. Dr. Lange noted Petitioner's description of the accident and that her symptoms included soreness in the low back from the very beginning, increasing the next day or so, and that additionally over time she developed bilateral lower extremity discomfort, worse on the right. It was noted that the "pecking order" of symptoms was 80% low back pain and 20% lower extremity discomfort (significantly more on the right than the left). (PX16).

The report reflects that Dr. Lange opined that Petitioner's current diagnoses were that of (1) axial low back pain; (2) bilateral lower extremity symptoms (significantly more to the right than the left), consistent with radicular complaints; (3) although Dr. Gornet had suggested the potential for herniation to the right at L4-5, such herniation was not seen on personal review of the imaging nor was it diagnosed by the radiologist, but it was noted that the axial slices were simply of poor diagnostic quality. Dr. Lange indicated that it was felt that all diagnoses were work-related to the April 18, 2014 incident. It was noted that Petitioner's current condition had not resolved, and that further treatment was associated with the accident of April 18, 2014 incident. A repeat MRI was suggested, as was myelography followed by CT scanning. It was noted that the testing was assumed to be positive, and that one possible surgical approach would be a bilateral partial facetectomy with perhaps the placement of an interspinous implant to maintain a mildly flexed spinal segment position. Dr. Lange noted that Petitioner had not yet attained maximum medical improvement and, as Petitioner had not reached maximum medical improvement, it was noted that an estimate of permanency would be premature. (PX16).

The Form 45 was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The report was dated April 22, 2014 and noted a date of accident of April 18, 2014. It was noted that Petitioner was unloading a food cart off of the food truck, and that Petitioner stated the food cart tipped over and she tried to catch it, injuring her lower back and left foot. (RX1).

The Workers' Compensation Employee's Notice of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The report noted a date of injury of April 18, 2014, and that the accident was reported on April 21, 2014. It was noted that Petitioner was unloading a Cambro (food cart)

from a truck at the loading dock of the lower treatment center. It was noted that the cart was tipping over while Petitioner was unloading it, that she tried to hold it and pull it back up, but that it fell and hurt her back and landed on her left foot. (RX2).

The Supervisor's Report of Injury or Illness was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The report noted a date of accident of April 18, 2014, and that the accident was reported on April 22, 2014. It was noted that Petitioner was unloading a Cambro off a truck and that the cart was tipping over. It was noted that Petitioner tried to pull it back up but it fell. Petitioner reported that she hurt her back and it landed on her left foot. (RX3).

The IME Report of Dr. David Lange dated December 9, 2014 was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The report was duplicative of Petitioner's Exhibit 16. (RX4).

CONCLUSIONS OF LAW

The parties stipulated that Petitioner sustained an accident on April 18, 2014 that arose out of and in the course of her employment with Respondent, and that Petitioner's condition of ill-being was causally connected to this injury. (AX1).

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 in this matter. As a result thereof, the Arbitrator gives no weight to this factor.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that she continues to work for Respondent. The Arbitrator finds that the nature and demands of her position will likely have some affect on her permanent partial disability and, as such, 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 37 years old on her date of accident. Given the younger age of Petitioner and the fact that her treating physician, Dr. Gornet, gave her a full duty/no restriction release, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that there was no evidence proffered at arbitration to demonstrate that this work accident has impaired or otherwise affected Petitioner's future earnings capacity. The Arbitrator places no 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 she is lifting heavy things, she gets pain in her back. Petitioner testified that on bad weather days, she notices that she gets achy when it rains. Petitioner testified that she can sleep no longer than about six hours, and then has to get up and walk around because she has pain in her back. She testified that she can drive, but if she drives an hour or so, she gets sore. She testified that she takes over-the-counter medication daily,

usually once per day. She testified that she takes the Tramadol only when she needs it, perhaps a couple of times a week. At her final office visit with Dr. Gornet on April 14, 2016 visit, it was noted that Petitioner continued to do well. It was noted that Petitioner was at maximum medical improvement and if she desired, she could follow-up in one year but it was noted that she was very pleased with her result. (PX9). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely her continued complaints and purported limitations, were not corroborated by her treating records at the conclusion of her treatment with Dr. Gornet. 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 20% loss of use of the person-as-a-whole under Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marian Padula,

Petitioner,

vs.

NO: 12 WC 17162

Kolatek Bakery, Inc.,

16IWCC0744

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 2, 2016 is hereby affirmed and adopted.

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

DATED: NOV 18 2016

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:10/20/16
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PADULA, MARIAN
Employee/Petitioner

Case# **12WC017162**

16IWCC0744

KOLATEK BAKERY INC
Employer/Respondent

On 2/2/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.46% 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:

1938 ALEKSY BELCHER
MATTHEW J BELCHER
350 N LASALLE ST SUITE 750
CHICAGO, IL 60654

0507 RUSIN & MACIOROWSKI LTD
JOHN A MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

16IWCC0744

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Marian Padula Case # 12 WC 17162
Employee/Petitioner

v.
Kolatek Bakery, Inc.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **8/24/2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0744

FINDINGS

On 02/09/2012, 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.

In the year preceding the injury, Petitioner earned $30,680.00; the average weekly wage was $590.00.

On the date of accident, Petitioner was 56 years of age, single , with 0 children under 18.

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

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

ORDER

The Arbitrator finds Petitioner's average weekly wage for the year preceding the accident to be **$590.00** per week with earnings of $30,680.00 for the year.

The Arbitrator finds that Petitioner failed to prove accidental injury arising out of and in the course of his employment on February 9, 2012. Wherefore, Petitioner's claim for compensation is denied.

The Arbitrator also finds that Petitioner failed to prove any causal connection between an alleged accident of February 9, 2012 and his hernia condition. Wherefore, Petitioner's claim for compensation is denied.

In light of the Arbitrator's finding of failure to prove accidental injury and causation, Petitioner's claims for temporary total disability, medical expenses, and permanency benefits are hereby denied.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest of at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 31, 2015
Date

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FEB 2 - 2016

MARIAN PADULA v. KOLATEK BAKERY
12 WC 17162

INTRODUCTION

This matter proceeded to hearing on August 24, 2015 before Arbitrator Steven Fruth. The disputed issues were: ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***E:*** Was timely notice of the accident given to Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***G:*** What were Petitioner's earnings?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** What temporary benefits are in dispute? *TTD*; ***L:*** What is the nature and extent of the injury?

Petitioner, Marian Padula, Bartlomiej Kolatek, the manager and a pastry chef for Respondent, Zofia Kolatek, owner of Respondent, and Malgrzata Sajdak, salesperson for Respondent testified at trial. Petitioner, Ms. Kolatek, and Ms. Sajdak testified through a Polish translator.

STATEMENT OF FACTS

Petitioner testified that he had been a sausage maker for Respondent for 3 years. He testified that as a sausage maker, he was responsible for grinding meat in a special mixer, adding spices, and using a stuffing machine to stuff the meat in a casing before sending it to be smoked. He testified that in order to grind meat in the mixer, he had to bring containers of meat from a cooler and place the meat into the grinder by lifting and flipping each container to shoulder-height level and pouring it into the mixer. He further testified that on average, these containers of meat weighed approximately 50 lbs., and depending on the day, he would make 300 to 500 lbs. of sausages a day.

Petitioner testified that once he began the sausage making process, he had to finish that run of sausage or else the meat would spoil. Each sausage run took about 2 hours to make, without smoking it. Although he had been asked by his boss, Zofia Kolatek, to work faster, he testified that in order to finish all of the tasks to complete sausage production and keep his work station clean, it was necessary for him to work more than 40 hours a week. At a minimum, he worked 10 hours per week of overtime; he earned $14.75 an hour. Petitioner testified that at no time was he ever told that he was making too much sausage. Nor did Respondent ever discard product due to his overproduction of sausage. He also testified that he did not have any staff or helpers that would assist him in any of his job duties, including any lifting that was required.

On February 9, 2012 Petitioner testified he arrived to work at 6:00 a.m. He testified that on that morning, as he was lifting approximately 50 lbs. of meat to shoulder level, he felt a very sharp

pain on the right side of his groin. He walked to his car. At that time, he asked his co-worker, Adam, to call his boss, Zofia Kolatek, in order to inform her of his groin pain. Petitioner does not recall Adam making any statement regarding complaints Petitioner made about a hernia that he had for 5 years, or that Petitioner had difficulty walking for a number of years. When Ms. Kolatek arrived, Petitioner told her that his pain started as he was lifting meat into the grinder. He testified that he was not doing anything unusual when he felt the pain; he was just performing his usual job duties like every other day.

Bartlomiej Kolatek, the manager and pastry chef for Respondent, was called as an adverse witness by Petitioner. He had arrived at work at 7: 30 a.m. When he first saw Petitioner the day of the incident Petitioner was in considerable pain. Petitioner was in his car in the parking lot. Sophie and Adam, Petitioner's assistant, were there too. Petitioner wanted to go home. He said he had this problem before and did not want to go to the hospital.

Mr. Kolatek drove Petitioner to Gottlieb Memorial Hospital (Gottlieb), arriving about noon. Petitioner testified that he did not directly speak to anyone at the hospital. Mr. Kolatek served as a translator for Petitioner with medical and nursing staff at Gottlieb. Mr. Kolatek testified that as he translated Petitioner said he woke up with groin pain that day before work. Petitioner said, as Mr. Kolatek translated, that his complaints had been long-standing and that he had done nothing to cause his current pain. Petitioner further said it did not happen at work. Mr. Kolatek testified that he translated the doctor's recommendation of immediate surgery to address a strangulated hernia. Petitioner reported that he had had a hernia for years and had been treated by a Dr. Greg on Belmont Ave. Mr. Kolatek testified that Petitioner further added that surgery had been recommended before the date of the incident.

Petitioner's medical records from Gottlieb were admitted into evidence as Petitioner's Exhibit #1. Petitioner's emergency room complaints of abdominal pain and dysuria were noted. The place of occurrence of complaints was noted as "home" and the time of incident was noted as "12". There were no notes documenting that Petitioner reported having a hernia for years before.

. Dr. Robert Geller diagnosed Pettioner with an incarcerated (strangulated) right inguinal hernia with small bowel obstruction. It was noted that Petitioner was diabetic and a heavy smoker. Dr. Geller performed emergency surgery to repair the hernia. Petitioner was discharged the next day. He was advised to follow up with Dr. Geller in one week, and to refrain from any lifting.

Petitioner's medical records from Dr. Robert Geller were admitted into evidence as Petitioner's Exhibit #5. At the follow up visit on February 16, 2012 Dr. Geller noted some increased swelling and kept Petitioner off work. On follow up on February 23 Dr. Geller noted that Petitioner's swelling had decreased but that he should remain off work for 2 more weeks. It was also noted that Petitioner was not taking pain medication. On March 8, 2012 Dr. Geller noted that

Petitioner was healing well post-operatively and would be able to return to work with 15 lb. lifting restrictions on March 12, 2012, with an expected full duty work release on March 26, 2012.

Petitioner testified that he returned to light duty work for Respondent on March 12, 2012, and resumed to full duty work not long thereafter. When he returned to work, he requested to be paid for the time that he was off work and tendered his medical bills to Ms. Kolatek. He testified that Ms. Kolatek initially agreed to pay his medical bills; but she later advised him to file for bankruptcy to "take care" of the bill. At no time did Petitioner ever go back to Gottlieb with Mr. Kolatek to talk to anyone about his medical bills or finances. Mr. Kolatek testified that Petitioner threatened to "ruin" Zofia for refusing to pay his medical bills.

Petitioner quit working for Respondent in April 2012 after a disagreement over another employee's unrelated work accident. He testified that he did not make any threats to anyone when he quit. Petitioner testified that for some time in January of 2012, and before that in 2010 and 2011, he treated with Dr. Grzegorz, located on Belmont, just before Harlem, for his blood sugar. He denied treating with any doctor for a hernia condition in January 2012. He testified that he never told Mr. Kolatek that he had treated with Dr. Grzegorz for a hernia condition, nor was he asked to provide Dr. Grzegorz' s contact information when he was at Gottlieb Hospital.

He further testified that he did not have any medical condition that prevented him from performing the physical tasks of a sausage maker for Respondent before February 9, 2012. He also testified that at no time prior to February 9, 2012, did he ever have a conversation with Malgrzata, salesperson for the Respondent, where he complained of pain in his intestines or that he had received treatment by Dr. Grzegorz for a hernia. Petitioner specifically denied that he had a hernia problem for the previous 5 years.

Petitioner further testified that he is presently employed as a sausage maker at Alex's Deli. He began working as a sausage maker at Alex's Deli shortly after he quit working for Respondent. He is paid a weekly salary similar to what he was earning working for the Respondent in 2012. His job duties at Alex's Deli are also similar to the duties when he worked for the Respondent. However, at Alex's Deli, machine lifts are used to transport and unload meats out of the boxes. Petitioner testified that since his surgery, he is afraid to left heavy things. He no longer lifts heavy objects, or does any lifting from the ground if it's not convenient.

Bartlomiej Kolatek also testified for Respondent. He testified that his family owns Kolatek Bakery, and for a period of time, the bakery made sausages. Petitioner was hired to make sausages in 2009. Sausage making involves grinding meat with spices, putting the meat in a sausage stuffer, operating a machine which squirts the mix into casings onto a table, and then twisting the casing around. One of the requirements to making sausage includes loading the sausage meat into the grinder. He testified that the boxes of meat that arrived from Respondent's vendor weighed a minimum of "a couple pounds" to a maximum of approximately 30 lbs.

Mr. Kolatek testified that Petitioner's position was head chef, and head chefs don't do menial labor, such as lifting. He testified that head chefs tell other workers what to do, and he instructed other employees to do the meat production. He testified that Petitioner had 2 helpers that worked for him and moved the boxes out of the cooler to set up for production. One helper smoked the meat, and the other would prepped meat production. One of those workers was Adam, who was also a sausage maker, but second in line to Petitioner. Petitioner would dictate all the work, and Adam would then do it. He further testified that there was always at least one person working with Petitioner, another person would do most of the labor. He testified that in the years before February 9, 2012, he worked every day that Petitioner worked, and he never saw Petitioner lift a box of meat. He further testified that helpers would lift the boxes of meat for Petitioner.

Mr. Kolatek testified that Petitioner set his own hours, beginning at 6:00 a.m. and working until Petitioner thought the work was done. Despite preferring that Petitioner let assistants do a lot of the other work, he testified that Petitioner worked, give or take, at least 50 hours a week for Respondent. Petitioner was not required to work overtime. He further testified that from the date of Petitioner's hire, some time in June of 2009, until February 9, 2012, Petitioner did not have any physical problems that prevented him from performing his job duties as a sausage maker.

Mr. Kolatek testified that on February 9, 2012, he arrived to work at 7:30 a.m. He testified that Petitioner arrived to work that morning at 6:00 a.m. Prior to his arrival, Mr. Kolatek received a phone call from Zofia, who reported that Petitioner was in pain. He testified that he did not see what Petitioner did that morning between 6:00 a.m. and 7:30 a.m. When he arrived, he saw Petitioner in the parking lot in his car. He testified that he asked Petitioner what happened, and Petitioner said he did nothing out of the ordinary which caused this, and he felt that it may have happened during sleep or when he showed up for work. He testified that Petitioner told him that he took a couple of pills at, had breakfast, and went to lay down in hopes that it would go away. Mr. Kolatek further testified that Petitioner then asked that he be left alone to rest and get better. He testified that he checked on Petitioner about every 20-30 minutes. By late morning, he convinced Petitioner to go to the hospital. He drove Petitioner to the hospital in his vehicle and during the car ride to the hospital, Petitioner stated that he had a hernia for about 5 years, and that this did happen regularly and usually went away.

Mr. Kolatek further testified that while he and Petitioner were waiting in the emergency room, Petitioner stated that his doctor, Dr. Greg, had recommended that he have surgery to fix his hernia. He further testified that he told the medical providers that Petitioner's injury did not happen at work because Petitioner told him that he didn't do anything unusual that would cause this hernia and Petitioner "woke up and he was in pain, and usually it had gone away." He further testified that he translated for Petitioner during his consultation with Dr. Geller. Dr. Geller asked Petitioner about his history and prior treatment, and Petitioner stated that he was treating with a

doctor for his hernia, that this kind of flare-up has happened before, and that his doctor had recommended surgery.

Mr. Kolatek also testified that he translated Dr. Geller's medical recommendations. Petitioner's girlfriend arrived about 4:00 p.m. and he left just prior to Petitioner going in for surgery. He testified that at no time through when he left the hospital did Petitioner ever state that this was anything that happened at work. He also testified that all the history given to the medical providers at the hospital about how the accident happened came from him, and since he was not present when Petitioner arrived to work that morning, he has no idea whether or not Petitioner got hurt while lifting a tub of meat.

Mr. Kolatek testified that there was not enough time for Petitioner to have begun lifting boxes to start the sausage making process by 7:30 a.m. He testified that Petitioner had only prepared casings for the meat and got the spices ready for meat production. He later testified that he is only assuming what Petitioner had done that morning because the only thing that he knew when he got to work was that Petitioner was hurting.

Mr. Kolatek testified that Petitioner repeatedly said that his condition did not happen at work because when he was asked what he had done and why he was in such pain, Petitioner's response was "I don't know. I didn't do anything to cause this." He thinks Petitioner did not lift the heavy boxes that were needed to begin meat production that day because Petitioner has people that were under him to do the menial labor.

Mr. Kolatek testified that nobody at the bakery offered to pay any of Petitioner's medical bills or lost wages because his condition was preexisting. Respondent didn't pay Petitioner's hospital bills because Petitioner never really asked. Mr. Kolatek further testified that about a month and a half after Petitioner's surgery, he went back to Gottlieb Hospital with Petitioner to translate information as to Petitioner's finances to obtain financial assistance for his bills. He testified that at that time, Petitioner did not mention to Gottlieb Hospital that this was due to anything that happened at work. He testified that his first knowledge that Petitioner was alleging he was hurt at work was in May, when he received the Application for Adjustment.

Mr. Kolatek also testified that he received a note from Dr. Geller indicating that Petitioner may return to work with light-duty work restrictions on March 12, 2012, a little over one month after Petitioner's surgery. He testified that Petitioner returned to restricted duty work at that time. He did not ever offer to pay any of Petitioner's wages for the time he was off work, or any of Petitioner's medical bills, because his injury was a preexisting condition and did not happen at work.

Zofia Kolatek also testified for Respondent. She testified that Petitioner was hired as a helper and then became a chef in the sausage making department. She also testified that Petitioner had helpers to assist in making sausage, which included helping carry boxes of meat to

the work station. She does not know how much a full box of meat weighs. She testified that Petitioner was able to make a lot of product. She does not know how many hours Petitioner worked per week from February 2011 to February 2012, or whether he worked overtime. She testified that Petitioner scheduled his work hours around how much product he understood was needed to be made and sold. Sometimes she told Petitioner not to make a certain product because it wasn't selling very well. She testified that Petitioner never objected to overtime hours.

With regard to Petitioner's incident at the bakery on the morning in question, Ms. Kolatek testified that Adam, another employee for Respondent, told her that Petitioner was sitting in his car. When she asked Adam what happened, Adam told her that Petitioner came in with pain, took pain medication at home and at work, and the pain would not go away. Adam also told her that Petitioner has been walking around with a hernia for the past 5 years.

When she saw Petitioner he told her that he had strong pain. She asked him what happened and he said "nothing". He told her that he was not doing anything and was not lifting anything. She brought him water and called her son, Bartlomiej Kolatek, who took Petitioner to the hospital. She testified that Petitioner asked her son to stay with Petitioner at the hospital because he does not speak English. She later testified that she was not at the hospital and it was her son who had told her that Petitioner had asked him to stay.

Ms. Kolatek testified that she did not know, or have any knowledge, that Petitioner had a hernia before the morning of February 9, 2012, when she spoke to Petitioner in the parking lot. At that time Pettioner told her he had had a hernia before and that surgery had been recommended by Dr. Grzegorz. When she asked him why he wasn't treating his hernia, Petitioner told her he did not have insurance.

Ms. Kolatek testified that Petitioner was able to work before this incident, but did not know whether he was able to work on February 9, 2012. He did not report to work on February 10, 2012 because he was in the hospital recovering from surgery. She testified that Petitioner never asked her to pay the hospital bills. She also testified that when Petitioner quit working in April of 2012, he told her that he was going to destroy her.

Malgrzata Sajdak also testified for Respondent. She testified that she is employed by Zofia and Bartlomiej Kolatek. She was hired as a salesperson around the beginning of 2010 and has worked for Respondent for 5 years. She testified that she was familiar with Petitioner when he worked as a sausage maker for Respondent. She testified that sausage makers have to lift boxes, but she also testified that she never saw Petitioner lift anything. Petitioner had a helper named Adam who lifted most things. She had occasion to speak to Petitioner during the workday and would talk to him 3 or 4 times a week when she had to use the smoked meat coolers at the back of the store.

Ms. Sajdak testified that Petitioner's accident was 3 years ago, but she does not remember the exact date. She was not working at the time of the alleged incident. When she arrived to work that afternoon, there was a lot of talk about Mr. Kolatek taking Petitioner to the hospital after Petitioner spent 2 hours in his car.

Ms. Sajdak testified that in about 2010, Petitioner complained that he had a hernia. She testified that from 2010 up until February 2012, he complained about his hernia about numerous times. She testified that at the beginning of 2012, Petitioner told her he had some therapy for his hernia. He did not tell her that he had been hurt at work that caused a hernia.

Petitioner's Exhibit #6, Petitioner's 2011 paycheck stubs and 2011 IRS W-2, was admitted in evidence without objection. The Paycheck stubs show payment for overtime for every pay period encompassed. The W-2 shows Petitioner's earnings of $49,678.63 for 2011.

CONCLUSIONS OF LAW

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

This disputed issue rests solely on the credibility of the witnesses testifying at trial. Petitioner testified clearly and unequivocally the he developed pain while in the course of his employment as he was preparing to make sausage. He also testified that he did not have a hernia before the event on February 9, 2012. On the other hand, equally clear and unequivocal was the testimony of Bartlomiej Kolatek, Zofia Kolatek, and Malgrzata Sajdak. They all testified that Petitioner had stated that he had problems with a hernia for years before the incident on February 9, 2012. Mr. Kolatek and Ms. Kolatek also testified clearly and unequivocally that Petitioner reported that he woke up with groin pain the day of the incident and that this was a common event for Petitioner. They also testified that Petitioner stated that nothing at work caused his complaints.

While the number of witnesses testifying to a particular fact may not be credible if a lesser number of witnesses is more credible when testifying to that fact, the Arbitrator does find that Mr. Kolatek, Ms. Kolatek, and Ms. Sajdak are more credible than Petitioner on the issue of Petitioner having a hernia before the date of the alleged incident on February 9, 2012. They all testified that Petitioner had similar complaints for years before the incident, something Petitioner denied. The Arbitrator also finds Mr. Kolatek and Ms. Kolatek more credible than Petitioner on the issue of when Petitioner's groin pain first arose – whether at home before work or at work. The Arbitrator looks to the Gottlieb records for further support, where it was noted that Petitioner's complaints began at "home".

The Arbitrator, therefore, finds that Petitioner failed to prove that he sustained an injury from an accident that arose out of and in the course of his employment by Respondent.

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

The evidence clearly shows that Petitioner had complaints of ill-being at his workplace on February 9, 2012. There is no dispute that principals of Respondent, Bartlomiej Kolatek and Zofia Kolatek, had notice of Petitioner's complaints of ill-being on February 9, 2012. Mr. Kolatek in fact conveyed Petitioner to the Emergency Room of Gottlieb on the day of the incident.

Therefore, the Arbitrator finds that Respondent was given timely notice of the claimed injury in accord with that Act.

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

In light of conclusions stated above this issue is moot.

Even so the Arbitrator takes note that Pettioner was diagnosed and treated for an incarcerated inguinal hernia. He underwent emergency surgical repair of the hernia with appropriate follow up medical care. Petitioner testified that he had no problems or symptoms relating to a hernia prior to February 9, 2012. However, credible evidence offered by Respondent contradicts Petitioner's testimony. Respondents' evidence established that Pettioner in fact admitted on more than one occasion and to different people that he had a pre-existing hernia and that he woke on the morning of February 9, 2012 with pain associated with a strangulated hernia.

The Arbitrator therefore concludes that Petitioner failed to prove that he sustained an incarcerated inguinal hernia that was caused by any work-related event.

G: What were Petitioner's earnings?

Petitioner was employed by Respondent for more than 52 weeks, or 1 year, at the time of the accident. Petitioner earned $14.75 an hour, which is corroborated by Petitioner's 2011 paycheck stubs (PX #6). Petitioner testified that he worked 40 hours a week, and a minimum, worked 10 hours of overtime per week. Paycheck stubs show Petitioner worked an average of 15.6 hours of overtime per week.

§10 of the Act states that overtime is to be excluded in calculating a claimant's average weekly wage. Overtime hours may be included in average weekly wage if the employee is required to work overtime as a condition of his or her employment worked. Petitioner, as custom and practice, worked in excess of 40 hours a week. However, there was no evidence that the work

hours in excess of 40 per week were required by Respondent. In fact, the evidence showed that Pettioner had almost exclusive control over his weekly work hours.

Therefore, in accord with §10 of the Act, the Arbitrator concludes that Petitioner's average weekly wage was $590.00.

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

In light of the Arbitrator's findings above that Pettioner failed to prove that he sustained an injury from an accident that arose out of and in the course of Petitioner's employment by Respondent, as well as the findings regarding failure to prove causation, this issue is moot.

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

In light of the Arbitrator's findings above that Pettioner failed to prove that he sustained an injury from an accident that arose out of and in the course of Petitioner's employment by Respondent, as well as the findings regarding failure to prove causation, this issue is moot.

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

In light of the Arbitrator's findings above that Pettioner failed to prove that he sustained an injury from an accident that arose out of and in the course of Petitioner's employment by Respondent, as well as the findings regarding failure to prove causation, this issue is moot.

Arbitrator Steven J. Fruth

December 31, 2015
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Luis M. Berdecia,

Petitioner,

vs.

NO: 11 WC 23383

16IWCC0745

1555 N. Astor Condominimum Association,

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 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 November 10, 2015 is hereby affirmed and adopted.

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

16IWCC0745

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

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

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

DATED: NOV 18 2016

MB/mam
o:10/20/16
43

Mario Basurto

David L. Gore

Stephen Mathis

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

BERDECIA, LUIS M
Employee/Petitioner

Case# **11WC023383**

16IWCC0745

1555 N ASTOR CONDOMINIUM ASSOCIATION
Employer/Respondent

On 11/10/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1987 RUBIN & CLARK LAW OFFICES LTD
CATHERINE K DOAN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

2097 GRANT & FANNING
DANIEL K SWANSON
300 S RIVERSIDE PLZ SUITE 2050
CHICAGO, IL 60606

16IWCC0745

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)

Luis M. Berdecia,
Employee/Petitioner
v.
1555 N. Astor Condominium Association,
Employer/Respondent

Case # **11** WC **23383**

An *Application for Adjustment 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 Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **May 26, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0745

FINDINGS

On the date of accident, **April 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$36,991.24**; the average weekly wage was **$711.37**.

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

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

Respondent shall be given a credit of **$0** for TTD, **$97,202.61** for TPD, **$0** for maintenance, and $ for other benefits, for a total credit of **$97,202.61**.

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

ORDER

Because Petitioner failed to prove a causal connection exists between the current condition of ill-being in his lumbar and the accident on April 21, 2011, prospective medical for the low back is denied.

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

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

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

Signature of Arbitrator

November 9, 2015
Date

ICArbDec19(b)

NOV 10 2015

Luis M. Berdecia v. 1555 N. Astor Condominium Association
11 WC 23383

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth on May 26, 2015. The parties stipulated that Petitioner sustained bilateral shoulders injuries which were caused by an accident at work on April 20, 2011. There is no dispute regarding the necessity of medical care and treatment for the claimed shoulder injuries.

Petitioner also claimed to have sustained a low back injury caused by the accident. The disputed issues regarding Petitioner's claimed back injury were: ***F:*** Is Petitioner's current condition of ill-being causally related to the injury?; ***O:*** Is Petitioner entitled to prospective medical care?

FINDINGS OF FACT

Petitioner testified that he worked as a garage attendant for Respondent since August 2008. He testified that 1555 N. Astor is a 48 floor building. He parked cars for the residents, performed building maintenance, carried objects for the residents, and washed cars.

Petitioner testified that he had not sustained any accidents or injuries to his back prior to April 20, 2011. Further, Petitioner denied that he had any medical treatment for his back prior to April 20, 2011. Prior to the accident of April 20, 2011, Petitioner testified that he did not have any problems with his back.

On cross-examination Petitioner again denied any problems with his low back prior to April 21, 2011. When he was shown the chart note by Dr. Preston Wolin on May 31, 2011 (RX #1) reflecting "a back injury at work 2-3 years ago." Petitioner testified that he did not recall giving Dr. Wolin that history. He repeated that he had not sustained any accidents involving his back prior to April 20, 2011. Petitioner testified that he did not review the medical records of Dr. Wolin and did not have any control as to what was documented in the records.

On April 20, 2011, Petitioner was working maintenance and cleaning the downstairs garage with sweeping compound. Petitioner had to sweep the floor using a large broom. He began to feel pain in his back as he was sweeping. He also had to bring buckets of compound up and down the stairs. He carried 2 buckets at a time. Each bucket weighed 20-25 lbs. Petitioner had to climb up and down 3 flights of stairs approximately 3 times. As he was going down the stairs, carrying the buckets, he felt a pop in his shoulders and pain in his back.

Petitioner presented in the emergency department of Advocate Illinois Masonic Medical Center (PX #1) on April 21, 2011. Petitioner complained of left shoulder and

right lower back pain since that night before. He reported that he had been lifting 20 lb. pails of paint with each arm up and down stairs. He suddenly developed sharp 10/10 pain with a click in his left shoulder. He reported 10/10 lower back pain also. He reported back pain radiating into his buttock and mid-thigh. Petitioner gave a history of bilateral shoulder ligament surgery, left knee arthroscopy, and arthralgias, and myalgias. Petitioner reported that he smoked cigarettes.

On examination Petitioner's left shoulder was tender to palpation and upon abduction. Shoulder range of motion was limited by pain. Shoulder strength was diminished on the left. The low back was also tender to palpation. It was noted that Petitioner had a positive straight leg raise on the right, but then another note stated no pain on straight leg raise. He had an injection of a narcotic for pain. Petitioner was diagnosed with shoulder strain and lower back strain. He was discharged to home with prescriptions for Norco and Flexeril. He was to follow-up with his family doctor or Dr. Dormitorio.

Following the medical treatment at Illinois Masonic Medical Center, Petitioner returned to work for Respondent. He testified that while he was working he continued to experience pain in his back and shoulders.

Petitioner eventually sought medical treatment with Dr. Preston Wolin (PX #2) on May 31, 2011. Petitioner reported that he felt a pop in his shoulders as he was carrying buckets weighing 15-20 lbs. at work. He also complained of back pain. Petitioner gave a history a back injury 2-3 years before which was successfully treated with conservative care. Petitioner also reported that he had had a prior arthroscopy to the left knee and 2 prior arthroscopies to the right knee. He also had left shoulder surgery in 2003 and right shoulder surgery in 2006. Petitioner had been able to return to work without restrictions after that history of surgeries. Petitioner was a 1 pack-a-week smoker.

The back pain was on the right side and radiated into the posterior aspect of the right leg. Back range of motion was limited and Petitioner had a positive straight leg raise on the right at 70°. Leg strength was normal. Lumbar x-rays were normal. Dr. Wolin diagnosed lumbar sprain with possible herniated disc. Dr. Wolin recommended an MRA for both shoulders to rule out rotator cuff or labral pathology and physical therapy for the back for 4-6 weeks.

On a June 6, 2011 telephone call Petitioner's reported that his back condition was not improving. Dr. Wolin referred Petitioner to Dr. Lawrence Frank for further treatment for the low back. Thereafter Dr. Wolin provided medical treatment for Petitioner's bilateral shoulder condition and not his back condition. On June 14, 2011 Petitioner saw Dr. Wolin for his shoulders and discussed shoulder surgery. Dr. Wolin noted that Petitioner should continue treatment for his severe back pain and should follow up with him when his back improved.

Petitioner also saw Dr. Mehul Garala in June 2011. Dr. Garala diagnosed back strain complicated by facet syndrome. He too recommended facet injections.

Petitioner saw Dr. Wolin on August 12, 2011 in follow-up after shoulder surgery. Dr. Wolin noted Petitioner's report that he had had a series of back injections and was much improved. It was noted that Petitioner was free of back pain.

Petitioner continued to follow with Dr. Wolin 19 times for his shoulder problems and surgeries throughout 2011, 2012, and 2013 through July without mention of the condition of his back.

On August 13, 2013 Petitioner saw Dr. Wolin for his shoulder problems again. On the visit he reported that he had fallen onto his elbow and forearm while walking his dog. He complained of increased right shoulder pain. On September 17, 2013 Petitioner was in for another shoulder check. At that time he complained of lower right sided back pain radiating into his right leg. He also complained of numbness and tingling in the right foot. Petitioner stated these complaints began about 2 months before and were getting progressively worse. Dr. Wolin noted that there had been no new injury. He referred Petitioner back to Dr. Frank.

The only other Dr. Wolin notes about Petitioner's back condition were on December 7, 2013 and May 6, 2015. On December 7 he noted Petitioner's back problems were being managed by Dr. Frank. On May 6 he noted Petitioner's current care with Dr. Frank for his back but that shoulder physical therapy was limited by back pain.

Petitioner was examined by Dr. Frank (PX #3) on June 7, 2011. Dr. Frank noted a history of localized back pain from repetitive bending and lifting of 15 -20 lb. pails. Petitioner continued to work without restrictions as a garage attendant. Petitioner reported that back x-rays showed arthritis. Petitioner complained that he could only stand 10-15 minutes or walk half a block without pain. Dr. Frank diagnosed of lumbar sprain likely complicated by lumbar facet syndrome. He recommended a prednisone taper, Daypor, and physical therapy.

On June 15, 2011 Petitioner saw Dr. Frank with worsening back pain from working. Petitioner continued to report localized back pain with radiating into the bilateral buttocks. Dr. Frank recommended that Petitioner undergo bilateral L3-4, L4-5, and L5-S1 facet joint injections and begin physical therapy.

Dr. Frank administered the facet joint injections on August 4, 2011 at Elmhurst Outpatient Surgery Center. (PX #5) The post-operative diagnosis was facet syndrome, lumbar spondylosis, and lumbar sprain. Petitioner testified that the injections gave him some relief but that he still had some pain.

Petitioner followed up with Dr. Frank on August 11, 2011. Petitioner reported a 95% improvement in the back pain. He reported that he was able to sit and walk as he pleased. Petitioner had a slight soreness of the right gluteal region. Dr. Frank noted an impression of lumbar sprain complicated by facet syndrome, markedly improved. Dr. Frank cleared Petitioner to undergo surgery for his shoulder condition. He noted that Petitioner's back condition would not impede any potential recovery for shoulder surgery. Petitioner was to return as needed.

Dr. Frank performed an EMG/NCV for Petitioner's left shoulder and arm on August 17, 2011. On January 10, 2012 Dr. Wolin ordered work conditioning for Petitioner's shoulder. Petitioner underwent an FCE for his left shoulder at the recommendation of Dr. Wolin. Petitioner testified that he was not able to complete the FCE due to back pain and an injury to his thumb.

Petitioner testified that between August 2011 and September 2013 he did not receive any medical treatment for his back condition. However, he received ongoing medical treatment for his bilateral shoulder condition.

Petitioner also testified that between August 11, 2011 and September 2013 he did not sustain any new accidents involving his back. He testified that in early August 2013 he tripped over his dog. He reported this incident to Dr. Wolin. In his August 13, 2013 progress note Dr. Wolin documented that Petitioner had a fall 5 days before while walking his dog. He landed on his left side and scrapped his left forearm and right elbow. He noticed some increase in right shoulder pain. There was no note of back pain in reference to the fall. Petitioner testified that tripping over his dog did not affect his back condition. He noticed symptoms in his back prior to the fall. He did not report any back complaints to Dr. Wolin.

Petitioner testified that the pain in his back came back gradually after August 2011. The pain was the same as in 2011 and was in the same location as in 2011. Petitioner decided to seek medical treatment from Dr. Frank because the pain was becoming worse and traveling down his leg.

Petitioner saw Dr. Frank on September 23, 2013. (PX #3) Petitioner complained of right sided low back pain with radiation into the right leg into the great toe. Petitioner reported that the symptoms came on gradually 2 to 3 months prior to the visit. Dr. Frank documented no new back injury. Pain was noted at 7/10. Range of back motion was limited by pain. Sensation was normal. Leg strength was 5/5. Dr. Frank diagnosed lumbosacral spondylosis without myelopathy and lumbar radiculopathy. Dr. Frank noted that leg pain was a new feature. He recommended an MRI and continued Flexeril. Petitioner testified that it was not necessary to inform Dr. Frank of the August 2013 fall since it did not affect his back.

On October 11, 2013 Petitioner was unchanged. Dr. Frank noted that Petitioner had not sustained a new injury to his back; rather, he had gradually increasing back pain for 2-3 months without specific injury. Dr. Frank noted that the symptoms began in April 2011 while Petitioner was doing maintenance work and lifting 5 gallon buckets. Subjective complaints of back pain were noted on the physical examination. There were no objective findings. The exam was noteworthy for 3 positive Waddell signs, particularly exaggerated pain exclamations.

Dr. Frank diagnosed lumbosacral spondylosis without myelopathy, lumbar dis degeneration, and heartburn. He recommended lumbar facet joint injections at L3-4, L4-5, and L5-S1. He stated that the condition was work-related. Petitioner underwent the facet joint injections on October 31, 2013. (PX 5)

Petitioner returned to Dr. Frank on November 25, 2013. Dr. Frank noted that Petitioner had 100% symptom relief until about a week before when the pain in the buttock started to return. Petitioner had full range of motion but complained of pain with left bending. Waddell's were now negative. Dr. Frank recommended physical therapy and considered RFN (radiofrequency neurotomy). He again stated the condition was work-related.

On December 16, 2013 Dr. Frank recommended RFN at right L2, L3, L4, and L5. The physical exam was essentially unchanged, including negative Waddell's. He noted that Petitioner was having symptoms suggestive of facet and myofascial pain. He reiterated that the condition was work-related.

Petitioner was examined by Dr. Mark Levin pursuant to §12 of the Act on May 6, 2014. Petitioner gave a history of an injury on April 21, 2011 when he was working job duties that were not normal for him. He developed back pain so severe he almost fainted. Petitioner was treated at Illinois Masonic Medical Center and released. He continued to work until June 2011 without medical care. He reported pain at 5/10 at the beginning of his shift and increased to 7/10 by the end of shift.

Petitioner reported that he initially consulted Dr. Wolin, who referred him to Dr. Frank for his back pain. Dr. Frank gave Petitioner spinal injections which resolved his back pain.

Petitioner testified that he has not undergone the medical treatment recommended by Dr. Frank since it has not been authorized. He does want to undergo the RFN recommended by Dr. Frank.

Petitioner was examined by Dr. Mark Levin on May 6, 2014 pursuant to §12 of the Act. Petitioner testified that he was truthful and honest with Dr. Levin. Petitioner gave a history that he was hurt at work on April 21, 2011. Petitioner was covering for another worker and that he was not doing his normal job. As he was sweeping and carrying 25 lb. pails he developed low back pain so severe he almost fainted.

Petitioner was seen at Illinois Masonic Medical Center emergency room. He was treated and x-rayed. Petitioner continued to work until June 2011. During work he had 5/10 pain at the beginning of his shift and then 7/10 pain at the end of shift. He also reported occasional right leg pain then. Petitioner then consulted Dr. Preston Wolin. Dr. Wolin treated Pettioner's shoulder problems and referred him to Dr. Lawrence Frank for evaluation of the low back complaints.

Petitioner reported that Dr. Frank administered trigger point injections in his lumbar spine. He reported that his back pain resolved by the time of his shoulder surgery in August 2011.

Petitioner reported that he did not have any medical care for his back between August 2011 and October 2013. He went back to Dr. Frank on October 3, 2013 for a flare-up of back pain. Petitioner had an MRI and another lumbar injection. The last injection gave relief for only a month. Petitioner reported that Dr. Frank was

recommending a burning procedure for his nerve, which Dr. Frank said should relieve pain for about 2 years.

At the IME, Petitioner reported intermittent pain ranging from 4/10 to 6/10. He was not taking medication for his back. He reported pain after sitting or standing for 5-10 minutes, with minimal walking, and driving 30-60 miles.

On examination Dr. Levin observed Petitioner's side-to-side gait, but also noted Petitioner's ability to heel-heel and toe-toe walk. Petitioner could touch his knees but had pain on hyperextension. Petitioner reported low back pain on supine straight-leg at 70° but no pain complaints on seated straight-leg. Petitioner reported deceased sensation over the medial and laterals aspects of the thighs.

Dr. Levin then reviewed Petitioner's October 9, 2013 lumbar MRI and Petitioner's medical records from Dr. Wolin, Dr. Garala, and Dr. Frank. Dr. Levin noted that the MRI showed minimal right-sided bulging at L2-3 without evidence of a disc herniation. There was also facet arthritis without nerve impingement at L4-5 and L5-S1. Dr. Levin noted Dr. Frank's chart entry on August 11, 2011 that petitioner had realized 95% improvement in back pain. Thereafter Petitioner was treated by Dr. Wolin for his shoulders.

Dr. Levin noted Dr. Wolin's chart entry dated February 9, 2012 where Petitioner gave a history of a back injury 2 to 3 years before that was treated conservatively. Dr. Levin also noted the numerous clinical visits in 2012 and 2013 with Dr. Wolin where petitioner did not complain of back pain.

Dr. Levin noted that Petitioner reported back pain to Dr. Wolin during a September 17, 2013 clinical visit. Petitioner then returned to Dr. Frank on October 11, 2013 with back pain. Petitioner had reported to Dr. Frank that his back pain had returned 2 months before. Petitioner continued with Dr. Frank through November 25, 2103, at which time Dr. Frank was recommending radiofrequency (ablation) at right L2-3, L4, and L5.

In his May 6, 2014 report to Respondent's insurer (Exhibit #1 to RX #2) Dr. Levin opined that Petitioner's low back pain resolved by the end of 2011. The treatment in 2011 with facet injections resolved Pettioner's comaplints. He opined that the complaints of back pain at the time of the IME were due Petitioner's underlying facet syndrome.

Petitioner testified at the hearing that his back is getting worse. He has pain in his back which shoots down his right leg. Sometimes his right leg gives out. Petitioner said he has difficulty sitting and standing. He tries not to take pain medication for his back condition. He uses hot pads for his back pain.

Evidence Deposition of Dr. Lawrence Frank (PX #8)

Dr. Frank gave his deposition on February 17, 2015. Dr. Frank specializes in physical medicine and rehabilitation. He described his practice as nonoperative orthopedics or the cardiology of orthopedics. He is board-certified in physical medicine and rehabilitation, pain management, sports medicine, and electrodiagnostic medicine. The majority of Dr. Frank's practice deals with musculoskeletal medicine.

Dr. Frank refreshed his memory of Petitioner's case with his clinical records. He testified that petitioner presented on June 7, 2011 with complaints of low back pain for 6 weeks. Petitioner reported that he hurt his back with repetitive bending and lifting of 15-20 lb. pails. Dr. Frank recited his findings on physical exam as documented in his records. He confirmed his diagnosis of a lumbar sprain with facet syndrome. He noted that Petitioner had been unable to get physical therapy due to time constraints at work.

Dr. Frank recommended facet joint injections. He testified that the injections only provide temporary relief. Injections can provide relief from 2 weeks to several years. Dr. Frank administered injections on August 4, 2011. The injections provided 95% relief of Petitioner's symptoms. Dr. Frank testified that the injections were also diagnostic since the relief confirmed that the facet joints were the source of Pettioner's pain.

Petitioner returned to Dr. Frank on September 23, 2013 with complaints of right-sided back pain for the previous 2 to 3 months. Petitioner complained of pain radiating into the leg and great toe. Dr. Frank was concerned due to the new symptomology. He was aware that Petitioner had undergone some shoulder surgeries since he last saw petitioner in 2011. Dr. Frank restarted anti-inflammatory medication and ordered an MRI.

Dr. Frank reviewed the MRI with Petitioner on October 11, 2013. The MRI showed a disc herniation at L2-3 on the right, which did not correspond to Pettioner's leg complaints and numbness in the great toe. Dr. Frank had no explanation for the leg symptoms. At that time he recommended repeat facet injections. The injections were administered on October 31. On November 25, 2013 Petitioner reported 100% relief of his back pain for only 2 weeks. Thereafter the pain returned. At that time Dr. Frank recommended radiofrequency neurotomy. That procedure can provide relief anywhere from 6 months to 2 years.

Dr. Frank opined that Petitioner's diagnosis is facet syndrome. He also opined that the work related accident on April 20, 2011 caused Petitioner's current condition. He further opined that Petitioner is not at MMI. Dr. Frank went on to explain that the 2 year gap in his care for Petitioner was due to Petitioner being too busy with his care for his shoulder injuries.

Dr. Frank then testified to his disagreement with the opinions of Respondent's expert, Dr. Mark Levin. He disagrees with Dr. Levin's opinion that Petitioner's injury was an exacerbation because Petitioner never had back pain before the original injury.

Dr. Frank noted that Petitioner's complaints were exactly the same even though years apart.

On cross-examination Dr. Frank acknowledged that lumbosacral spondylosis with myelopathy is that same as facet syndrome. He also acknowledged that the 2 year gap from 2011 to 2013 could be because Petitioner was not having back pain. He did note that petitioner did not report that he fell while walking his dog in 2013. Dr. Frank further acknowledged that petitioner complaints in 2013 were gradual in onset over 2-3 months. Petitioner's MRI showed degenerative disc disease.

Dr. Frank admitted that he might change his causation opinion with new information about another incident. He also noted that he cannot rule out symptom magnification in any patient.

On re-direct examination Dr. Frank noted that petitioner presented with back pain comaplints in different locations in 2011 and in 2013. He continued and noted that Pettioner's complaints did not correspond to the LRI findings at L2-3. He testified that there is an 80% recurrence of back pain but it would depend on the circumstances if the recurrence related back to the original condition. Dr. Frank also testified that, assuming someone with Pettioner's condition fell, a fall could aggravate a pre-existing fact syndrome.

Evidence Deposition of Dr. Mark Levin (RX #2)

Dr. Levin gave his deposition on April 15, 2015. He devotes 20% of his professional time on IMEs, 90% of which are for the defense. He refreshed his recollection with his office records and narrative report. Dr. Levin repeated his findings and opinions set forth in his May 6, 2014.

Dr. Levin testified that Petitioner had denied any back pain or treatment for his back prior to the April 21, 2011 activity. He clarified that he did not believe that event on April 21 was an accident. Dr. Levin noted that clinical records documented Petitioner's report of a back injury and conservative medical care 2 to 3 years before the 2011 event. He again noted that Petitioner had no complaint of back pain in a sitting straight-leg test but had back pain on the right at 70° in supine on the right. He also noted that Petitioner had reduced pin-prick sensation over the medial and lateral aspects of his right thigh. The remainder of the neurological exam was normal.

Dr. Levin opined that Petitioner had chronic facet arthritis which was exacerbated by the April 21, 2011 work activities. He further opined that the care and treatment by Dr. Frank in 2011 was appropriate. He opined that the series of injections resolved Petitioner's complaints in 2011. Dr. Levin finally opined that Petitioner's complaints in 2013 and at the IME were consistent with Petitioner's underlying condition which pre-existed 2011. Therefore, he opined that Pettioner's complaints in 2013 were not causally related to the work activity in April 2011.

Dr. Levin did opine that Dr. Frank's treatment in 2013 was appropriate to relieve Petitioner's complaints but was not related to the 2011 injury.

On cross-examination Dr. Levin testified that the radiofrequency ablation recommended by Dr. Frank was appropriate treatment for Petitioner's condition. He reiterated his opinion that the April 2011 injury was an exacerbation of pre-existing arthritic facets. He noted Petitioner's complete, asymptomatic resolution after Dr. Frank's treatment in 2011.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner failed to prove that a causal connection exists between his current lumbar condition of ill-being and the work accident in April 2011.

The Arbitrator finds that the Dr. Franks' opinion that Petitioner's current condition of lumbar pain is related to the April 2011 workplace incident is not persuasive. Dr. Frank's opinion is in part based on the history given by Petitioner that he had not had a prior back injury or had had prior treatment for his back. The Arbitrator finds that Petitioner was not credible when he made such a denial. At the hearing Pettioner repeated his denial of a prior back injury or treatement. Petitioner was confronted on cross-examination with the May 31, 2011 chart note of Dr. Wolin, wherein it was noted that Petitioner had injured his back 2 to 3 years before and had received medical treatment for that injury.

A physician's opinion is not credible if it is not based on an accurate patient history or the patient's accurate report of subjective complaints. The Arbitrator also notes that Petitioner denied a prior back injury at his IME with Dr. Levin. Dr. Levin noted inconsistent observations during straight-leg raise testing while seated and while supine. These issues further undermine Pettioner's credibility.

The Arbitrator notes that Petitioner, over time, had variously reported that he was injured on April 20, 2011 and on April 21, 2011. The Arbitrator does not place any weight on that discrepancy in evaluating Pettioner's lack of credibility.

In addition, even assuming *arguendo,* that Petitioner was truthful in his history to Dr. Frank, Dr. Frank's causation opinion regarding Petitioner's condition in October 2013 is based on speculation. While causation can be proved circumstantially by a chain of events that chain of events must be more closely related in time than what is present here. Dr. Levin's opinion that Petitioner's current condition is due to Petitioner's underlying pre-existing arthritic facets and is not related to the workplace incident is clearly more persuasive.

Also, during the course of his care with Dr. Frank Petitioner displayed 3 positive Waddell signs. The 5 panel Waddell is intended to identify non-organic causes for subjective complaints, complaints without relation to objective findings. This is another

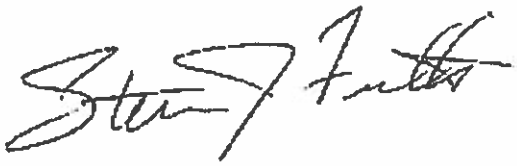
factor in assessing Petitioner's lack of credibility.

Finally, Dr. Frank did not know about Pettioner's fall while walking his dog in August 2013. This may in fact have been as minor as Petitioner described. However, it is unknown whether that event would have affected Dr. Frank's causation opinion. But, it is another example of an incomplete history provided by Petitioner. A valid opinion must be based on all available facts.

Therefore, as stated above, Pettioner failed to prove that the current condition of ill-being in his lumbar spine is causally related to the workplace incident in April 2011.

O: Is Petitioner entitled to prospective medical care?

In light of the foregoing findings this issue is moot. Therefore, Petitioner's claim for further prospective medical is hereby denied.



November 9, 2015

Steven J. Fruth, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RONALD SINDE,

Petitioner,

vs.

NO: 10 WC 33190
11 WC 4724

NICHOLS SIDING & WINDOWS,

Respondent.

16IWCC0746

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, prospective medical, wage rate, temporary total disability (TTD), penalties, and permanent partial disability (PPD), and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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).

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

Pursuant to Section 10 of the Act:

> The compensation shall be computed on the basis of the 'Average weekly wage' which shall mean the actual earnings of the employee in the employment in which he was working at the time of the injury during the period of 52 weeks ending with the last day of the employee's last full pay period immediately preceding the date of injury, illness, or disablement excluding overtime, and bonus divided by 52; but if the injured employee lost 5 or more calendar days during such period, 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. Where the employment prior to the injury extended over a period of less than 52 weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee actually earned wages shall be followed. Where by reason of the shortness of the time during which the employee has been in the employment of his employer or of the casual nature or terms of the employment, it is impractical to compute the average weekly wages as above defined, regard shall be had to the average weekly amount which during the 52 weeks previous to the injury, illness or disablement was being or would have been earned by a person in the same grade employed at the same work for each of such 52 weeks for the same number of hours per week by the same employer." 820 ILCS 305/10

Sinde testified that he was a seasonal employee. T.32. He worked 5 days a week, 40 hours per week depending on the weather. *Id.* The wage statement reveals that Sinde worked 118 days during 29 weeks preceding the injury. RX.6. He earned $8,273.75. *Id.* The Commission finds that this represents 23.6 weeks worked (118/5) with a corresponding AWW of $350.58 ($8,273.75/23.6).

The Commission, therefore, modifies the AWW from $306.44 to $350.58. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on January 5, 2016, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $350.58 per week for a period of 7-2/7 weeks, August 5, 2010 – September 24, 2010, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further

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hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that 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: NOV 21 2016

MJB/tdm
O: 10/18/16
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

SINDE, RONALD D
Employee/Petitioner

Case# **10WC033190**
11WC004724

NICHOLS SIDING & WINDOWS
Employer/Respondent

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On 1/5/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0393 THOMAS R LICHTEN LTD
53 W JACKSON BLVD
SUITE 1634
CHICAGO, IL 60604

2593 GANAN & SHAPIRO PC
TIMOTHY STEIL
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Ronald D. Sinde
Employee/Petitioner

Case # 10 WC 33190

v.

Consolidated cases: 11 WC 04724

Nichols Siding & Windows
Employer/Respondent

16IWCC0746

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on November 20, 2015. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☒ Other Section 12 Travel Expense

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FINDINGS

On the date of accident, August 4, 2010, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $8,273.75; the average weekly wage was $306.44.

On the date of accident, Petitioner was 48 years of age, single with 0 dependent child(ren).

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

Respondent shall be given a credit of $10,981.97 for TTD, $0.00 for TPD, $0.00 for maintenance, and $1,962.64 for other benefits, for a total credit of $12,944.61.

Respondent is entitled to a credit of $76,664.23 under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $220.00 per week for seven and two-sevenths (7 2/7) weeks commencing August 5, 2010, through September 24, 2010, as provided in Section 8(b) of the Act.

Based upon the Arbitrator's Conclusions of Law attached hereto, all other claims for compensation are denied.

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

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

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

William R. Gallagher

William R. Gallagher, Arbitrator
ICArbDec19(b)

December 28, 2015
Date

JAN 5 - 2016

Petitioner filed two Applications for Adjustment of Claim which alleged he sustained accidental injuries arising out of and in the course of his employment for Respondent. In case number 11 WC 04724, the Application alleged that Petitioner sustained a work-related accident on June 22, 2009, that caused injuries to the "Head, neck, left foot and ankle, body." In case number 10 WC 33190, the Application alleged that Petitioner fell from the back of a truck on August 4, 2010, and sustained injuries to the "Left ankle/foot trapezius/MAW, left anterior chest wall/MAW." (Arbitrator's Exhibits 3 and 4).

The two cases were previously consolidated for trial and were heard in a 19(b) proceeding wherein Petitioner sought an order for payment of medical bills, travel expenses, temporary total disability benefits as well as prospective medical treatment. Petitioner also filed a Petition for Section 19(k) and Section 19(l) penalties and Section 16 attorneys' fees. Respondent disputed liability in both cases on the basis of accident, notice and causal relationship. Respondent also disputed the average weekly wage alleged by Petitioner. Finally, there was also a dispute as to the amount of credit Respondent was entitled to for payment of compensation benefits (Arbitrator's Exhibits 1 and 2).

Petitioner worked for Respondent for approximately 11 years and his job duties included installation of replacement windows, siding, soffits, etc. In regard to the accident of June 22, 2009, Petitioner testified that shortly after he completed some metal work, he fell down some stairs and sustained an injury to his left foot and left shoulder. Petitioner stated that he informed his boss, Chuck Nichols, of the accident that same day. However, Petitioner did not seek any medical treatment after the accident of June 22, 2009, and, other than the remainder of that workday, Petitioner did not miss any time from work as a result of that accident.

In regard to the accident of August 4, 2010, Petitioner testified that he was on a trailer and was in the process of bending some metal that was to be placed on windows. When Petitioner stepped off of the trailer, he stepped on a stool and fell landing on his left shoulder, striking his head and twisting his left ankle.

Subsequent to the accident of August 4, 2010, Petitioner sought medical treatment at the ER of Sarah Bush Lincoln Health Center where he was seen by Dr. Joseph Burton. According to Dr. Burton's records, Petitioner turned/rolled his left ankle. In addition to the left ankle/heel pain, Petitioner had "minimal tenderness in the left trapezius area." Petitioner also denied any "spine pain." Dr. Burton ordered x-rays which were negative for any fracture and he diagnosed Petitioner as having sustained an acute left ankle/foot sprain. Dr. Burton recommended Petitioner use an Ace bandage and follow-up with his primary care physician (Petitioner's Exhibit 4).

The ER records of August 4, 2010, also contained entries made by Christy Klingler, an RN. One of those entries contained a statement that Petitioner also felt a sharp pain in his neck and left shoulder which he rated as 6/10. As previously noted, the record completed by Dr. Burton did not make any reference to Petitioner having any neck symptoms (Petitioner's Exhibit 4).

At trial, Petitioner testified that he advised his boss, Chuck Nichols, of the accident of August 4, 2010, sometime after he was seen in the ER. Petitioner stated that Nichols came to his residence the following day and informed him that he could either resign or be fired. Petitioner refused to resign and Nichols fired him. Petitioner stated that he has not worked at all since August 5, 2010.

Petitioner testified that on August 10, 2010, he was at the house of a friend who was replacing a floor in a bathroom. Petitioner gave his friend directions on how to remove the floor and then cut the plywood for the under surface of the floor. Petitioner specifically denied that he participated in any cutting of the plywood. Petitioner stated that he went home for lunch and began to feel "fuzzy." When another friend of his knocked at the front door, Petitioner got up to answer the door, but felt dizzy. Petitioner then proceeded to get on his knees and crawled to the door and when he placed his right hand on the doorknob and placed his shoulder against the door, he passed out. Petitioner stated that he did not strike either his head or neck.

Following the preceding incident, Petitioner was again seen in the ER of Sarah Bush Lincoln Health Center on August 10, 2010. According to the ER records, Petitioner had a syncopal event after being outside for approximately one hour helping some friends cut some plywood. Petitioner returned to his home, drank some water and passed out when he attempted to stand. It was noted that Petitioner had hypertension and a long history of cigarette smoking. Findings on clinical examination (which included the neck) were benign and various lab tests were ordered (Petitioner's Exhibit 11).

On August 18, 2010, Petitioner was seen at the Occupational Health Department of Sarah Bush Lincoln Health Center by Stacey Harminson, PA-C. At that time, Petitioner informed PA Harminson that on August 4, 2010, he sustained an injury to his left foot/ankle when he stepped off of a trailer and onto a stool. Petitioner also stated that when he fell he landed on his left side and had neck and anterior chest pain since the fall. Harminson opined that Petitioner had a left ankle sprain, trapezius strain and a left anterior chest wall strain (Petitioner's Exhibit 12).

Petitioner was subsequently seen by PA Harminson on September 1 and September 17, 2010. Because of Petitioner's neck complaints, she ordered an MRI scan which was performed on September 22, 2010. The scan revealed disc bulges at C5-C6 and C6-C7. When PA Harminson saw Petitioner on September 24, 2010, she referred Petitioner to Dr. Terrence Pencek, a neurosurgeon, for further evaluation of the neck. In regard to the left ankle, Harminson ordered x-rays of the ankle which were negative. On examination, the range of motion of the ankle was full and there was no swelling (Petitioner's Exhibit 12).

Dr. Pencek initially saw Petitioner on November 5, 2010. According to his record of that date, Petitioner fell while walking when his foot hit a stool which caused him to fall onto his left side. Petitioner fell down a flight of stairs and experienced neck pain which worsened. Dr. Pencek reviewed the MRI and opined that Petitioner had severe cervical stenosis at C5-C6 and C6-C7. He recommended Petitioner have surgery consisting of a discectomy and fusion at both levels (Petitioner's Exhibit 6).

At the direction of Respondent, Petitioner was examined by Dr. Richard Lehman, an orthopedic surgeon, on May 5, 2011. In connection with his examination of Petitioner, Dr. Lehman

reviewed medical records provided to him by Respondent which included the records of August, 2010, from Sarah Bush Lincoln Health Center. Dr. Lehman's findings on examination of the left ankle were normal. He opined that Petitioner sustained a soft tissue injury to the left ankle which would have resolved approximately six weeks. In regard to the cervical spine, Dr. Lehman opined that Petitioner had spinal stenosis and pre-existing degenerative arthritis. Dr. Lehman noted that Petitioner did not have cervical spine symptoms on August 4, 2010, but had cervical spine symptoms on August 18, 2010. He opined that Petitioner's cervical spine condition was not related to either the accident of June 22, 2009, or August 4, 2010 (Respondent's Exhibit 2).

Petitioner was again seen by Dr. Pencek on June 30, 2011. At that time, Petitioner still had pain in the neck and left shoulder. Dr. Pencek stated that he was going to proceed with the cervical spine surgery he had previously recommended (Petitioner's Exhibit 14).

Dr. Pencek performed surgery on July 20, 2011, and the procedure consisted of a discectomy and fusion with metal hardware at C5-C6 and C6-C7. Following surgery, Dr. Pencek prescribed a bone stimulator and ordered physical therapy and work hardening. When Dr. Pencek saw Petitioner on December 27, 2011, Petitioner advised that it was too painful for him to continue work hardening. Petitioner also stated that he complained of neck pain when in the ER in August, 2010, but that the doctor only wrote down his foot complaints. Dr. Pencek recommended that Petitioner have a CT scan to determine if there was a pseudoarthrosis (Petitioner's Exhibit 14).

At Respondent's request, Dr. Lehman reviewed medical records for treatment Petitioner had received subsequent to his examination of May 5, 2011, and he prepared a supplemental report dated January 31, 2012, regarding same. In respect to the physical therapy records, Dr. Lehman noted that in October, 2011, Petitioner experienced discomfort when he was lifting laundry out of a washing machine and also experienced neck discomfort when he lifted a snake that weighed approximately 80 pounds to get it back in its cage. Dr. Lehman opined that these activities were outside his restrictions and that they had the effect of lengthening the time of his treatment and recovery (Respondent's Exhibit 2).

At trial, Petitioner was questioned about the preceding. He agreed that he stressed his neck while removing laundry. In regard to his lifting of the snake, Petitioner stated that he had a pet snake that weighed about 50 pounds which had escaped from its cage. Petitioner testified that he and a friend lifted the snake and put it back in its cage. He stated that this did cause some increase of his neck pain, but had no permanent effect on his condition.

On June 10, 2013, Petitioner had a CT scan and x-rays of the cervical spine performed. The CT scan revealed foraminal stenosis at C5-C6 and C6-C7, but no evidence of spinal cord or nerve root impingement. X-rays revealed the post-operative changes but no observed motion between flexion and extension (Petitioner's Exhibit 15).

At the direction of his attorney, Petitioner was examined by Dr. Samuel Chmell, an orthopedic surgeon, on January 18, 2014. In connection with his examination of Petitioner, Dr. Chmell reviewed diagnostic studies and medical records provided to him by Petitioner's counsel. At that time, Petitioner informed Dr. Chmell that he fell down some stairs in June, 2009, and injured his

left ankle and left shoulder. He also informed Dr. Chmell that he injured his left shoulder, left ankle and neck/cervical spine in August, 2010, when he stepped off of the trailer at work, stepped on a stool and fell to the ground. Petitioner did not inform Dr. Chmell of anything else that occurred in August, 2010 (Petitioner's Exhibit 8; Deposition Exhibit 2).

Dr. Chmell examined Petitioner's cervical spine and left foot/ankle. The examination of the cervical spine revealed a markedly reduced range of motion, loss of cervical lordosis and muscular spasm. The examination of the left foot/ankle revealed a reduced range of motion and soft tissue swelling. Dr. Chmell opined that Petitioner had sustained serious injuries to the left ankle and shoulder on June 22, 2009, and serious injuries to the left shoulder, left ankle and cervical spine on August 4, 2010. In regard to causality, Dr. Chmell opined that Petitioner had sustained a traumatic aggravation of degenerative disc disease of the cervical spine and disc herniations at C5-C6 and C6-C7. He attributed the need for surgery to the accident of August 4, 2010. He also opined that Petitioner had a failed fusion and that additional cervical spine surgery was indicated. He further opined that Petitioner was totally disabled from any employment (Respondent's Exhibit 8; Deposition Exhibit 2).

At Respondent's request, Dr. Lehman reviewed additional medical records and prepared another supplemental report dated March 7, 2014. Dr. Lehman specifically referenced Petitioner's fainting episode of August 10, 2010, which he opined would be the more likely cause of Petitioner's cervical symptoms than the accident of August 4, 2010. He specifically noted that the medical record of August 10, 2010, noted that Petitioner had been working outside with a friend for about one hour and, that if Petitioner had significant cervical problems, it would have been unlikely that he would have been able to participate in such an activity (Respondent's Exhibit 2).

Dr. Chmell was deposed on December 12, 2014, and his deposition testimony was received into evidence at trial. Dr. Chmell's testimony on direct examination was consistent with his medical report and he reaffirmed the opinions contained therein (Petitioner's Exhibit 8; pp 9-28).

On cross-examination, Dr. Chmell acknowledged that he had not reviewed any medical records from June 22, 2009, to August 4, 2010, and that his opinion regarding causality in regard to the accident of June 22, 2009, was based solely on the history provided to him by Petitioner and not any medical records. When Dr. Chmell reviewed the ER record of August 4, 2010, he agreed that it did not specifically reference that Petitioner had neck or left shoulder pain, but left trapezius tenderness. He admitted that Petitioner denied any spine pain which would be inclusive of the cervical, thoracic and lumbar spine. He agreed that the only diagnostic studies performed at that time were of the left foot/ankle and that none were performed of either the neck or left shoulder. He also agreed that Petitioner did not inform him of the subsequent fainting episode of August 10, 2010, and that he had been cutting plywood (Petitioner's Exhibit 8; pp 45-49).

Dr. Lehman was deposed over the course of two days, March 30, 2015, and June 30, 2015. Dr. Lehman's testimony on direct examination was consistent with his medical reports and he reaffirmed the opinions contained therein. In regard to causality of Petitioner's neck/cervical spine condition, Dr. Lehman noted the lack of cervical spine complaints on August 4, 2010, and that the MRI subsequently performed was indicative of a long-term degenerative process not an acute process. In regard to Petitioner's fainting episode of August 10, 2010, Dr. Lehman noted

that the medical record stated that Petitioner had been working outside for approximately one hour and had been cutting plywood. He opined that would have been biomechanically impossible for Petitioner to engage in that activity if he had sustained an acute cervical spine injury. Dr. Lehman stated that Petitioner's fainting on August 10, 2010, had the mechanics of an injury which could have aggravated Petitioner's cervical spine condition (Respondent's Exhibit 3; pp 34, 62-63).

Dr. Lehman also testified that his examination of Petitioner's left ankle was normal, there was no loss of range of motion or swelling and the ankle was stable. He opined that Petitioner's left ankle sprain had resolved. He also opined that an ankle sprain would have resolved in approximately six weeks following the injury (Respondent's Exhibit 3; pp 30-32, 37).

On cross-examination, Dr. Lehman was questioned about the entry in the ER record of August 4, 2010, made by Christy Klingler where she stated that Petitioner had neck and left shoulder pain 6/10. Dr. Lehman testified that Petitioner had some complaints in the trapezius; however, no x-rays were ordered or taken of either Petitioner's left shoulder or neck. While the ER record contained this one reference to neck complaints, Dr. Lehman opined that this was not of any relevance because Petitioner was not worked up for any cervical spine issues at that time. Dr. Lehman also noted that the record from Dr. Burton stated that Petitioner's chief complaint was the left foot and ankle and that Petitioner denied any spine pain (Respondent's Exhibit 4; pp 20-24, 52-53).

At trial, Petitioner testified that he still has significant complaints in the neck and left foot/ankle and he wants further medical treatment including the surgery recommended by Dr. Chmell. Petitioner also stated that he has not been able to return to any type of work since the accident of August 4, 2010.

There were disputes regarding the computation of Petitioner's average weekly wage in both cases. In case number 11 WC 04724, Petitioner alleged an average weekly wage of $360.00 and Respondent claimed that it was $306.44. In case number 10 WC 33190, Petitioner alleged an average weekly wage of $380.00 and Respondent claimed that it was $306.44 (Arbitrator's Exhibits 1 and 2).

At trial, Petitioner testified that he was paid $9.50 per hour, that the work was seasonal and that he worked 40 hours per week. This was the basis for Petitioner's claim of an average weekly wage of $380.00. Respondent tendered into evidence a wage statement for Petitioner's earnings from August 3, 2009, through August 5, 2010. This statement indicated that Petitioner's hourly rate was $9.00 until July 10, 2010, when it was raised in $9.50 per hour. Petitioner's total earnings for that period of time which excluded some overtime was $8,273.75. Because of the seasonal nature of the work, Petitioner worked 27 weeks during that period. This was the basis for Respondent's position that Petitioner had an average weekly wage of $306.44, $8,273.75 divided by 27 weeks (Respondent's Exhibit 6).

Petitioner also sought payment of medical bills and reimbursement for some prescription medications pertaining to his neck condition that amounted to $4,807.69 (Petitioner's Exhibits 10 and 16). Petitioner also sought reimbursement of $500.00 for payments he made to a friend to

drive him to/from physical therapy because he did not have a vehicle of his own. Petitioner did not produce any evidence/documentation of this claim.

Petitioner also sought payment of an additional $191.17 (the amount claimed on the stip sheet) for expenses incurred by him in connection with his Section 12 examination of May 5, 2011, by Dr. Lehman. Petitioner tendered into evidence a receipt from Enterprise Rent-A-Car for vehicle rental from May 4, through May 7, 2011, for $232.62; a receipt from Golden Corral for a meal for Petitioner and his family for $30.56; a receipt for snacks for $13.54; and gas receipts for $72.00, $28.26, and $25.00. These receipts totaled $401.72. Respondent had previously paid Petitioner $210.00 to cover his travel expenses meaning that the actual disputed amount was $191.72 (Petitioner's Exhibit 19).

At trial, Petitioner testified that Enterprise was the cheapest car rental. He drove to his daughter's residence in Springfield. She then drove Petitioner along with her children (because she did not have a babysitter) and back the following day. Petitioner then drove back to his residence the next day. Petitioner stated that he used this procedure because his neck condition made it difficult for him to drive a long distance and that is why he sought the assistance of his daughter.

Respondent claimed a credit for temporary total disability benefits of $12,944.61. Petitioner disputed same and, when questioned by the Arbitrator at trial, he stated that, according to his computations, Respondent was actually entitled to a credit of approximately $200.00 less. At trial, Respondent tendered into evidence a print out of benefits paid. On August 5, 2011, Petitioner received an advance of permanent partial disability in the amount of $1,962.64. There were further payments made by Respondent to Petitioner of $10,981.97, for total of $12,944.61 (Respondent's Exhibit 5).

Conclusions of Law

In regard to disputed issues (C) and (E) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner sustained a work-related accident on August 4, 2010, and that he gave notice to Respondent within the time prescribed by the Act.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony regarding how he sustained the accident of August 4, 2010, and his giving notice to Respondent was unrebutted.

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

The Arbitrator concludes that Petitioner's current condition of ill-being in regard to the left foot/ankle is related to the accident of August 4, 2010, but that Petitioner's current condition of ill-being in regard to the neck/cervical spine is not related to the accident of August 4, 2010.

In support of this conclusion the Arbitrator notes the following:

It was undisputed that Petitioner sustained a left ankle strain/sprain as a result of the accident of August 4, 2010. The nature and extent of the injury has yet to be determined.

The ER records of August 4, 2010, as prepared by Dr. Burton, only referred to Petitioner having sustained an injury to his left foot/ankle and that he had minimal tenderness in the left trapezius area. There was no reference to Petitioner having any neck symptoms. Although the ER record does contain an entry prepared by an RN which stated that Petitioner had neck pain, Dr. Burton's record specifically noted that Petitioner denied any spine pain.

The medical record of August 10, 2010, regarding Petitioner's fainting episode noted that he been cutting plywood at a friend's home. Petitioner's testimony that he only provided direction as to how to perform this task was questionable and contrary to the medical record.

It was not until August 18, 2010 (two weeks post-accident) that Petitioner gave a specific history of having injured his neck as a result of the accident of August 4, 2010.

Dr. Lehman examined Petitioner at Respondent's request and reviewed various medical records. In addition to noting the lack of any neck symptoms or any work-up or diagnostic procedures in regard to the neck on August 4, 2010, Dr. Lehman opined that if Petitioner had, in fact, sustained an acute neck injury on August 4, 2010, it would have been impossible for him to engage in the activity of cutting plywood on August 10, 2010. Further, Dr. Lehman opined that the mechanics of Petitioner's fainting on August 10, 2010, could have aggravated the underlying cervical spine condition.

While Dr. Chmell opined that Petitioner's cervical/neck condition was related to the accident of August 4, 2010, it is relevant to note that Petitioner never informed him of the fainting incident that occurred on August 10, 2010.

The Arbitrator finds the opinion of Dr. Lehman to be more persuasive than that of Dr. Chmell.

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

The Arbitrator concludes that Petitioner had an average weekly wage of $306.44.

In support of this conclusion the Arbitrator notes the following:

Petitioner's earnings for the 27 weeks in which he worked for the year preceding the date of accident, excluding overtime, amounted to $8,273.75; $8,273.75 divided by 27 weeks equals $306.44 per week.

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

The Arbitrator concludes that Respondent is not responsible for the medical bills tendered into evidence at trial. Further, Respondent is not responsible for reimbursement to Petitioner for travel expenses purportedly incurred by him going to/from physical therapy.

In support of this conclusion the Arbitrator notes the following:

The medical bills tendered were for treatment Petitioner received because of his neck/cervical spine condition which the Arbitrator has found not to be causally related to the accident of August 4, 2010. In regard to Petitioner's claim for reimbursement of $500.00 for travel to/from physical therapy, Petitioner tendered no evidence other than his testimony regarding same.

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

Based upon the Arbitrator's conclusion of law in disputed issue (F) the Arbitrator concludes that Petitioner is not entitled to prospective medical treatment.

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

The Arbitrator concludes that Petitioner is entitled to temporary total disability benefits of seven and two-sevenths (7 2/7) weeks commencing August 5, 2010, through September 24, 2010.

In support of this conclusion the Arbitrator notes the following:

Petitioner was under medical treatment for his left ankle sprain and was not working. When seen on September 24, 2010, the examination Petitioner's left ankle was normal.

Dr. Lehman opined that Petitioner's left ankle sprain would have resolved in approximately six weeks.

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

Based upon the Arbitrator's conclusion of law in disputed issue (F) the Arbitrator concludes Petitioner is not entitled to penalties and attorneys' fees.

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

The Arbitrator concludes that Respondent is entitled to a credit of $12,944.61.

In support of this conclusion the Arbitrator notes the following:

As noted herein, Respondent tendered into evidence a record of the payments made which indicated that Respondent had paid Petitioner payments that totaled $12,944.61.

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

The Arbitrator concludes that Petitioner is not entitled to any further reimbursement for expenses incurred in connection with the Section 12 examination by Dr. Lehman.

In support of this conclusion the Arbitrator notes the following:

Petitioner did not show that a three-day car rental was necessary for a Section 12 examination that took a portion of one day. The gasoline expense submitted would have been included in the mileage amount Petitioner received.

Further, Respondent is not responsible for providing meals and refreshments for other members of Petitioner's family that accompanied him during said examination.

William R. Gallagher, Arbitrator

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

SINDE, RONALD D
Employee/Petitioner

Case# **11WC004724**

10WC033190

NICHOLD SIDING & WINDOWS
Employer/Respondent

16IWCC0746

On 1/5/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0393 THOMAS R LICHTEN LTD
53 W JACKSON BLVD
SUITE 1634
CHICAGO, IL 60604

2593 GANAN & SHAPIRO PC
TIMOTHY STEIL
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Ronald D. Sinde
Employee/Petitioner

v.

Nichols Siding & Windows
Employer/Respondent

Case # 11 WC 04724

Consolidated cases: 10 WC 33190

16IWCC0746

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on November 20, 2015. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, June 22, 2009, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $n/a; the average weekly wage was $n/a.

On the date of accident, Petitioner was 47 years of age, single with 0 dependent child(ren).

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

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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

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

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

William R. Gallagher

William R. Gallagher, Arbitrator
ICArbDec19(b)

December 28, 2015
Date

JAN 5 - 2016

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim which alleged he sustained accidental injuries arising out of and in the course of his employment for Respondent. In case number 11 WC 04724, the Application alleged that Petitioner sustained a work-related accident on June 22, 2009, that caused injuries to the "Head, neck, left foot and ankle, body." In case number 10 WC 33190, the Application alleged that Petitioner fell from the back of a truck on August 4, 2010, and sustained injuries to the "Left ankle/foot trapezius/MAW, left anterior chest wall/MAW." (Arbitrator's Exhibits 3 and 4).

The two cases were previously consolidated for trial and were heard in a 19(b) proceeding wherein Petitioner sought an order for payment of medical bills, travel expenses, temporary total disability benefits as well as prospective medical treatment. Petitioner also filed a Petition for Section 19(k) and Section 19(l) penalties and Section 16 attorneys' fees. Respondent disputed liability in both cases on the basis of accident, notice and causal relationship. Respondent also disputed the average weekly wage alleged by Petitioner. Finally, there was also a dispute as to the amount of credit Respondent was entitled to for payment of compensation benefits (Arbitrator's Exhibits 1 and 2).

Petitioner worked for Respondent for approximately 11 years and his job duties included installation of replacement windows, siding, soffits, etc. In regard to the accident of June 22, 2009, Petitioner testified that shortly after he completed some metal work, he fell down some stairs and sustained an injury to his left foot and left shoulder. Petitioner stated that he informed his boss, Chuck Nichols, of the accident that same day. However, Petitioner did not seek any medical treatment after the accident of June 22, 2009, and, other than the remainder of that workday, Petitioner did not miss any time from work as a result of that accident.

In regard to the accident of August 4, 2010, Petitioner testified that he was on a trailer and was in the process of bending some metal that was to be placed on windows. When Petitioner stepped off of the trailer, he stepped on a stool and fell landing on his left shoulder, striking his head and twisting his left ankle.

Subsequent to the accident of August 4, 2010, Petitioner sought medical treatment at the ER of Sarah Bush Lincoln Health Center where he was seen by Dr. Joseph Burton. According to Dr. Burton's records, Petitioner turned/rolled his left ankle. In addition to the left ankle/heel pain, Petitioner had "minimal tenderness in the left trapezius area." Petitioner also denied any "spine pain." Dr. Burton ordered x-rays which were negative for any fracture and he diagnosed Petitioner as having sustained an acute left ankle/foot sprain. Dr. Burton recommended Petitioner use an Ace bandage and follow-up with his primary care physician (Petitioner's Exhibit 4).

The ER records of August 4, 2010, also contained entries made by Christy Klingler, an RN. One of those entries contained a statement that Petitioner also felt a sharp pain in his neck and left shoulder which he rated as 6/10. As previously noted, the record completed by Dr. Burton did not make any reference to Petitioner having any neck symptoms (Petitioner's Exhibit 4).

At trial, Petitioner testified that he advised his boss, Chuck Nichols, of the accident of August 4, 2010, sometime after he was seen in the ER. Petitioner stated that Nichols came to his residence the following day and informed him that he could either resign or be fired. Petitioner refused to resign and Nichols fired him. Petitioner stated that he has not worked at all since August 5, 2010.

Petitioner testified that on August 10, 2010, he was at the house of a friend who was replacing a floor in a bathroom. Petitioner gave his friend directions on how to remove the floor and then cut the plywood for the under surface of the floor. Petitioner specifically denied that he participated in any cutting of the plywood. Petitioner stated that he went home for lunch and began to feel "fuzzy." When another friend of his knocked at the front door, Petitioner got up to answer the door, but felt dizzy. Petitioner then proceeded to get on his knees and crawled to the door and when he placed his right hand on the doorknob and placed his shoulder against the door, he passed out. Petitioner stated that he did not strike either his head or neck.

Following the preceding incident, Petitioner was again seen in the ER of Sarah Bush Lincoln Health Center on August 10, 2010. According to the ER records, Petitioner had a syncopal event after being outside for approximately one hour helping some friends cut some plywood. Petitioner returned to his home, drank some water and passed out when he attempted to stand. It was noted that Petitioner had hypertension and a long history of cigarette smoking. Findings on clinical examination (which included the neck) were benign and various lab tests were ordered (Petitioner's Exhibit 11).

On August 18, 2010, Petitioner was seen at the Occupational Health Department of Sarah Bush Lincoln Health Center by Stacey Harminson, PA-C. At that time, Petitioner informed PA Harminson that on August 4, 2010, he sustained an injury to his left foot/ankle when he stepped off of a trailer and onto a stool. Petitioner also stated that when he fell he landed on his left side and had neck and anterior chest pain since the fall. Harminson opined that Petitioner had a left ankle sprain, trapezius strain and a left anterior chest wall strain (Petitioner's Exhibit 12).

Petitioner was subsequently seen by PA Harminson on September 1 and September 17, 2010. Because of Petitioner's neck complaints, she ordered an MRI scan which was performed on September 22, 2010. The scan revealed disc bulges at C5-C6 and C6-C7. When PA Harminson saw Petitioner on September 24, 2010, she referred Petitioner to Dr. Terrence Pencek, a neurosurgeon, for further evaluation of the neck. In regard to the left ankle, Harminson ordered x-rays of the ankle which were negative. On examination, the range of motion of the ankle was full and there was no swelling (Petitioner's Exhibit 12).

Dr. Pencek initially saw Petitioner on November 5, 2010. According to his record of that date, Petitioner fell while walking when his foot hit a stool which caused him to fall onto his left side. Petitioner fell down a flight of stairs and experienced neck pain which worsened. Dr. Pencek reviewed the MRI and opined that Petitioner had severe cervical stenosis at C5-C6 and C6-C7. He recommended Petitioner have surgery consisting of a discectomy and fusion at both levels (Petitioner's Exhibit 6).

At the direction of Respondent, Petitioner was examined by Dr. Richard Lehman, an orthopedic surgeon, on May 5, 2011. In connection with his examination of Petitioner, Dr. Lehman

reviewed medical records provided to him by Respondent which included the records of August, 2010, from Sarah Bush Lincoln Health Center. Dr. Lehman's findings on examination of the left ankle were normal. He opined that Petitioner sustained a soft tissue injury to the left ankle which would have resolved approximately six weeks. In regard to the cervical spine, Dr. Lehman opined that Petitioner had spinal stenosis and pre-existing degenerative arthritis. Dr. Lehman noted that Petitioner did not have cervical spine symptoms on August 4, 2010, but had cervical spine symptoms on August 18, 2010. He opined that Petitioner's cervical spine condition was not related to either the accident of June 22, 2009, or August 4, 2010 (Respondent's Exhibit 2).

Petitioner was again seen by Dr. Pencek on June 30, 2011. At that time, Petitioner still had pain in the neck and left shoulder. Dr. Pencek stated that he was going to proceed with the cervical spine surgery he had previously recommended (Petitioner's Exhibit 14).

Dr. Pencek performed surgery on July 20, 2011, and the procedure consisted of a discectomy and fusion with metal hardware at C5-C6 and C6-C7. Following surgery, Dr. Pencek prescribed a bone stimulator and ordered physical therapy and work hardening. When Dr. Pencek saw Petitioner on December 27, 2011, Petitioner advised that it was too painful for him to continue work hardening. Petitioner also stated that he complained of neck pain when in the ER in August, 2010, but that the doctor only wrote down his foot complaints. Dr. Pencek recommended that Petitioner have a CT scan to determine if there was a pseudoarthrosis (Petitioner's Exhibit 14).

At Respondent's request, Dr. Lehman reviewed medical records for treatment Petitioner had received subsequent to his examination of May 5, 2011, and he prepared a supplemental report dated January 31, 2012, regarding same. In respect to the physical therapy records, Dr. Lehman noted that in October, 2011, Petitioner experienced discomfort when he was lifting laundry out of a washing machine and also experienced neck discomfort when he lifted a snake that weighed approximately 80 pounds to get it back in its cage. Dr. Lehman opined that these activities were outside his restrictions and that they had the effect of lengthening the time of his treatment and recovery (Respondent's Exhibit 2).

At trial, Petitioner was questioned about the preceding. He agreed that he stressed his neck while removing laundry. In regard to his lifting of the snake, Petitioner stated that he had a pet snake that weighed about 50 pounds which had escaped from its cage. Petitioner testified that he and a friend lifted the snake and put it back in its cage. He stated that this did cause some increase of his neck pain, but had no permanent effect on his condition.

On June 10, 2013, Petitioner had a CT scan and x-rays of the cervical spine performed. The CT scan revealed foraminal stenosis at C5-C6 and C6-C7, but no evidence of spinal cord or nerve root impingement. X-rays revealed the post-operative changes but no observed motion between flexion and extension (Petitioner's Exhibit 15).

At the direction of his attorney, Petitioner was examined by Dr. Samuel Chmell, an orthopedic surgeon, on January 18, 2014. In connection with his examination of Petitioner, Dr. Chmell reviewed diagnostic studies and medical records provided to him by Petitioner's counsel. At that time, Petitioner informed Dr. Chmell that he fell down some stairs in June, 2009, and injured his

left ankle and left shoulder. He also informed Dr. Chmell that he injured his left shoulder, left ankle and neck/cervical spine in August, 2010, when he stepped off of the trailer at work, stepped on a stool and fell to the ground. Petitioner did not inform Dr. Chmell of anything else that occurred in August, 2010 (Petitioner's Exhibit 8; Deposition Exhibit 2).

Dr. Chmell examined Petitioner's cervical spine and left foot/ankle. The examination of the cervical spine revealed a markedly reduced range of motion, loss of cervical lordosis and muscular spasm. The examination of the left foot/ankle revealed a reduced range of motion and soft tissue swelling. Dr. Chmell opined that Petitioner had sustained serious injuries to the left ankle and shoulder on June 22, 2009, and serious injuries to the left shoulder, left ankle and cervical spine on August 4, 2010. In regard to causality, Dr. Chmell opined that Petitioner had sustained a traumatic aggravation of degenerative disc disease of the cervical spine and disc herniations at C5-C6 and C6-C7. He attributed the need for surgery to the accident of August 4, 2010. He also opined that Petitioner had a failed fusion and that additional cervical spine surgery was indicated. He further opined that Petitioner was totally disabled from any employment (Respondent's Exhibit 8; Deposition Exhibit 2).

At Respondent's request, Dr. Lehman reviewed additional medical records and prepared another supplemental report dated March 7, 2014. Dr. Lehman specifically referenced Petitioner's fainting episode of August 10, 2010, which he opined would be the more likely cause of Petitioner's cervical symptoms than the accident of August 4, 2010. He specifically noted that the medical record of August 10, 2010, noted that Petitioner had been working outside with a friend for about one hour and, that if Petitioner had significant cervical problems, it would have been unlikely that he would have been able to participate in such an activity (Respondent's Exhibit 2).

Dr. Chmell was deposed on December 12, 2014, and his deposition testimony was received into evidence at trial. Dr. Chmell's testimony on direct examination was consistent with his medical report and he reaffirmed the opinions contained therein (Petitioner's Exhibit 8; pp 9-28).

On cross-examination, Dr. Chmell acknowledged that he had not reviewed any medical records from June 22, 2009, to August 4, 2010, and that his opinion regarding causality in regard to the accident of June 22, 2009, was based solely on the history provided to him by Petitioner and not any medical records. When Dr. Chmell reviewed the ER record of August 4, 2010, he agreed that it did not specifically reference that Petitioner had neck or left shoulder pain, but left trapezius tenderness. He admitted that Petitioner denied any spine pain which would be inclusive of the cervical, thoracic and lumbar spine. He agreed that the only diagnostic studies performed at that time were of the left foot/ankle and that none were performed of either the neck or left shoulder. He also agreed that Petitioner did not inform him of the subsequent fainting episode of August 10, 2010, and that he had been cutting plywood (Petitioner's Exhibit 8; pp 45-49).

Dr. Lehman was deposed over the course of two days, March 30, 2015, and June 30, 2015. Dr. Lehman's testimony on direct examination was consistent with his medical reports and he reaffirmed the opinions contained therein. In regard to causality of Petitioner's neck/cervical spine condition, Dr. Lehman noted the lack of cervical spine complaints on August 4, 2010, and that the MRI subsequently performed was indicative of a long-term degenerative process not an acute process. In regard to Petitioner's fainting episode of August 10, 2010, Dr. Lehman noted

that the medical record stated that Petitioner had been working outside for approximately one hour and had been cutting plywood. He opined that would have been biomechanically impossible for Petitioner to engage in that activity if he had sustained an acute cervical spine injury. Dr. Lehman stated that Petitioner's fainting on August 10, 2010, had the mechanics of an injury which could have aggravated Petitioner's cervical spine condition (Respondent's Exhibit 3; pp 34, 62-63).

Dr. Lehman also testified that his examination of Petitioner's left ankle was normal, there was no loss of range of motion or swelling and the ankle was stable. He opined that Petitioner's left ankle sprain had resolved. He also opined that an ankle sprain would have resolved in approximately six weeks following the injury (Respondent's Exhibit 3; pp 30-32, 37).

On cross-examination, Dr. Lehman was questioned about the entry in the ER record of August 4, 2010, made by Christy Klingler where she stated that Petitioner had neck and left shoulder pain 6/10. Dr. Lehman testified that Petitioner had some complaints in the trapezius; however, no x-rays were ordered or taken of either Petitioner's left shoulder or neck. While the ER record contained this one reference to neck complaints, Dr. Lehman opined that this was not of any relevance because Petitioner was not worked up for any cervical spine issues at that time. Dr. Lehman also noted that the record from Dr. Burton stated that Petitioner's chief complaint was the left foot and ankle and that Petitioner denied any spine pain (Respondent's Exhibit 4; pp 20-24, 52-53).

At trial, Petitioner testified that he still has significant complaints in the neck and left foot/ankle and he wants further medical treatment including the surgery recommended by Dr. Chmell. Petitioner also stated that he has not been able to return to any type of work since the accident of August 4, 2010.

There were disputes regarding the computation of Petitioner's average weekly wage in both cases. In case number 11 WC 04724, Petitioner alleged an average weekly wage of $360.00 and Respondent claimed that it was $306.44. In case number 10 WC 33190, Petitioner alleged an average weekly wage of $380.00 and Respondent claimed that it was $306.44 (Arbitrator's Exhibits 1 and 2).

At trial, Petitioner testified that he was paid $9.50 per hour, that the work was seasonal and that he worked 40 hours per week. This was the basis for Petitioner's claim of an average weekly wage of $380.00. Respondent tendered into evidence a wage statement for Petitioner's earnings from August 3, 2009, through August 5, 2010. This statement indicated that Petitioner's hourly rate was $9.00 until July 10, 2010, when it was raised in $9.50 per hour. Petitioner's total earnings for that period of time which excluded some overtime was $8,273.75. Because of the seasonal nature of the work, Petitioner worked 27 weeks during that period. This was the basis for Respondent's position that Petitioner had an average weekly wage of $306.44, $8,273.75 divided by 27 weeks (Respondent's Exhibit 6).

Petitioner also sought payment of medical bills and reimbursement for some prescription medications pertaining to his neck condition that amounted to $4,807.69 (Petitioner's Exhibits 10 and 16). Petitioner also sought reimbursement of $500.00 for payments he made to a friend to

drive him to/from physical therapy because he did not have a vehicle of his own. Petitioner did not produce any evidence/documentation of this claim.

Petitioner also sought payment of an additional $191.17 (the amount claimed on the stip sheet) for expenses incurred by him in connection with his Section 12 examination of May 5, 2011, by Dr. Lehman. Petitioner tendered into evidence a receipt from Enterprise Rent-A-Car for vehicle rental from May 4, through May 7, 2011, for $232.62; a receipt from Golden Corral for a meal for Petitioner and his family for $30.56; a receipt for snacks for $13.54; and gas receipts for $72.00, $28.26, and $25.00. These receipts totaled $401.72. Respondent had previously paid Petitioner $210.00 to cover his travel expenses meaning that the actual disputed amount was $191.72 (Petitioner's Exhibit 19).

At trial, Petitioner testified that Enterprise was the cheapest car rental. He drove to his daughter's residence in Springfield. She then drove Petitioner along with her children (because she did not have a babysitter) and back the following day. Petitioner then drove back to his residence the next day. Petitioner stated that he used this procedure because his neck condition made it difficult for him to drive a long distance and that is why he sought the assistance of his daughter.

Respondent claimed a credit for temporary total disability benefits of $12,944.61. Petitioner disputed same and, when questioned by the Arbitrator at trial, he stated that, according to his computations, Respondent was actually entitled to a credit of approximately $200.00 less. At trial, Respondent tendered into evidence a print out of benefits paid. On August 5, 2011, Petitioner received an advance of permanent partial disability in the amount of $1,962.64. There were further payments made by Respondent to Petitioner of $10,981.97, for total of $12,944.61 (Respondent's Exhibit 5).

Conclusions of Law

In regard to disputed issues (C) and (E) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner sustained a work-related accident on June 22, 2009, and that he gave notice to Respondent within the time prescribed by the Act.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony regarding the accident of June 22, 2009, and his giving notice to Respondent was unrebutted.

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

The Arbitrator concludes that Petitioner's current condition of ill-being is not related to the accident of June 22, 2009.

In support of this conclusion the Arbitrator notes the following:

Petitioner did not seek any medical treatment and, other than the remainder of the workday the accident occurred on, Petitioner lost no time from work.

Because of the preceding, Dr. Chmell's opinion that Petitioner sustained a "serious injury" on June 22, 2009, was not credible.

In regard to disputed issues (G) and (K) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issue (F).

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

Based upon the Arbitrator's conclusion of law in disputed issue (F) the Arbitrator concludes that Petitioner is not entitled to penalties or attorneys' fees.

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

ANGELA COWELL,

Petitioner,

vs. NO: 11 WC 30743

STATE OF ILLINOIS,
MENARD CORRECTIONAL CENTER

16IWCC0747

Respondent.

DECISION AND OPINION ON REVIEW PURSUANT TO §19(h)/8(a) OF THE ACT

This matter comes before the Commission pursuant to Petitioner's §19(h)/8(a) Petition. Procedurally, this matter was tried before Arbitrator Gallagher on September 17, 2012. The arbitrator found that Cowell sustained a work-related injury on July 21, 2011 when she was carrying a bundle of heavy papers and experienced pain in her right shoulder and back. The arbitrator awarded all reasonable and necessary medical expenses and found that petitioner sustained 3% loss of use of the man-as-a-whole.

The Respondent and petitioner appealed to the Commission. In its Decision dated November 1, 2013, Commissioner Daniel Donohoo, along with Commissioners Basurto and Gore affirmed and adopted the Decision of the Arbitrator.

Petitioner's attorney subsequently filed its §19(h)/8(a) Petition on May 6, 2014. The §8(a) Petition was argued before Commissioner Joshua Luskin on May 29, 2015. At hearing, Petitioner asked the Commission to award continued treatment with Dr. Steven Granberg, a referral to Dr. Paletta, and payment of unpaid medical expenses.

During the May 29, 2015 hearing, Cowell testified that her symptoms have been continuous and have gotten worse since the accident. She has a burning feeling in the middle of her back that shoots up her arm and neck. T.6. She has also treated with Dr. Steven Granberg of Millennium Pain Management. T.7. She has not sustained any additional accidents and Respondent has not sent her for a Section 12 examination. T.9. She completed her Master's degree and now works as a therapist for DHS.

Since the original arbitrator hearing, Cowell underwent a series of three suprascapular nerve blocks and trigger point injections on October 15, 2012, August 19, 2013, and February 12, 2014. During the examination portion of those visits, Cowell reported continued upper back and right shoulder pain, which she described as moderate but a constant, burning type pain. The diagnoses were right shoulder pain, right suprascapular neuropathy, cervicalgia, and myofascial pain. It was further noted that Cowell was diagnosed with lupus and was having a lot of side effects from the medication. PX.5.

Petitioner underwent another series of trigger point injections with Dr. Granberg between April 2014 and May 2014. During her May 21, 2014 visit, Cowell stated that her neck pain radiated into her right shoulder blade. She described her pain as a dull ache that was severe and burning. PX.5.

Cowell testified that she has systemic lupus that affects her organs more than her joints. T.13.

Petitioner's attorney filed its second §19(h)/8(a) Petition on February 2, 2016. The §8(a) portion of the Petition was argued before Commission Ruth White on April 5, 2016. Petitioner asked the Commission to enter an award of prospective medical treatment and payment of outstanding medical expenses.

During the April 5, 2016 hearing, petitioner's attorney indicated that the May 29, 2015 hearing dealt with the injections only, as surgery had not been recommended until September 2015.

Cowell underwent an initial spinal examination with Dr. Matthew Gornet of the Orthopedic Center of St. Louis on July 10, 2015. Petitioner reported right scapular pain, right trapezial pain, and pain into her right shoulder with intermittent tingling in her right arm. She reported that her pain began as a result of her July 21, 2011 work accident. Her symptoms remained constant and low level, but would become more severe with arm activity, reaching, pulling or prolonged fixed head position such as driving or working on a computer. Her symptoms were all right sided. PX.7.

Petitioner underwent a cervical MRI without contrast on July 10, 2015. Dr. Gornet reviewed the MRI and noted that it revealed an obvious annular tear at C5-C6, which, he noted, correlated with petitioner's symptoms. Dr. Gornet noted that based upon the right foraminal

views, it was quite clear that Cowell had a large right sided annular tear that was consistent with her scapular pain and symptoms. There was also a subtle annular tear at C6-C7. Dr. Gornet noted that the August 31, 2011 MRI suggested an annular tear at C5-C6, which was at the same location as the current study. PX.7.

Dr. Gornet opined that Cowell sustained an annular tear in her cervical spine at the time of her injury and her symptoms have never gone away. His diagnosis would easily account for her trapezial pain, her scapular pain, and her intermittent arm symptoms. Her symptoms were not consistent with suprascapular nerve palsy. Dr. Gornet referred Cowell to Dr. Boutwell for C5-C6 and C6-C7 injections. PX.7.

Petitioner underwent a C5-C6 epidural steroid injection on August 6, 2015 and a C6-C7 epidural steroid injection on August 20, 2015. PX.7.

Dr. Gornet recommended a C5-C6 cervical disc replacement on September 10, 2015. PX.7.

Cowell testified that her condition has continued to worsen since the last hearing. Her pain is constant and burning in her shoulder and neck. She has missed work due to her condition. She has to drive a lot for work and it is extremely uncomfortable. She takes Percocet on an as needed basis; however, she cannot take it when she is going to drive. Respondent has not had her undergo a Section 12 examination. T.11. Petitioner denied any new accidents or injury.

Section 8(a) of the Act provides that the claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of claimant's injury. 820 ILCS 305/8(a). An employer's liability under this section of the Act is continuous so long as the medical services are required to relieve the injured employee from the effects of the injury. *Efengee Electrical Supply Co. v. Industrial Comm'n*, 36 Ill. 2d 450, 453, 223 N.E.2d 135 (1967). However, the employee is only entitled to recover for those medical expenses which are reasonable and causally related to her industrial accident. *Zarley v. Industrial Comm'n*, 84 Ill. 2d 380, 389, 418 N.E.2d 717, 49 Ill. Dec. 697 (1981).

Cowell sustained a work-related accident on July 21, 2011 that resulted in an injury to her neck and right shoulder. Following the original decision, Cowell continued to experience neck and shoulder pain as a result of her work accident. She underwent a series of injections and ultimately came under Dr. Gornet's care who ordered an MRI. Dr. Gornet reviewed the MRI and noted that it revealed an obvious tear at C5-C6. He further noted that the tear correlated with petitioner's symptoms and that she was in need of a C5-C6 cervical disc replacement.

The Commission notes that the respondent offered no defense to rebut the reasonableness or necessity of the proposed treatment or of the medical expenses incurred. Respondent's defense is that Cowell's condition is related to her lupus. However, respondent offered no opinion or

16IWCC0747

evidence to support that petitioner's current condition is related to her lupus. Rather, the evidence establishes that Cowell sustained a C5-C6 annular tear as a result of the accident, remains symptomatic as a result, and is now in need of the C5-C6 disc replacement. Dr. Gornet's opinion—the only opinion in this matter—is that the tear and the need for surgery is related to the original accident.

The Commission, therefore, finds that Petitioner is entitled to all reasonable and necessary medical expenses related to the July 21, 2011 work-related accident and is entitled to prospective medical treatment as recommended by Dr. Gornet.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Section §19(h)/8(a) Petition is granted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for prospective medical treatment as recommended by Dr. Gornet.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay all reasonable and necessary medical expenses pursuant to §8(a), and subject to the medical fee schedule.

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

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

DATED: NOV 21 2016

MJB/tdm
O: 10-18-16
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COWELL, ANGELA
Employee/Petitioner

Case# **11WC030743**

ST OF IL/MENARD CORRECTIONAL CENTER
Employer/Respondent

16IWCC0747

On 10/25/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.15% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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

OCT 25 2012

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Angela Cowell
Employee/Petitioner

v.

State of Illinois/Menard Correctional Center
Employer/Respondent

Case # 11 WC 30743

Consolidated cases: n/a

16IWCC0747

An *Application for Adjustment 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 September 17, 2012. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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 $58,356.00; the average weekly wage was $1,122.23.

On the date of accident, Petitioner was 34 years of age, married with 3 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 1 as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule. Respondent shall receive 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 $673.34 per week for 15 weeks because the injuries sustained caused the three percent (3%) loss of use of the body 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

October 22, 2012
Date

OCT 25 2012

Findings of Fact

Petitioner filed an Amended 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 July 21, 2011. According to the Application, Petitioner sustained injuries to the back, neck, body as a whole and the right shoulder/arm as a result of repetitive lifting/traumatic incident while lifting. The Application thereby alleges both repetitive trauma and a specific date of accident. Respondent disputed liability on the basis of accident and causal relationship.

Petitioner testified she worked for Respondent as an OTS Officer and that her job duties required her to do a substantial amount of paperwork in respect to inmate movement. On July 21, 2011, Petitioner was carrying a stack of paperwork which she estimated weighed between 60 and 65 pounds with her right arm and she felt pain and a burning sensation under her right shoulder and back. Immediately following this occurrence, Petitioner obtained some assistance from a Correctional Officer.

Petitioner testified she had no prior right shoulder problems; however, the records from her family physician, Dr. James Krieg, contained an entry dated June 24, 2011, which stated Petitioner had complaints of pain in the "...right arm and shoulder for about 6 weeks unassociated with any particular injury but is aggravated with lifting at work which she does quite of bit down in the prison." Further, Dr. Krieg had x-rays of the right shoulder and cervical spine taken of Petitioner on July 11, 2011, at Memorial Hospital of Carbondale.

The day after the accident, Petitioner was seen by Dr. Krieg and his record of July 22, 2011, stated: "Yesterday she was at work at Menard's when she was lifting a large stack of papers with her right arm. She felt a sharp stabbing pain across her upper right shoulder through to her neck." Dr. Krieg opined Petitioner had right shoulder pain and right cervical radicular symptoms. Dr. Krieg authorized Petitioner to be off work for a couple days and prescribed some medication.

On July 25, 2011, Petitioner was seen at the ER of Sparta Community Hospital primarily for migraine headaches. The record of that date also noted right shoulder and neck pain due to an object falling on the shoulder. The records also stated that the shoulder pain started three to four days ago and that Petitioner was hurt lifting.

On August 17, 2011, Petitioner was seen by Dr. David Raskas and his records stated that on July 24, 2011, Petitioner was lifting a stack of paper that weighed 60 to 65 pounds and she experienced a tearing and ripping sensation in her shoulder and neck. Dr. Raskas recommended MRI's of the right shoulder and cervical spine and referred Petitioner to Dr. George Paletta. Dr. Raskas also authorized Petitioner to continue to work. MRI's of the right shoulder and cervical spine were performed on August 31, 2011. The MRI of the shoulder revealed mild supraspinatus tendinopathic change. The cervical spine MRI was normal. Dr. Raskas saw Petitioner that same day and reviewed the MRI's. He opined Petitioner had shoulder impingement syndrome and cervical radiculopathy.

Petitioner was seen by Dr. George Paletta on September 14, 2011. The history noted in Dr. Paletta's records stated that Petitioner's onset of symptoms dated to late July and that she had to

lift large stacks of paper that weighed 40 to 60 pounds. Dr. Paletta reviewed the MRI of the right shoulder and noted the tendinopathy of the supraspinatus. Because of the presence of radicular symptoms, Dr. Paletta recommended EMG and nerve conduction studies. Dr. Paletta also opined that the right upper extremity condition was causally related to the work activities or aggravated by them.

On referral from Dr. Paletta, Dr. Dan Phillips performed nerve conduction studies on September 19, 2011. Dr. Phillips' record of that date also contained a history of the accident of July 24, 2011. The nerve conduction studies were normal and Dr. Paletta commented that the etiology of Petitioner's pain was unclear and recommended referral to a physiatrist. Dr. Paletta then referred Petitioner to Dr. Steven Granberg who saw her on November 30, 2011.

Dr. Granberg initially saw the Petitioner on November 30, 2011, and his record likewise contained a history of the work accident. He treated Petitioner from that time through June 5, 2012, giving her some nerve blocks and trigger point injections. Petitioner testified that these did provide her with some relief but that she still has a burning type of pain in the right shoulder and she needs assistance from others when doing any lifting of heavy bundles of paper.

Conclusions of Law

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

The Arbitrator finds Petitioner sustained an accidental injury arising out of and in the course of her employment for Respondent on July 21, 2011, when she was carrying a heavy bundle of paper and experienced pain in the right shoulder and back.

In support of this conclusion the Arbitrator notes the following:

The Arbitrator finds Petitioner was a credible witness on her own behalf. Further, the Arbitrator notes that the records of Dr. Krieg, Dr. Raskas, Dr. Paletta, Dr. Phillips and Dr. Granberg all contain a consistent history of the work injury of July, 2011. While Petitioner did have some symptoms of right shoulder pain shortly before the accident, they were not particularly severe.

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

The Arbitrator finds Petitioner's condition of ill-being in the right shoulder and neck is causally related to the accident of July 21, 2011.

In support of this conclusion the Arbitrator notes the following:

The Arbitrator notes the history of the work-related injury was contained in all of Petitioner's treating physicians' records. Further, Dr. Paletta specifically stated that there was a causal relationship between the accident and the condition of ill-being. There was no evidence to the contrary.

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

The Arbitrator finds Respondent is liable for payment of Petitioner's medical bills 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 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator finds Petitioner has sustained permanent partial disability to the extent of three percent (3%) loss of use of the body as a whole.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lori Anderson,
Petitioner,

vs.

NO: 10WC 35907

Dollar Tree, Inc.,
Respondent,

16IWCC0748

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 21, 2015, is hereby affirmed and adopted.

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

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

The party commencing 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: NOV 21 2016
o111616
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ANDERSON, LORI
Employee/Petitioner

Case# **10WC035907**

DOLLAR TREE INC
Employer/Respondent

16IWCC0748

On 7/21/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% 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:

0000 BRISKMAN BRISKMAN & GREENBERG
SUSAN FRANSEN
175 N CHICAGO ST
JOLIET, IL 60432

0208 GALLIANNI DOELL & COZZI LTD
ROBERT J COZZI
20 N CLARK ST 18TH FL
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Lori Anderson
Employee/Petitioner

v.

Dollar Tree, Inc.
Employer/Respondent

Case # **10** WC **35907**

Consolidated cases: **N/A**

16IWCC0748

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **New Lenox**, on **June 2, 2015**. After reviewing all of the evidence presented, the undersigned Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 28, 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 as explained *infra*.

Timely notice of this accident ***was*** given to Respondent as explained *infra*.

Petitioner's current condition of ill-being ***is*** causally related, ***in part***, to the accident as explained *infra*.

In the year preceding the injury, Petitioner earned **$43,218.24**; the average weekly wage was **$831.12**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **no** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services as explained *infra*.

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

Respondent shall be given a credit of **$10,369.05** for TTD, **$0** for TPD, **$0** for maintenance, and **$22,353.53** for other benefits (i.e., long-term disability benefits), for a total credit of **$32,722.58**.

Respondent is entitled to a credit **as reflected in Petitioner's Exhibit 36 and for any amounts reflected in the medical bills** under Section 8(j) of the Act. *See* AX1.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner has established that she sustained a compensable accident at work.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $554.08/week for 19 weeks, commencing June 28, 2010 through November 7, 2010, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from June 28, 2010 through June 4, 2015, and shall pay the remainder of the award, if any, in weekly payments.

As stipulated by the parties, Respondent shall receive credit of $10,369.05 for temporary total disability benefits paid and $22,353.53 for other benefits (i.e., long-term disability benefits), for a total credit of $32,722.58. *See* AX1.

Medical Benefits

Respondent shall pay reasonable and necessary medical services and out-of-pocket expenses reflected in Petitioner's Exhibits related to the low back through June 4, 2013 that remain unpaid to be paid by Respondent pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Petitioner's claim for payment of other medical bills is denied.

As agreed, Respondent shall be given a credit as reflected in Petitioner's Exhibit 36 and for any amounts reflected in the medical bills 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. *See* AX1.

Permanent Partial Disability: Person as a whole (Low Back)

Respondent shall pay Petitioner permanent partial disability benefits of $498.67/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.

Penalties

As explained in the Arbitration Decision Addendum, Petitioner's claim for penalties and fees under Sections 19(k), 19(l) or 16 of the Act is denied.

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

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

Signature of Arbitrator

July 17, 2015
Date

ICArbDec p. 3

JUL 21 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Lori Anderson
Employee/Petitioner

v.

Dollar Tree, Inc.
Employer/Respondent

Case # **10** WC **35907**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute at this hearing include accident, causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement to a period of temporary total disability benefits commencing on commencing June 29, 2010 through June 2, 2015[1], the nature and extent of the injury, and Respondent's liability for penalties and attorney's fees pursuant to Sections 16, 19(k) and 19(l) of the Illinois Workers' Compensation Act. Arbitrator's Exhibit[2] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

Petitioner testified that she was employed by Respondent prior to June 28, 2010 since about 2006. Tr. at 20-21. She was the Receiving Department Manager and then switched to the Shipping Department Manager sometime between 2009 and 2010. *Id.* On the date of accident, Petitioner was a Receiving Department Manager, but working as the Shipping Department Manager because another manager was off of work. Tr. at 21.

Petitioner testified that the duties of both positions were very physical. Tr. at 22. She explained that she had to lift, open, and close shipping doors as well as help load and unload trucks. *Id.* She moved pallets of water with a hand dolly. *Id.* Petitioner also had to bend and twist to scan information from different pallets. *Id.* She worked from 8:00 a.m. until about 3:00 p.m. on the first shift, but explained that most of the time she was there earlier, sometimes around 2:00/3:00 a.m. working sometimes until 3:00/4:00 p.m. Tr. at 23.

Petitioner explained that the shipping department responsibilities included loading the trucks in a timely fashion and making sure all the product pallets—for products too small or too heavy to ride the conveyer belt—were scanned. Tr. at 24. She described a hand-held scanner used for this purpose in which she would type a ZIP code and then scan the bar code. Tr. at 25.

Petitioner also testified on cross examination that around the time of her accident she spent a good part of her day crawling around on her hands and knees because she was in charge of scanning the pallets. Tr. at 60. She explained that in 2010 she spent more than four hours per day on her hands and knees while working in the shipping department. Tr. at 60-61. She also testified that the hours per day that she was on her hands and knees

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[1] Respondent stipulated that Petitioner is only entitled to temporary total disability benefits commencing June 29, 2010 through November 6, 2010. AX1. The parties also stipulated that Respondent is entitled to a credit for temporary total disability paid totaling $10,369.05 as well as $22,353.53 in long term disability benefits paid to Petitioner through Dollar Tree. Tr. at 5-6.

[2] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. Exhibits attached to depositions will be further denominated with "(Dep. Exh. _)." The Arbitration Hearing Transcript is denominated as "Tr." with corresponding page numbers.

depended on the volume that they had, which changed every day such that some days she was so positioned more than four hours per day. Tr. at 61.

June 28, 2010

Petitioner testified that she sustained an accident at work around the beginning of her shift at 6:00/6:30 a.m. Tr. at 25. She testified that she was scanning product bar codes on the pallets near door 55, right in front of the shipping door scanning pallets in an area measuring about eight feet in length. Tr. at 25-26. Petitioner explained that she had to crawl and bend on the floor to scan the UPS labels, which she had to find because the "pickers" that put the product on the line or on the pallet "just throw it on there[.]" Tr. at 26.

With regard to the exact mechanism of injury, Petitioner testified that she was "crawling on the floor looking for bar codes, and then once I finished that pallet that I was working on, I turned around to do the one behind me and I felt something that I had never felt before in my back, sharp shooting pain." Tr. at 27. Petitioner testified that she was holding the scanner at the time and looking over her right shoulder on "all fours and then squatting[,]" when she felt something in her back. Tr. at 27-28.

Petitioner testified that this was something she had not felt before and she ran back to the office, took some Ibuprofen and called the safety manager, Ramona Salliers (phonetic). Tr. at 28. She explained that she told the safety manager that she thought she did something to her back, took some Ibuprofen, and was going to continue working until she heard from her. *Id.* Petitioner testified that she did not hear from the safety manager that day and that she did finish working, albeit with assistance from other staff and another manager. Tr. at 28-29. Petitioner explained that she had lower back pain, pain shooting down her right leg, and, as the day went on, she started to have to walk bent over because it hurt her so badly to stand upright. Tr. at 29. Petitioner testified that she never felt pain like this before her accident. Tr. at 41.

Medical Treatment

Petitioner then went to Physicians Immediate Care and was released the same day. Tr. at 30-31. The medical records reflect that Petitioner reported right-sided back pain with radiation down the right leg. PX1. On examination, Dr. Jon Price noted normal heel-toe ambulation, a negative straight leg raise, and negative Waddell's signs x 5. *Id.* He also noted tenderness of the lumbar spine bilaterally, more so on the right, flexion as far as the knee, lateral flexion at 15/30 on the right and 10/30 on the left, and lateral rotation at 10/30 on the right and 15/30 on the left. *Id.* He diagnosed Petitioner with a lumbar strain with right leg radiation. *Id.* Dr. Price applied a back support, directed Petitioner to ice her back, prescribed Naproxen 220 mg every 8 hours, and released her to work full duty. *Id.*

Incident Report

Petitioner went to work the next day because she had to fill out a safety report, which is protocol when a manager gets hurt. Tr. at 29. She spoke with the safety manager at the end of that day. *Id.* Petitioner's manager filled out the report then gave her a drug test after which she was told to drive herself to the company physician. Tr. at 30.

Respondent offered its Exhibit 1, which is entitled "Workers Comp" and contains questions and handwritten information from Petitioner regarding the circumstances of her claimed accident at work on June 28, 2010.

RX1. The document is dated June 29, 2010 and notes Ramona Saylers as the contact person. *Id.* Petitioner noted the following in describing the incident with regard to the mechanism of injury:

> On Monday, June 28 at approximately 6:15-6:30AM I was walking the shipping dock to start looking at what pallets needed to be scanned. Started at door 55 and worked my way checking freight to be scanned at that door for the upcoming "waves" we would be working. Got to door 54, looked at one pallet, turn to my right to look at the next pallet and I felt the pinch in my right lower back. It startled me. I rubbed my back a bit + kept moving. The pain wasn't letting me up + I had a very busy day ahead of me. I was filling in for the two shipping mgrs that were on vacation. I walked back to my office + called Ramona Saylers, our safety mgr, and I asked if she had any back patches because I felt I had just twisted my back + maybe all I would need was a patch for some relief. ....

Id. On cross examination, Petitioner acknowledged that she did not indicate that she was crawling around on her hands and knees when this happened. Tr. at 58. In this document, Petitioner went on to describe persons with whom she interacted on June 28 and 29, 2010, her exchanges with Ms. Saylers, and her treatment at Physicians' Immediate Care at Respondent's direction at length. *Id.*

Chiropractic Treatment

Petitioner then saw Dr. Richard McCarthy at the Chiropractic and Acupuncture Center right after going to Physicians Immediate Care. Tr. at 31. She testified that she had been there prior to June 28, 2010 for treatment of headaches, tension in her neck, tension in her lower back aches and pains. *Id.* On cross examination, acknowledged that she saw Dr. McCarthy before June 28, 2010 for a couple years as needed, sometimes monthly sometimes every two months, to address headaches or stiffness in the neck. Tr. at 61-62. She also acknowledged that he addressed her low back complaints and adjusted her, but testified that those complaints were different. Tr. at 62-63. Petitioner explained that the prior treatment she received with Dr. McCarthy benefitted her, but the symptoms always came back. Tr. at 63.

Petitioner returned to Dr. McCarthy on June 29, 2010. Tr. at 31-32. Petitioner testified that compared to her pain and treatment before the accident on June 28, 2010, she was now walking bent over, and "as soon as they saw me they asked me what had happened to me and I told him I got hurt on the job and they said we're not touching you, you know you need to go and have yourself examined by your primary, we can't put our hands on you." *Id.* Petitioner explained that they did give her hot and cold packs and electric stimulation for the lower back. Tr. at 32.

The medical records reflect that Petitioner reported severe low back pain with radiation into the right hip and legs. PX5. Petitioner also reported that she was injured at work when "she was turning to examine pallets at work and felt pinch in back." *Id.* She indicated that she was very uncomfortable and had severe pain as well as difficulty walking and getting up and down. *Id.* Dr. McCarthy diagnosed lumbar disc, radiculopathy, and an illegible diagnosis. *Id.* He placed her off work. *Id.*

A handwritten note dated June 29, 2010 from the office of Richard McCarthy, D.C states in relevant part that Petitioner was "currently being treated in our office for a work-related lower back injury. She has been instructed to remain off from work until her symptoms improve. Her status will be re-evaluated at the end of the week." PX3.

When she returned to Dr. McCarthy on June 30, 2010, he noted Petitioner's ongoing pain and response to current treatment. PX5. He continued to diagnose Petitioner with acute low back pain and radiculopathy on July 1, 2010. *Id.* Petitioner returned to Dr. McCarthy through August 23, 2010. *Id.*

Primary Care – Dr. Wrona

Petitioner testified that she then went to see her family physician, Dr. Wrona. Tr. at 33. She explained that she never saw him for the type of pain with which she presented after the accident at work. *Id.* Petitioner testified that Dr. Wrona examined her and gave her an injection, which she stated did not help her even a little bit. Tr. at 34.

On July 2, 2010, Petitioner underwent a lumbar MRI as ordered by Dr. Wrona. PX16. The interpreting radiologist noted: (1) mild diffuse bulging of the L3-L4 annulus fibrosis without significant mass effect; (2) a broad-based and predominantly central disc protrusion at L5-S1 with mild mass effect upon the adjacent dural sac; (3) mild hypertrophy of the facets at L5-S1; and (4) no other lumbar abnormalities. *Id.*

Pain Management – Dr. Abusharif

Petitioner then saw Dr. Abusharif at Pain Center of Illinois and testified that they administered a series of three injections, which helped her for just a little bit, but did not stop the pain shooting down her legs and across her lower back. Tr. at 35-36.

The medical records reflect that on July 8, 2010, Petitioner saw Dr. Faris Abusharif. PX6. She reported low back pain that radiated down the right leg to the calf. *Id.* She reported the mechanism of injury occurring in an accident at work on June 28, 2010 "and repetitive lifting." *Id.* Dr. Abusharif diagnosed Petitioner with lumbar disc displacement and lumbar radiculopathy. *Id.* He recommended and administered a lumbar transforaminal epidural steroid injection at L5-S1. *Id.* He kept Petitioner off work and noted that the injection was likely to be administered in a series. *Id.* Petitioner returned to Dr. Abusharif on July 22, 2010 for a second lumbar transforaminal epidural steroid injection and he kept her off work. *Id.*

On July 26, 2010, a physical therapist in Dr. Abusharif's office noted the following:

> This is a 47-year-old female who reports to physical therapy after sustaining an injury at work while twisting on June 28, 2010. The patient denies any previous history of back pain or limitation. The patient was treated initially with steroid injection as well as oral steroids which did not help her lower back pain after which she was seen by a chiropractor and diagnosed with a disc injury. She was then seen by Dr. Abusharif and received a steroid epidural injection which helped significantly reduce her right lower extremity radicular pain. She continues to complain of significant lower back pain and back muscle spasms as well as pain through the buttocks. She notes increased pain with walking for greater than 15 to 20 minutes as well as sitting for greater than 15 to 20 minutes or with any leaning or bending maneuvers. She notes decreased pain with use of her medication. She generally sleeps in a left side lying position throughout the night fairly well, however, her sleep is affected and she cannot tolerate the supine position. Her job requires standing full-time as well as walking frequently, lifting up to 20 to 30 pounds and bending and twisting throughout her work shift. The patient works full time.

PX6. The physical therapist assessed Petitioner with multiple tissue lesions involving the lumbar spine and pelvis. *Id.* He noted that Petitioner's MRI would be reviewed to further correlate the right lower extremity radiculopathy with the lumbar spine, but noted that she also appeared to have left sacroiliac joint instability and

a sprain of the dorsal SI ligaments. *Id.* He recommended physical therapy and provided a sacroiliac belt to stabilize the pelvis. *Id.*

First Section 12 Examination – Dr. Phillips

Dr. Phillips testified that he saw Petitioner for the first evaluation at Respondent's request on July 30, 2010 at which time Petitioner gave him a history that she was bent over while she was working scanning a label on a pallet and developed severe low back pain that persisted and became particularly severe and excruciating by the following day. RX2 at 6. Dr. Phillips ultimately diagnosed Petitioner with a lumbar sprain/strain with the possibility of a mild disc injury, although he testified that he found no specific MRI findings pointing to an acute disc injury. RX2 at 10-11. He recommended six weeks of active lumbar physical therapy and anticipated that Petitioner would be able to return to full duty work thereafter. RX2 at 11.

In so concluding, Dr. Phillips testified that he understood Petitioner's medical treatment to that point included chiropractic care and injections. RX2 at 6-7. Dr. Phillips also reviewed Petitioner's July 2, 2010 MRI films which showed mild disc dessication (i.e., drying out), normally preserved disc heights, and a tiny central disc prolapse or bulge that was not compression the nerves with a sign of high intensity, or fissure/cracking, in the disc. RX2 at 7-9. He also conducted a physical examination, which revealed ability to walk on heels and toes with pain, discomfort during the exam and more comfort lying on her side, tenderness in the lumbar spine, limited lumbar range of motion due to pain, a normal lower extremity neurological examination, and low back pain, but no radiating pain caused with straight leg raise testing. RX2 at 9-10.

Continued Medical Treatment

On August 6, 2010, Petitioner returned to Dr. Abusharif. PX6. His records reflect that she received a lumbar transforaminal epidural steroid injection at L5-S1 and a sacroiliac joint injection. *Id.*

In a letter to Andy Lanz at Specialty Risk Services dated August 20, 2010, Dr. Abusharif noted his review of Dr. Phillips' IME report. PX6. He agreed that Petitioner was "not quite at maximal medical improvement and she does require additional physical therapy to work on stabilization and lumbosacral reaching and increased range of motion." *Id.* He noted that Petitioner only "had resultant axial back pain with a complete resolution of the additional pain. However, on additional consultation, she was reporting the pain to be very severe, and it did respond to the transforaminal epidural steroid injection. One thing Dr. Phillips comments on is that there is no radicular pain at the consultation which is true, but the reason that it was not present is because it resolved after the injection. The back pain was still present to a significant degree, although it was reduced about 50% and I felt that with the facet joint injection and physical therapy, she will obtain normal range of motion and I would recommend that she continue with physical therapy." *Id.*

On August 30, 2010, Petitioner underwent a cervical CT scan as ordered by Dr. Wrona for evaluation of a neck mass and pain. PX2. The interpreting radiologist noted a mild degenerative change at C5-C6 and otherwise benign or unremarkable findings. *Id.* She also underwent a chest CT scan, which was unremarkable. *Id.*

On September 2, 2010, Petitioner returned to Dr. Abusharif for the last time. PX6. He noted her report of "significant improvement in her symptoms. She has no radicular pain since undergoing the transforaminal ESI. She is primarily reporting hip pain. She is progressing meeting her goals in physical therapy. She presented with hip pain. It is located bilateral hips, left thigh and tail bone. It is described as aching, muscle spasms, weakness and sharp pain. The symptom is ongoing. The frequency of episodes is daily and unchanged. The complaint is

5-6/10." *Id.* Dr. Abusharif updated Petitioner's diagnosis to lumbago and lumbar disc displacement. *Id.* He ordered Zanaflex, four more weeks of physical therapy, and kept her off work. *Id.*

Medical Treatment for Other Issues

Petitioner testified that after her third injection she had a reaction of some sort with left breast enlargement and that Dr. Wrona sent her to various physicians for evaluation including doctors at the Mayo Clinic, Dr. Flosi, Dr. Pacella, and Dr. Shirazi. Tr. at 36-37.

On September 2, 2010, Petitioner also saw Dr. Daniel Pacella, a general surgeon, on one occasion as referred by Dr. Wrona. PX12. He noted her past history of lower back issues and saw her for consultation of her lymphnodes issue. *Id.* On September 10, 2010, Dr. Pacella Petitioner picked up her disk of diagnostic films and did not return. *Id.*

On cross examination, Petitioner testified that in the late summer of 2010 she was preparing to be married. Tr. at 64. She was married in September in Iowa and was then off in October of 2010. Tr. at 64-65.

On September 16 and 20, 2010, Petitioner saw Dr. Wasif Shirazi. PX12-PX13. Dr. Shirazi noted that Petitioner reported the following history:

> ... in June of this year, during her workday, turned suddenly and felt a stabbing right flank pain. The pain progressed over the course of a few days. She subsequently saw a physician in regard to workers' compensation and was told that she may have a strain. I understand that x-rays performed were essentially unremarkable. She saw a chiropractor who felt that she might have developed a disc problem. She informed me that she may have had an MRI that showed disk disease. She has received several steroid injections through Dr. Abusharif with some relief of her discomfort; however, she continues to be limited in terms of motion and activity. She is receiving physical therapy.
>
> In late August, around the 25th, she felt a nontender lump in the upper aspect of the breast bone while showering. This was followed by swelling in the supraclavicular fossa bilaterally. I understand that she saw you [Dr. Wrona] at that point and was treated with a Medrol Dosepak with no improvement in her symptoms. CT imaging of the neck was unremarkable for gross lymphadenopathy. The thyroid was also unremarkable. A CT of the chest was performed and unremarkable for lymphadenopathy, pulmonary lesions or bone involvement in the area of the sternum.
>
> Blood work performed around that time revealed an essentially unremarkable chemistry profile, normal TSH, and normal CBC indices. She was subsequently seen by Dr. Pacella, who did not palpate a concerning or discreet abnormality in the left breast. Mammography performed on the 13th of September revealed no specific evidence of a mass.

Id. Dr. Shirazi ordered repeat bloodwork and a left breast MRI. *Id.* He noted that Petitioner appears to have mild asymmetry of the breasts with some fullness in the upper left outer quadrant with no discreet mass and some fluid retention. *Id.*

The medical records of Dr. Sam Flosi reflect that on September 28, 2010 Petitioner reported a back injury sustained on June 28, 2010 involving L3-S1 and undergoing epidural steroid injections and taking prednisone. PX7. She also reported noticing that her left breast was enlarged over Labor Day[3] weekend and seeing Dr.

[3] The Arbitrator takes judicial notice of the U.S. calendar in 2010 showing that Labor Day fell on September 6, 2010.

Wrona on September 10, 2010 who ordered a mammogram. *Id.* Petitioner also reported that she saw Dr. Sherazi, an oncologist on September 16, 2010. *Id.* Dr. Flosi addressed Petitioner's reports of various gynecological issues and continued to provide treatment including a hysteroscopy/D&C performed on October 14, 2010 for pre- and post-operatively diagnosed post-menopausal bleeding. *Id.*

Orthopedic Care – Dr. Heim

Petitioner also saw Dr. Stephen Heim on September 28, 2010. PX14; RX3 (Dep. Exh. 3). Petitioner testified that she saw Dr. Heim, an orthopedic doctor, who examined her and ordered physical therapy. Tr. at 37-38. Petitioner reported the following history:

> She indicates she had no ongoing or persistent low back symptoms until she was injured at work on 6/28/10. She indicates that her job does require quite a bit of bending, twisting and at times heavy lifting. On 6/28/10 she was checking in pallets of product. She indicates that each box on the pallet had to be scanned, and she was reportedly bending and twisting simultaneously and ordered a scan of the individual boxes. At one particularly [sic] time, as she bent and twisted, she felt a very acute pain at the lumbosacral junction, more on the right than on the left. This seemed to worsen in terms of the intensity through the day, and ultimately then began to radiate also into the right buttock, down the posterior aspect of the right lower leg. Some numbness and tingling was present in the posterior aspect of the right lower leg. She did see an industrial medicine physician and was placed on Naprosyn, followed by an oral prednisone course. She subsequently was seen by a pain specialist, undergoing two epidural steroid injections. After the epidural steroid injections, her leg has resolved, and there is no remaining lower extremity symptoms [sic]. She also underwent a facet injection without any improvement from that particular injection.
>
> She continues to have waxing and waning back pain at the level of the lumbosacral junction. She indicates she is most improved symptom wise if she is recumbent with her hips and knees flexed over a pillow. Her back pain is aggravated by persistent standing, and especially by bending or twisting. She indicates even leaning over a counter as to wash her face, brush her teeth or wash dishes will provoke her back pain. There is no radicular or long tract symptoms. She will awaken from her sleep periodically when she turns in her sleep. Otherwise, she does not have night pain. There is no history of fevers, chills or night sweats. The patient again does remain off of work wince 6/30 due to the severity of her back pain.
>
> ....

PX14. Dr. Heim reviewed Petitioner's July MRI and diagnosed lumbar disc degeneration and lumbar pain/lumbago. *Id.* He kept her off work, ordered a more aggressive form of physical therapy, and recommended that Petitioner increase her activity level parallel to what she is doing in physical therapy. *Id.*

Petitioner then underwent the recommended left breast MRI on September 29, 2010. PX13. On October 7, 2010, Dr. Shirazi noted that Petitioner's left breast MRI was unremarkable for concerning abnormalities and that a small area of enhancement was consistent with normal tissue. *Id.*

Second Section 12 Examination – Dr. Phillips

Dr. Phillips next saw Petitioner on October 15, 2010. RX2 at 11-12. He testified that Petitioner reported undergoing about nine weeks of physical therapy that aggravated her symptoms and then seeing a new physician who sent her to a new physical therapist whom she had seen for a week and was helping. RX2 at 12-13. She

also reported that she had continuing back pain, that was now more diffuse, and radiating pain up to the mid back and down to the tailbone. *Id.* Petitioner also reported some buttock pain and that her pain was constant and not related to any particular activity. *Id.*

On physical examination, Dr. Phillips noted that Petitioner was quite "pain focused" and walked across the room with a strange gait, hobbling, that he could not explain on a spinal basis. RX2 at 13. He described the term "pain-focused" to mean subjective pain for which it would be hard to find any objective basis. RX2 at 17. She was tender when he barely touched her lumbar spine and now had only 10-15 degrees of movement of the lumbar spine in any direction limited by subjective back pain. *Id.* Dr. Phillips noted that Petitioner's neurological examination of the legs remained normal and that she had no weakness, numbness, loss of sensation suggesting that a disc or something else was pushing on a nerve. RX2 at 13-14.

Dr. Phillips again diagnosed Petitioner with a lumbar sprain/strain, but testified that he could not explain Petitioner's deterioration without any objective findings from an orthopedic standpoint. RX2 at 15-16. He recommended three weeks of work conditioning followed by a return to regular duty work. RX2 at 16, 22.

Petitioner testified that she was eventually notified that her benefits were terminated back in November of 2010. Tr. at 66. She received weekly disability payments through November of 2010 and then applied for long term disability which she received through Respondent. Tr. at 66-67.

Continued Orthopedic, Primary, & Hematological Treatment –
Dr. Heim, Dr. Wrona & Dr. Inwards (Mayo Clinic)

On November 2, 2010, Petitioner returned to Dr. Heim and reported "progressive system-wide symptomatology. She indicates that she did have a D&C on 10/14/10. She describes frequent lightheaded sensation, has had episodes of tingling diffusely in her spine, back pain at the level of the lumbosacral junction, tailbone pain extending up her spine through the thoracic area, swelling of her neck, groin, and breasts, a sense of numbness in both lower extremities diffusely with either flexion or extension, now experiencing pain diffusely through the left lower extremity in a non-dermatomal pattern, non-myotomal pattern, and after undergoing an attempt at lumbar traction, developed hypertension, tingling in both hands, both of which resolved after several minutes." PX14; RX3 (Dep. Exh. 4). Petitioner also reported that she needed assistance with activities of daily living. *Id.*

Dr. Heim indicated that he was "…not able to explain the degree of [Petitioner's] symptomatology nor relate them directly to her spine. It is not clear if any spine-related symptoms exist at this point." *Id.* He recommended that she return to her primary care physician and he placed her physical therapy on hold pending her consultation at the Mayo Clinic. *Id.* Dr. Heim further indicated that he was "not able to describe any specific functional limitations regarding [Petitioner's] spine." *Id.*

In an addendum note dated November 3, 2010, Dr. Heim noted his conversation with Dr. Wrona who cleared Petitioner for physical therapy and Dr. Wrona's indication that the "etiology of her complaints including swelling is elusive at this time, though he continues to search for its cause." PX14; RX3 (Dep. Exh. 5). Dr. Heim indicated that Petitioner should return to physical therapy followed by work hardening. *Id.*

Petitioner also sought treatment on November 16 and 17, 2010 at the Mayo Clinic and saw a hematologist, Dr. David James Inwards. PX26-PX27. She underwent a mammogram, CT scan of the chest, MRI of the cervical spine and MRI of the lumbar spine. *Id.* Dr. Inwards noted the following history:

I have interviewed this patient as well as reviewing approximately 30 pages of outside records. She typically works as a supervisor in a shipping area, and in June bent over to scan a universal bar code on a palate [sic] and had a pop sensation in her lower right back. Subsequent this progressed to more back pain with some symptoms in the legs, and she ultimately had an MRI on July 2, 2010, which demonstrated an L3-L4 disc bulge and an L5-S1 rather broad-based disc herniation. She has been undergoing physical therapy for that as well as injections and epidurals over a period of time but still has considerable pain in her back. This is a workers comp related abnormality.

She is actually here because of concerns as to whether there might be some sort of other generalized process going on. At one point in August she felt that there was a prominence over her sternum anteriorly. She was seen in regard to that. She also had a period in time when she thought her left breast was enlarged compared to the right. She underwent carpal tunnel syndrome of the neck and chest as well as mammograms and an MRI with no significant findings. She also is aware of her neck being a bit more prominent bilaterally. She has not been able to be as physically active as usual and has not been able to work and so has gained about 17 pounds. She is also post menopausal out about a year and began to have some spotting and so had a D&C done on October 14, 2010, with normal results. She has had some hot flashes and sweats. She also had an episode where her blood pressure was elevated, and she felt poorly whole doing some physical therapy activities. Her blood pressure improved after that. She does feel dizzy at times. Reviewing outside laboratory tests I would note that she had once a lipid profile that showed significant hyperlipidemia. She was not aware of that prior to that time. Her father does have hyperlipidemia by report. She also had some macrocytosis on a CBC at one point as well as an elevated LDH. She has had a number of other negative tests along the way. Her back pain is really the limiting factor for her, and she also noticed sensitivity of areas on her legs as well.

PX26-PX27. Dr. Inwards diagnosed Petitioner with a herniated disc with back pain, noting that this was her biggest health problem and disruptive to her life. *Id.* He recommended a referral to the Mayo clinic spine center if Petitioner needed it. *Id.* After undergoing additional testing, Dr. Inwards noted that Petitioner would need to continue to work with her providers at home or see someone at the spine center, although he did not think it was likely that there would be a big change in her management and that he saw no underlying signs of lymphoma or other sinister disorder. *Id.*

Dr. Inwards also noted that someone previously had questioned whether Petitioner had lymphoma given her elevated LDH test and ordered a repeat LDH; however Dr. Inwards also noted that he did not feel any mass on any site with which Petitioner was concerned and that it was "highly unlikely" that they would find evidence of a lymphoproliferative disorder. *Id.* With regard to her macrocytosis, glaucoma, and hyperlipidemia, Dr. Inwards noted that they would follow up with other testing. *Id.* When Petitioner returned on November 17, 2010, he noted the same diagnoses as the prior day of a herniated disc with back pain, macrocytosis, glaucoma, and hyperlipidemia. *Id.*

Petitioner last saw Dr. Heim for orthopedic follow up on December 7, 2010. PX14; RX3 (Dep. Exh. 6). At that time she reported no specific or endocrine abnormalities noted after her consultation at the Mayo Clinic and worsening spine pain radiating diffusely into the lower extremities to the knees with any physical activity or movement aggravating her pain severely. *Id.* Dr. Heim maintained Petitioner's diagnoses of lumbar disc degeneration and lumbar pain/lumbago. *Id.* Dr. Heim noted "[a]t this point in time, I remain unable to explain the degree of [Petitioner's] symptomatology as related to her spine." *Id.* He released her from his care and referred her to Dr. Ondra at Northwestern or Dr. Nockels at Loyola for consultation. *Id.*; *see also* Tr. at 38-39.

Neurosurgical, Rheumatologic & Pain Management Care at Loyola –
Dr. Nockels, Dr. Raghavendra, Dr. Ostrowski,

The medical records reflect Petitioner went to Loyola for care with Dr. Russell Nockels, a neurosurgeon, on February 21, 2011. PX20. Petitioner reported that she was injured at work on June 28, 2010 and:

> [b]ent over to scan a UPC label on a pallet and felt a sudden extreme pain in low back and down right leg. Reported injury but still had to work. Saw PCP two days later, received steroid injection in right buttock and given MDP, neither of which helped. Had MRI, sent to pain MD, given facet injection which improved the right leg pain but not the back pain. Sent to PT, five weeks into it, pain changed and she felt lower- sacral pain moreso than before. Had 2 ESI with no relief. Patient reported swelling in neck, sternum and left breast after second injection. Detailed work up was done and was negative for lymphoma or other pathology. Patient now has c/o tingling in low back and bilateral calves, thighs feel as if they are bruised. Also has noticed tingling in hands and feet. States she is more clumsy, both in terms of find motor function and balance. Describes urinary frequency.

Id. Dr. Nockels ordered MRIs and other diagnostics. *Id.* The interpreting radiologist of Petitioner's lumbar MRI noted mild degenerative changes at L3-L4 and L5-S1 and a disc bulge at L5-S1 with mild right facet arthropathy and an annular tear. *Id.* She also underwent a cervical MRI which showed multilevel degenerative changes most prominent at C5-C6 with Grade 1 posterior subluxation, a disc osteophyte complex, posterior ligamentous buckling causing moderate narrowing of the central canal and moderate-to-severe narrowing of the right neural foramen. *Id.*

On March 17, 2011, Dr. Nockels reviewed the MRI of Petitioner's entire spine. PX20. He noted that it showed moderate disc bulges at C5-C6 and C6-C7 without significant cord compression, and a mild disc bulge at L4-L5 without significant cord compression or nerve root compression. *Id.* Petitioner was instructed to follow up with a pain clinic and to return to see Dr. Nockels as needed. *Id.* Dr. Nockels noted no surgical lesion on the MRIs and agreed with the facet injection at L4 recommended by Dr. Greenlee. *Id.* Petitioner testified that Dr. Nockels did not recommend surgery. Tr. at 38-39.

Petitioner testified that she also treated with Dr. Meda Raghavendra out of Loyola who administered injections into her back for pain. Tr. at 45. The medical records reflect that Petitioner saw Dr. Raghavendra for pain management care on March 22, 2011. PX20. She reported pain at work while scanning multiple pallets and her treatment with various doctors to that point. *Id.* Dr. Raghavendra noted that Petitioner was hardly able to walk, had very guarded, limited, and painful movements on examination, and that her ambulation was slow and deliberate. *Id.* Petitioner was diagnosed with low back pain and lumbar radiculopathy, and referred for a facet injection at L4 with Dr. Greenlee. *Id.*

Petitioner also saw Dr. Rochella Ostrowski for rheumatology care at Loyola on March 25, 2011. PX20. Dr. Ostrowski noted the following history:

> Pt is a 47yfemale here for evaluation of back pain. She sees neurosurgery and was told that she is not a surgical candidate. She has had facet injection in 8/2010 at Pain Center of Illinois, at L5-S1 which did not help. She is going to have one at L4-L5 at the end of this month.
> She has a herniated disc. Prior to her injury, she was running marathons and was very active. She had an injury 6/28/10. SHe is a shipping manager, and as she was bending and inspecting the packages (holding scanner), and then developed pain in her lower back. She has not had improvement in her back pain. States she has had epidural as well.
> Takes ibuprofen during the day and Flexeril at night. Now she has pain througout (sic) her lower legs and her legs feel bruised. She went through PT from July through November.

> Both legs started after the back injury. States that she has not had more than 4-5 hours of sleep since her back injury. With Flexeril, she can sleep up to 4-5 hours but without it.
> After the 1st facet injection had relief of right leg pain, but since then the pain has come back in both legs.

Id. On physical examination, Dr. Ostrowski noted no heat/cold intolerance, no significant alopecia (although Petitioner reported that "[s]ometimes finger turns a 'bluer shade" in cold[,]" no edema, 13 tender points throughout, full range of motion at all joints, no synovitis, and a normal neurological examination. *Id.* Dr. Ostrowski indicated that Petitioner did not appear to have a rheumatid autoimmune disease such as rheumatoid arthritis or ankylosing spondylitis and that her generalized pain was most consistent with fibromyalgia. *Id.* Dr. Ostrowski also indicated that "[t]he etiology is unclear, but lack of restorative sleep is associated with fibromyalgia, and patient states that she has not had more than 4-5 hours of sleep since she hurt her back. She will be seeing IR for facet injection for the back. … I recommend the above treatment options, which can be coordinated with patient's PCP and/or a psychiatrist if already involved. … I have no other recommendations to offer from a Rheumatological/autoimmune perspective regarding fibromyalgia. Patient is to return to clinic as needed." *Id.*

At a return neurosurgery visit on April 4, 2011, Dr. Nockels also noted "I am unable to get beyond the diagnostic phase for this patient. I am unable to determine a cause for her pain with certainty. She asked me to become involved in her work status, and – beyond accommodating her with off time during the required studies – I am unable to provide her with a definitive work status now or in the future." PX20. She was referred again to pain management and rheumatology. *Id.* Petitioner followed up on April 28, 2011 and was referred back to Dr. Ostrowski. *Id.*

On May 2, 2011, Petitioner saw Dr. Ostrowski. PX20. She reported chronic back pain after her injury at work, following up with neurosurgery and that she returned for evaluation of her fibromyalgia. *Id.* With regard to her pain, Dr. Ostrowski noted Petitioner's report of pain throughout both legs and, at times, pain from head to toe. *Id.* Dr. Ostrowski found no change in Petitioner's clinical presentation and indicated that an extended review of systems was otherwise negative. *Id.* Dr. Ostrowski noted the following:

> I discussed with [Petitioner] that I do not routinely follow fibromyalgia as it is not a rheumatic autoimmune disease. However, I can initiate therapy until she is either on a stable regimen or we have exhausted medical treatment options for fibromyalgia; At that time I would release her to the care of her primary care physician.
>
> Pt also asked about a note for excuse from work. I explained to her that I do not write notes for absence from work or for disability for the diagnosis of fibromyalgia. I recommend a formal functional capacity evaluation, and she will see PM&R for this assessment. I offered to provide her a copy of today's clinic note with objective findings that she can bring to her workman's comp liaison.
>
> Pt is interested in physical therapy for strengthening of her legs, and this may be pursued once she has also started medical tx as outlined below [including a PM&R evaluation, medication management, and check Vit D and TSH].

Id. When Petitioner returned to Dr. Ostrowski on September 19, 2011, she reported worsened foot pain in the morning, bilateral hand pain, and numbness in the left index finger and a patch near her left elbow that began that summer. *Id.* She also reported that she feels "like a new person" and that she was in physical therapy with a home exercise program. *Id.* Dr. Ostrowski noted that the etiology of the left paresthesias was unclear and that

the changes in her MRI would suggest more symptoms in the right arm. *Id.* She ordered an EMG to address numbness and adjusted her medication regimen. *Id.* Petitioner underwent the EMG on October 5, 2011, which was normal. *Id.*

Petitioner returned to the neurosurgery clinic and saw Dr. Nikhl Patel who discussed Petitioner's visit with Dr. Nockels on February 8, 2012. PX20. She reported resolution of her low back pain with right lower extremity radiation after her injection until recently, "baseline lower extremity fibromyalgia symptoms" and "baseline chronic bilateral hand numbness/tingling with clumsiness and nonprogressive neck pain VAS3." *Id.* Dr. Patel noted that Petitioner would undergo a repeat right L3-L4 transforaminal epidural steroid injection with Dr. Greenlee. *Id.*

Petitioner returned to Dr. Ostrowski on March 19, 2012. PX20. She reported worsened joint pain with weather changes, swelling in her fingers sometimes, and being out of employment insurance. *Id.* "She is tearful because she has not been able to go back to work due to her pain and has requested for my input regarding the causality of her fibromyalgia as a result of her work." *Id.* Dr. Ostrowski noted her discussion with Petitioner "...that I still am not able to give opinion as to the causality for fibromyalgia being linked to her work, since we still do not understand the full etiology of fibromyalgia. However, I am able to provide records as needed which document my exam findings, etc. Pt agreeable." *Id.*

Petitioner did not see Dr. Ostrowski after March 19, 2012. She testified that Dr. Ostrowski was the first physician to diagnose her with fibromyalgia. Tr. at 39. However, after trying out various medications, Petitioner decided not to continue treating with Dr. Ostrowski because she was not listening to her and Petitioner testified that she was not getting better. Tr. at 40.

Employment Separation

In the interim, Petitioner received a letter dated February 9, 2012 from Kathryn Johnson, HR Director for Respondent, who noted her review of Petitioner's file, that she had been released to return to work a significant time ago, and that she failed to return to work. PX49. Thus, Ms. Johnson indicated that Respondent was considering Petitioner to have voluntarily resigned from her position with Respondent. *Id.*

Petitioner responded to the February 9, 2012 letter from Respondent's HR Director in a letter dated April 18, 2012. PX49. Petitioner refuted the contents and representations made in Respondent's letter. *Id.*

Continued Rheumatologic & Foot Care – Dr. Nayak & Dr. DeVito

Petitioner then saw Dr. Veena Nayak. Tr. at 43. Petitioner testified that Dr. Nayak listened to her. *Id.* Petitioner testified that she prescribed Lyrica, Celebrex, Cymbalta and then later Amrix, which has alleviated some of the symptoms, but they have not completely gone away. Tr. at 44. Petitioner explained that Dr. Nayak also ordered additional physical therapy, which she underwent at Accelerated Rehabilitation Therapy Center. *Id.*

The medical records reflect that Petitioner then saw Dr. Nayak at Southland Rheumatology Center for an initial visit on June 26, 2012. PX23. Dr. Nayak noted the following history:

> Patient presents w/ diffuse myalgias and arthralgias and dx of fibromyalgia w/ hx of work related injury on 6/28/10 resulting in severe low back pain and MRI noted for herniated disc and annular tear in lumbar

> region for which she has undergone extensive physical therapy and epidural/facet injections in summer 2010. This resulted in side effect of enlarged left breast which was benign. In 2/11 she had bone scan which had some increased uptake in L4 region for which she received facet blocks. She continues to experience severe chronic diffuse pains in back and throughout w/ stiffness and recently notes stiffness w/ discomfort at rest in hands/fingers and persistent paresthesias. She has had MRI Cervical spine in 2011 which is noted for C5/C6 disc bulge. For her worsening insomnia associated w/ Chronic pain and sx of fibromyalgia amitriptyline has been prescribed by Dr. Ostrowsky at Loyola along w/ physical therapy. She also has used either ibuprofen or naproxen for back and diffuse body aches w/ some benefit. She has been unable to work as a result of the back injury and the diffuse myalgias and arthralgias that have followed. She now presents for second opinion w/ regard to management of her pain.

Id. Dr. Nayak noted a nonfocal neurological examination, significant stiffness in peripheral joints, and paralumbar muscle spasm with pain on flexion and extension. *Id.* She diagnosed Petitioner with lumbago, and unspecified myalgia and myositis. *Id.* She recommended continued physical therapy, a change in medication from amitriptyline to lyrica, and noted that Petitioner "has been encouraged to complete diagnostic blood work to ascertain etiology of symptoms." *Id.*

On July 23, 2012, Dr. Nayak noted Petitioner's report of continued stiffness "and swelling in hands worse at rest[,]" as well as persistent myalgias and arthralgias. PX23. Petitioner's physical examination was the same as at her initial visit with the exception that Petitioner completed her blood work and those results were noted. *Id.* Dr. Nayak maintained Petitioner's diagnoses, recommended continued physical therapy, and possibly adding Cymbalta to Petitioner's medication regimen. *Id.*

Petitioner testified that she also saw a foot doctor at Foot and Ankle Care on August 6, 2012 because her feet hurt so much to walk up and down stairs, or when I would get out of bed to walk on them they would burn and hurt. Tr. at 42. The medical records reflect that Petitioner saw Michael DeVito, DPM on this date. PX9. He noted that she was a prior patient over 10 years ago for bilateral foot comfort as a dog walker and the following:

> SHe re/re presents with chronic bilateral lower extremity pain with an unfortunate trauma history to her back. She was diagnosed with fibromyalgia nearly the same time, and suffered a back injury in 2010 while working. She has documented L3-L4 radiculopathy and L5-S1 possible tear/herniation of disc. Her symptoms of the lower extremity are present with light touch, hypersensitivity along the lateral aspects and dorsal aspects along the L5 and S1 dermatome. There is no sign of infection, no history of foot trauma, negative edema, normal range of motion and strength. Feet fell like they are on fire neuritis in nature and radiographs are normal. Patient has difficulty getting up from walking, and after sleeping and relates significant lifestyle changes since her injury with low back. She was able to run marathons, and had a successful dog walking business which she is unable to do now.

Id. Dr. DeVito noted that Petitioner's fibromyalgia and/or possibility of other collagen vascular disease might be contributing to her bilateral foot pain. *Id.* He diagnosed Petitioner with unspecified mononeuritis of the lower limb, unspecified disc disorder of the lumbar region, and pain in the soft tissues of her limbs. *Id.* Dr. DeVito indicated that her neuritic symptoms appeared to be consistent with the L5-S1 dermatome and referred her to an orthopedic surgeon or neurosurgeon for evaluation. *Id.* He also noted Petitioner's frustration with current treatments, and that she had no specific localized foot pathology as most of her symptoms were proximal in origin. *Id.*

Petitioner returned to Dr. Nayak on October 2, 2012 reporting her visit with Dr. DeVito and continued symptoms with additional GI discomfort and heartburn. PX23. Petitioner's physical examination remained

essentially unchanged. *Id.* Dr. Nayak adjusted Petitioner's medications and recommended continued physical therapy. *Id.*

On November 13, 2012, Petitioner reported to Dr. Nayak that she had an exacerbation of left hip pain and persistent flu-like symptoms with fatigue and bruised feeling throughout her body with hand stiffness and paresthesias. PX23. She also reported that she was unable to do physical therapy as it was no longer covered and that she was under some stress as her mother had been diagnosed with a terminal illness. *Id.* Dr. Nayak maintained Petitioner's diagnoses and ordered a Medrol DosePak for the hip and back pain. *Id.*

Narrative Report – Dr. Nayak

Dr. Nayak wrote an undated letter faxed on December 4, 2012. PX30 (Dep. Exh. 2). She noted her review of Petitioner's medical treatment to date and stated in pertinent part:

> Although [Petitioner] was not under my care prior to the work accident on June 28, 2010 and I had the opportunity to participate in her care one year after this incident,beginning June 26, 2012, after review of her medical records and after obtaining a complete medical history and performing a physical examination on [Petitioner], I believe that her symptoms of fibromyalgia may have been exacerbated by her work accident. At this time, while she is undergoing current treatment and therapy, she has been kept off work due to severity of her ongoing symptoms.

Id.

Continued Medical Treatment

On December 26, 2012, Petitioner saw Dr. Nockels who ordered an updated MRI, which Petitioner underwent on January 3, 2013. PX20. The interpreting radiologist noted slight worsening of L5-S1 spondylosis, stable L3-L4 spondylosis, and an otherwise unremarkable lumbar MRI. *Id.* Petitioner reported one month of worsening right-sided low back pain and left hip pain. *Id.* Petitioner was referred back to pain management. *Id.*

After completing a course of physical therapy, on January 31, 2013 Petitioner underwent a functional capacity evaluation at Newsome Work Performance Center. PX18-PX19. The examining physical therapist noted that Petitioner's results were valid and that she did not exhibit Waddell's signs, but that she perceived herself to be experiencing a high level of pain with severe disability indicating inappropriate illness behavior. *Id.*

Petitioner was released to work at the light physical demand level. *Id.* On cross examination, Petitioner acknowledged that the results of this functional capacity evaluation indicated that she could work on a light duty basis. Tr. at 71-72.

On February 21, 2013, Petitioner saw Dr. Nayak reporting no benefit with the Medrol DosePak and her treatment at Loyola for persistent left-sided back pain radiating to the left lateral hip region. PX23. She also reported that she "continues to have difficulty with weight bearing and ambulation as well as pain at rest over left lateral hip region despite regimen of cymbalta, lyrica, and celebrex." *Id.* Petitioner further reported having undergone laser trabeculoplasty to the right upper eye for glaucoma. *Id.* Dr. Nayak added a diagnosis of enthesopathy of the hip region and administered a depomedrol injection into the left hip trochanteric bursa. *Id.*

Deposition Testimony – Dr. Nayak

On February 28, 2013, Petitioner called Dr. Nayak as a witness who gave testimony at an evidence deposition. PX30. She is a board-certified rheumatologist who treats fibromyalgia, arthritic conditions, musculoskeletal disorders, and autoimmune conditions. PX30 at 4-6. She explained that about one third of her patients have fibromyalgia, whether alone or along with other conditions. PX30 at 6. Dr. Nayak testified about her care and treatment of Petitioner. *See generally* PX30.

Dr. Nayak explained fibromyalgia to be a clinical condition, a chronic pain syndrome that was generalized in the body to all four quadrants and "generally associated with certain conditions -- like fatigue, perhaps memory deficits, insomnia. It is -- one of the hallmarks is that it is a clinical syndrome which is diagnosed primarily on basis of a physical exam as well as in combination with history of the patient and the most important thing is to evaluate the diagnostic lab markers to rule out other types of conditions that may possibly be contributing to symptoms of the pain." PX30 at 7. She explained that fibromyalgia patients exhibit tender points in a set of 18 total points and usually 11 out of 18 tender points have to be present to diagnose a widespread soft-tissue pain syndrome. PX30 at 7-8. Dr. Nayak also testified that the physical examination is a helpful exam and there is some degree of subjectivity to it, but the exam is performed in an objective fashion as best as can be done. PX30 at 9.

With regard to Petitioner's physical examinations, Dr. Nayak testified that Petitioner had tenderness in all 18 points tested for fibromyalgia and later had 14 out of 18 points of tenderness as of her visit on February 21, 2013. PX30 at 10, 27-28. At her initial visit, Dr. Nayak noted Petitioner's swelling in the hands, but she testified that she did not believe that Petitioner mentioned anything resulting with tissues in the hand per se, rather body aches, and that was occurring closer to 2012 not 2010. PX30 at 11-12. Petitioner's complaints of stiffness throughout her visits are mostly subjective other than any muscle spasms she noted on examination. PX30 at 12-13, 31-32.

Dr. Nayak testified that she was aware that Petitioner had seen a rheumatologist, Dr. Ostrowski, who diagnosed Petitioner with fibromyalgia before she saw Dr. Nayak for the first time. PX30 at 15. She explained that she prescribed physical therapy, which was reasonable and one of the most important treatment modalities for fibromyalgia along with medications. PX30 at 18.

Dr. Nayak testified consistent with the opinion in her narrative report that she believed Petitioner's fibromyalgia may have been exacerbated by her accident at work. PX30 at 20, 39. She based that opinion on Petitioner's history at her initial visit "that she had not had these generalized pain symptoms prior to her accident [...] on June 28th, 2010." PX30 at 20-21, 39. Dr. Nayak also testified that an accident as described to her by Petitioner could lead to an aggravation of fibromyalgia. *Id.*

However, Dr. Nayak also testified that it was very difficult for her or anyone to pinpoint the causes of fibromyalgia; "[w]e are not quite clear on that in general terms in terms of etiology for fibromyalgia. However, we do know that trauma can exacerbate it and in this case it seems that it's very possible that trauma may have exacerbated her fibromyalgia." PX30 at 21-22. Later, Dr. Nayak testified that Petitioner's low back pain and fibromyalgia, with which she originally presented, were exacerbated after the accident at work. PX30 at 29-30.

Dr. Nayak testified that she did not review any of Petitioner's records regarding lumbar injections in the summer of 2010. PX30 at 15-16. She also testified that Petitioner's report of an enlarged breast is not an indication of fibromyalgia. PX30 at 22-23, 38. Dr. Nayak did not refer Petitioner to Dr. DeVito, a podiatrist, or review his

records. PX30 at 25-26, 37-38. She also testified that she did not know of Petitioner's functional capacity evaluation results. PX30 at 28-29.

Also, Dr. Nayak testified that Petitioner's reported symptoms of fatigue, and a feeling of bruising could be associated symptoms of fibromyalgia, but her left hip bursitis could be associated with her low back problems, an isolated condition, or her fibromyalgia. PX30 at 24-25, 42. She testified that she could not opine whether Petitioner's left hip bursitis was related to her accident at work. PX30 at 29, 42. With regard to Petitioner's ability to work, Dr. Nayak testified that Petitioner was unable to work at this time, but would hopefully be able to return to work in the future, as a result of Petitioner's low back pain and fibromyalgia. PX30 at 30-31.

On cross examination, Dr. Nayak testified that fibromyalgia is a clinical syndrome, but that "we don't know enough about the particular process to be able to identify specific pathophysiology of the disease process." PX30 at 32-33. She explained that there are some abnormalities in the neurotransmitters in fibromyalgia patients found in experimental laboratory testing, but there were no clinically available diagnostic tests to determine if a particular patient has these abnormalities. *Id.*

Dr. Nayak also explained that diagnosing fibromyalgia was "actually the exclusion of, you know, making sure that other tests are actually normal that's important to have while you're diagnosing -- making this diagnosis." PX30 at 36. She testified that fibromyalgia could occur with or without trauma and that the patients she sees generally come to her with a diagnosis with symptoms and that it was not necessarily stemming from a particular event that exacerbated the condition. PX30 at 36. Dr. Nayak further explained that "[w]e look for certain exacerbating things that might have brought on this process but sometimes we don't find anything, so it's very possible that it could be an etiology that we're unable to identify." *Id.*

Dr. Nayak acknowledged that she did not make any measurements to determine if Petitioner had non- or disuse atrophy. PX30 at 33. With regard to Petitioner's spine issues, she deferred to the treating orthopedic physicians. PX30 at 34-35. She also testified that muscle spasms were symptoms of pain and that someone could have fibromyalgia with or without muscle spasms. PX30 at 37. Dr. Nayak was unsure whether she placed Petitioner off work or needed to do so or if Petitioner was already off of work as ordered by her other physicians. PX30 at 35-36. She also testified that she did not review Petitioner's medical records from the Mayo Clinic. PX30 at 39-40.

On cross examination, Dr. Nayak also testified that she did not know whether Petitioner's fibromyalgia did or did not result from her accident at work, but that it happened after her accident at work. PX30 at 39.

Continued Medical Treatment

On April 12, 2013, Petitioner saw Dr. Raghavendra who ordered injections, continued treatment with rheumatology, and to continue aquatics. *Id.* Petitioner underwent the epidural steroid injection on April 15, 2013. *Id.* On May 6, 2013, Petitioner underwent intervention for the left hip. *Id.* Specifically, she had a left greater trochanter bursa injection as ordered by Dr. Raghavendra. *Id.*

Petitioner saw Dr. Raghavendra for follow up and injections thereafter. PX20. On July 15, 2013 she underwent a second injection to the left hip. *Id.* Petitioner also saw Dr. Nayak for follow up on September 10, 2013. *Id.*

Third Section 12 Examination – Dr. Phillips

Dr. Phillips examined Petitioner a third time at Respondent's request on June 4, 2013. RX2 at 17. He testified that he reviewed records from a hematologist, records from a pain management specialist (Dr. Alito), CT reports, cervical MRI report, lumbar MRI report, thoracic MRI report, various records from Loyola, records from Dr. Nockels, records from Dr. Hayward, records from Dr. Ostrowski, and records from Dr. Nayak. RX2 at 17-18, 36-37.

With regard to the lumbar spine, Dr. Phillips testified that the CT scan supported the mild degenerative changes he noted in Petitioner's MRI. RX2 at 18. Dr. Phillips testified that he did not review Petitioner's second lumbar MRI films, but that the report indicated essentially what he saw in the initial MRI films with the only difference being a note of mild right facet arthropathy (i.e., wear and tear of the right facet joint) which he testified was not a very significant finding. RX2 at 18-19, 36.

With regard to the other diagnostics of the spine, Dr. Phillips indicated that he did not see any sign of an acute injury that may have occurred in June of 2010. *Id.* Dr. Phillips also testified about his review of Dr. Nockels' records indicating that he (Dr. Nockels) could not determine a cause for Petitioner's pain with certainty. RX2 at 20-21. Dr. Phillips testified that he was also unable to determine a cause for Petitioner's pain with certainty. RX2 at 21.

Dr. Phillips also testified that he noted at least three positive Waddell signs on physical examination at this time. RX2 at 22. He described Waddell signs to be nonanatomic pain behavior, or signs that do not fit with spinal anatomy. RX2 at 23. Petitioner exhibited walking with an abnormal gait, walking on her heels and toes causing excruciating back pain, tenderness to palpation with even the lightest palpation of the lumbar area, a normal neurologic exam of the lower extremities, and even less range of motion than at her last visit with only 10 degrees available in any direction. RX2 at 22-23.

Ultimately, Dr. Phillips diagnosed Petitioner as having suffered a lumbar sprain/strain and he testified that he did not have a specific diagnosis for her ongoing, fairly diffuse complaints other than fibromyalgia, which he testified that was "sort of a catch phrase for just muscle pain[,]" as diagnosed by other treating doctors. RX2 at 23-24. He testified that Petitioner's sprain/strain should have resolved by the beginning of November of 2012 and that Petitioner required no further medical care beyond that which he recommended. RX2 at 24-25.

Deposition Testimony – Dr. Phillips

On November 7, 2013, Respondent called Dr. Frank Phillips as a witness who gave testimony at an evidence deposition. RX2. He is a board-certified orthopedic surgeon specializing in spinal disorders. RX2 at 4-5. Dr. Phillips testified about the occasions on which he examined Petitioner at Respondent's request and rendered several opinions. *See generally* RX2.

Dr. Phillips testified that, while he is not an expert in fibromyalgia but treats patients with that diagnosis, and he does believe that the condition exists, when he saw Petitioner in July of 2010 she did not exhibit any symptoms of fibromyalgia. RX2 at 24-28. With regard to the uptake noted in Petitioner's later lumbar MRI, Dr. Phillips testified that it was not caused by a back sprain and usually was related to arthritis in someone of Petitioner's age. RX2 at 30.

Dr. Phillips acknowledged on cross examination that he based his opinions on Petitioner's lack of back pain

prior to her accident at work. RX2 at 31-32. He also acknowledged that when he initially examined Petitioner in July and October of 2010 he did not have her treating medical records other than her MRI films. RX2 at 32-33. Dr. Phillips also referred to Petitioner's annular tear as noted in her later MRI to the fissure he identified in her July of 2010 MRI. RX2 at 35. He indicated that such a finding could be aggravated or cause pain and be related to trauma. *Id.*

Continued Medical Treatment

On December 23, 2013, Petitioner saw Dr. Raghavendra again reporting seven months of relief with the last injection and had another left lumbar interlaminar epidural injection. PX20.

Petitioner saw Dr. Nayak on January 7, 2014 reporting her ongoing treatment at Loyola for left hip bursitis and low back pain. PX23. Dr. Nayak noted that Petitioner's neurological examination was "unchanged" and scheduled a follow up in six months. *Id.*

2014 Hip Accident/Fall

The Loyola medical records reflect that Petitioner saw Dr. Raghavendra on March 28, 2014. PX20. She reported an acute pain exacerbation two days ago when she fell while holding a shelf unit for support that fell on her. *Id.* She was diagnosed with a flare up of left trochanter bursitis and given left hip injections. *Id.* Petitioner testified that she recovered from that fall and her pain then returned to the level it was before while treating for fibromyalgia. Tr. at 48.

Petitioner explained that she did not have hip pain like this before her accident; she thought she had broken her hip and went to see Dr. Nockels in 2012. Tr. at 46. She explained that she did not have any type of accident involving her hip and she did not remember feeling hip pain right after her accident at work on June 28, 2010. Tr. at 46-47. However, she had a fall at home while she was treating for fibromyalgia. Tr. at 47. Petitioner explained that she walked into her music room and her legs felt like they were going to buckle out from underneath her, so she grabbed a wall unit that she has in that room and it fell on top of her which made her fall. Tr. at 47. She explained that she when she landed there was a wooden box in which she keeps pictures that struck her right in the lower back on the left side. *Id.*

"Fibromyalgia Medical Source Statement"

Petitioner submitted a multi-part form for Petitioner's disability attorney entitled "Fibromyalgia Medical Source Statement." PX31 (Dep. Exh. 2); PX46. The form indicates that Petitioner had 14/18 tender points, left hip bursitis, sacroiliac stress pain, paralumbar muscle spasms, and pain on flexion and extension. *Id.* The form also indicates Petitioner's symptoms to include multiple tender points, nonrestorative sleep, chronic fatigue, muscle weakness, and subjective swelling. *Id.* At her second deposition, Dr. Nayak testified that this form was completed by Petitioner, Dr. Nayak's assistant and Dr. Nayak before she (Dr. Nayak) signed it on May 20, 2013. PX31 at 63-65, 69.

Narrative Letter – Dr. Wrona

In a narrative letter dated June 26, 2014, Dr. Wrona noted Petitioner's fall at home involving her shelving unit. PX24. He indicated that Petitioner's "low back pain and hip bursitis could have contributed to her fall injury. It is unclear to me what role fibromyalgia plays to this situation." *Id.*

Continued Medical Treatment

Petitioner returned to Dr. Raghavendra on September 29, 2014 reporting continued lumbar pain and radiation into the right leg. PX20-PX21. On examination, Dr. Raghavendra noted diffuse tenderness in the lumbosacral region due to fibromyalgia, myofascial pain, a negative straight leg raise test, and pain with FABER testing. *Id.* Dr. Raghavendra administered another left epidural steroid injection and recommended a TENS unit. *Id.* Petitioner testified that she last saw Dr. Radhavendra at this time and that she continues to receive maintenance treatment with Dr. Radhavendra and Dr. Nayak. Tr. at 45.

Supplemental Deposition Testimony – Dr. Nayak

On November 3, 2014, Petitioner called Dr. Nayak as a witness who gave testimony at a second evidence deposition. PX31. Dr. Nayak testified about ongoing treatment of Petitioner. *See generally* PX31.

Dr. Nayak testified that Petitioner's hip and low back conditions were being treated, to her knowledge, by Dr. Raghavendra and she deferred opinions about those conditions to him. PX31 at 51-54, 71. With regard to ongoing treatment of the fibromyalgia, Dr. Nayak testified that the treatment she recommended including water exercises were reasonable and necessary. *See generally* PX31.

Dr. Nayak testified that she saw Petitioner on July 7, 2014, but she did not have any specific notes about Petitioner's fall. PX31 at 56-57. She noted some deterioration, worsening fatigue, complaints about problems with cognitive functioning, and some mental type of issues that Petitioner reported were getting in the way of her functioning. PX31 at 57-59. Dr. Nayak opined that Petitioner was unable to work at the time of her deposition and that Petitioner was not ready to return to work at that time. PX31 at 65-66. She indicated that Petitioner's condition was long term and chronic, but could not opine whether she was prevented from ever returning to work. PX31 at 66.

Dr. Nayak was asked again whether she felt that Petitioner's accident contributed to her condition and she testified that based on the information available to her, Petitioner's symptoms were exacerbated by her accident and continued thereafter. PX31 at 67.

On cross examination, Dr. Nayak testified that Petitioner reported to her that when she fell [in 2014] she "was not thinking properly or having fibro fog, as she called it, and she mentioned that she fell at home." PX31 at 72. With regard to Petitioner's cognitive issues, Dr. Nayak testified that it can be part of fibromyalgia, but it was not mentioned in her notes. PX31 at 73-74. Dr. Nayak explained that at the time Petitioner first saw her, Petitioner presented with a history of a fibromyalgia diagnosis made by Dr. Ostrowski and Dr. Nayak indicated that she did not know exactly what happened at the time of Petitioner's accident at work. PX31 at 75-76. When asked if a "person bent over and bent from the waist and felt back pain" could result in a competent cause of fibromyalgia, Dr. Nayak testified that she could not really say it leads to fibromyalgia, but that it was difficult to say. PX31 at 76-77. Dr. Nayak also testified that she did not know what Petitioner's daily activities were. PX31 at 79-80.

With regard to the form completed on May 20, 2013, Dr. Nayak testified that it was Petitioner reporting that she could not stand, sit, walk for any length of time, or work. PX31 at 80-85; PX31 (Dep. Exh. 2). She testified that if Petitioner had muscle atrophy over the years she would have noted that in her medical records, which she did not. PX31 at 85. Dr. Nayak also testified on cross examination that she did not perform any cognitive testing on Petitioner to address Petitioner's complaints of cognitive deficits. PX31 at 85-86.

Deposition Testimony – Dr. Raghavendra

On December 4, 2014, Petitioner called Dr. Raghavendra as a witness who gave testimony at an evidence deposition. PX25. He is a board-certified pain management physician and testified that he has given several lectures and published works related to pain, but not particular to fibromyalgia. PX25 at 4-5. Dr. Raghavendra testified about his care and treatment of Petitioner. *See generally* PX25.

Dr. Raghavendra testified that Petitioner's pain as reported at her first visit on March 22, 2011 started since her work-related injury. PX25 at 12. He testified that he continued to treat her for underlying conditions found in her February 2011 lumbar MRI and fibromyalgia, which he defined as "whole body pains along with depression, anxiety, sleep disturbance." PX25 at 12-13. He explained that he diagnosed Petitioner with 10-months duration of back pain, work-related, associated with mild degenerative disc disease an annular tear and possible facet pain. PX25 at 15. He also explained that Petitioner reported that her back pain started after her injury at work and "who knows when the preexisting degenerative disc disease occurred, and at that time there is no mention of Fibromyalgia[,]" but it was his opinion that she had objective and subjective evidence of pain that started after her work accident and he was trying to treat that. PX25 at 17-19.

Dr. Raghavendra further testified that he felt Petitioner's need for an injections were necessary, but could not say if it was related to her work accident or not. PX25 at 16, 23-24, 30. He explained that Petitioner's pain started with her accident and the injections were to treat her pain. PX25 at 30-31. Dr. Raghavendra also testified that he did not review Petitioner's treatment records from Dr. Ostrowski. PX25 at 13. He also testified that he could not say or opine whether Petitioner's fibromyalgia diagnosis is related to the accident at work on June 28, 2010. PX25 at 13.

When Petitioner returned to him on April 12, 2013, Dr. Raghavendra testified that Petitioner had pain with bending forward and backward, decreased sensations on the left leg, a painful or tender right hip/bursa region, and normal muscle strength. PX25 at 20. He also testified that she had painful fibromyalgia regions all over her body. *Id.* He diagnosed her with ongoing lumbosacral pain since 2010, fibromyalgia, L5-S1 degeneration with an annular tear. PX25 at 21. Dr. Raghavendra testified that Petitioner did not specifically indicate when her hip pain started and that it was a part of all her other pain complaints. *Id.* However, he testified that her hip bursitis was part of fibromyalgia also. PX25 at 22. Dr. Raghavendra testified that he could not opine whether Petitioner had any permanent effects from the fall at home in March of 2014. PX25 at 25-28.

Dr. Raghavendra also testified that he could not opine whether Petitioner was able or unable to work at any level. PX25 at 32-33. He did not know what her job was at the time of her accident. *Id.* Dr. Raghavendra also testified that he had no opinion whether Petitioner had reached maximum medical improvement. PX25 at 33.

On cross examination, Dr. Raghavendra testified that he understood that Petitioner repetitively bent over to scan multiple pallets when she felt pain. PX25 at 34-35. He also testified that he had no opinion whether the findings in Petitioner's 2011 lumbar MRI were caused by Petitioner bending over on June 28, 2010. PX25 at 37-39.

Dr. Raghavendra also testified on cross examination that he never diagnosed Petitioner with fibromyalgia. PX25 at 41. On re-direct examination, he testified that while he did not diagnose Petitioner with fibromyalgia she showed signs of having the condition "[t]wo years later, not in the beginning visit." PX25 at 43.

Deposition Testimony – Dr. Heim

On March 31, 2015, Respondent called Petitioner's treating physician, Dr. Heim, as a witness who gave testimony at an evidence deposition. RX3. He is a board-certified orthopedic surgeon specializing in spinal disorders. RX3 at 4-5. Dr. Heim testified about his medical treatment of Petitioner and rendered several opinions. *See generally* RX3.

Dr. Heim testified that Petitioner first saw him on September 28, 2010 and he reiterated the notations made in his progress note of that date. RX3 at 6-10; RX3 (Dep. Exh. 3). He explained that he reviewed Petitioner's lumbar MRI of July 2, 2010 which generally corresponded with his findings when he reviewed her MRI films which essentially showed some early degenerative changes at L5-S1. RX3 at 10. Dr. Heim testified that his physical examination of Petitioner on this date did not show any sign of acute trauma and he diagnosed a degenerative L5-S1 disc with an annular tear and mechanical low back pain, which he described as pain that was aggravated by activity and improved by inactivity. RX3 at 12-13. He recommended physical therapy followed by work hardening and an increase in physical activity to parallel her efforts in physical therapy. RX3 at 13.

When he next evaluated Petitioner on November 2, 2010, Dr. Heim noted Petitioner's reports of various symptoms not limited to frequent light-headedness, episodes of diffuse tingling in the spine, swelling of the neck, groin and breast, numbness in both lower extremities, diffuse pain in a nondermatomal and non-myotomal patterns (i.e., ones that did not follow the distribution of any given nerve) after undergoing lumbar traction, hypertension, as well as tingling in both hands that resolved after several minutes. RX3 at 13-14. Dr. Heim testified that from Petitioner's physical examination it "did not appear that there was a specific spinal diagnosis that could explain the multiple and widespread symptoms." RX3 at 14-15. He noted that he could not explain the degree of her symptomatology or relate them directly to her spine. RX3 at 15.

As of Petitioner's last visit on December 7, 2010, Dr. Heim noted Petitioner's reports of ongoing and increasingly diverse symptoms as well as her treatment at the Mayo Clinic and for a D&C. RX3 at 17-18. Dr. Heim testified that he had no other scheduled visits with Petitioner and he referred her out to Dr. Nockels or Dr. Ondra, both spine surgeons. RX3 at 19-20, 24.

On cross examination, Dr. Heim testified that he did not note any swelling on physical examination as reported by Petitioner. RX3 at 21. With regard to the trigger point tenderness noted at the December 7, 2010 visit, Dr. Heim testified that it was noted due to Petitioner's report not his examination findings. RX3 at 22-23. He maintained that as of December 7, 2010, the etiology of Petitioner's reported symptoms could not be identified to the spine. RX3 at 23.

Dr. Heim also testified on cross examination that fibromyalgia is not a condition treated by surgeons, although he believed that it was a real condition suffered by some patients. RX3 at 23-24. He also opined that Petitioner's June 28, 2010 accident was responsible for Petitioner's initial complaints as of her initial visit with him. RX3 at 25-26.

Additional Information

Prior to June 28, 2010, Petitioner testified that she had a dog-walking business that she sold before the accident happened. Tr. at 49. She also ran many marathons and was very active, healthy and strong. *Id.*

At the time of the hearing, Petitioner used a cane and explained that she did so every day. Tr. at 49. It is something that was not prescribed by a doctor, but helps her with balance and she feels more stable standing or walking with it. *Id.* On cross examination, Petitioner testified that she had been using the cane for her left hip to assist with balance over the past 5-6 months, every day. Tr. at 70. She acknowledged that it was not prescribed by a doctor. *Id.*

With regard to the change in her symptoms after the accident at work, Petitioner testified that she was initially, mainly complaining of low back pain going into her leg and now it felt like her body was bruised all over to touch and she had burning sensations and tingling in her legs and feet. Tr. at 41. She explained that, sometimes, just to lay still her body hurt so badly that she did not want the sheets to touch her and she felt overall body pain like she had never experienced before. *Id.*

Petitioner testified that she took this picture on August 25, 2013 of her left hand to show the discoloration, how it was swelling, and that the pockets between her fingers were swollen. Tr. at 50-51. She explained that there are other occasions when her hand looks like this and the swelling is ongoing, but that it is very painful to move her fingers. Tr. at 51.

On cross examination, Petitioner also testified with regard to the mechanism of injury that she reported to her doctors. Tr. at 59. She testified that she did described to her doctors that she had to crawl around to look for the bar code label to be scanned and had to bend, turn and crawl to do so. *Id.* She explained that she may not have specifically stated to all of her doctors that she had to crawl, but she did describe what she had to do in order to scan. Tr. at 59-60.

Petitioner also testified that she is somewhat of an accomplished musician making CDs and playing the guitar and a "cajón," which is a type of drum. Tr. at 67. She explained that she has continued to play sparingly after June 28, 2010 for her church. Tr. at 67-68. She testified that she plays at her church maybe once every six weeks, can no longer stand when she plays, and plays the guitar limitedly now because her hands no longer have the dexterity that they used to have. Tr. at 69. She explained that she finds herself singing more than playing. *Id.* On re-direct examination, Petitioner testified that she has never earned money as a musician. Tr. at 74.

Petitioner testified that she has not been back to work since this accident. Tr. at 52. To the best of her knowledge, no doctor within the last 2 years has released her back to any type of work. *Id.* She began receiving social security benefits at a monthly rate of $1,459.00. Tr. at 53.

On cross examination, Petitioner testified that she has not conducted any type of a job search or attempted to pursue employment after June 28, 2010. Tr. at 72. She has an associate's degree in legal, secretarial and executive management. *Id.* Petitioner testified that she has not been treating with a psychiatrist for depression, but added that the Cymbalta helps with that. Tr. at 72. She also testified that she continues to drive an automobile. Tr. at 74-75.

Since her accident, Petitioner explained that she has suffered from depression and "fibro fog" where she cannot complete thoughts or sentences at times. Tr. at 54-55. She also testified that she has pain all day long and that these issues have affected intimate relations with her wife because it hurts to be touched. *Id.* Petitioner also testified that she experiences pain when the weather changes similar to having full-body flu with swelling, tingling, and burning in her legs and her feet, her elbows. Tr. at 55-56.

Petitioner testified that she continues to take her medications as well as over-the-counter D3 2000 for a vitamin D deficit and over-the-counter probiotic medications to address stomach issues and irritable bowel syndrome associated with the fibromyalgia medications. Tr. at 56. She explained that she never had to take such medications or had the swelling and other symptoms she described before June 28, 2010. *Id.*

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to Issues (C) and (D), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent and the date of the accident, the Arbitrator finds the following:

In light of the record as a whole, the Arbitrator finds that Petitioner has established that she sustained a compensable injury while working for Respondent on June 28, 2010 involving her low back. In so concluding, the Arbitrator notes that Petitioner's testimony about the mechanism of injury is not wholly consistent, her first orthopedic physician (Dr. Heim) was unable to correlate the extent of her subjectively reported symptoms to objective medical evidence of her low back condition, and that her first rheumatologist (Dr. Ostrowski) who diagnosed her with fibromyalgia was unable to causally connect to that diagnosis to her accident at work. Petitioner also asserts that her accident at work on June 28, 2010 stemmed from an acute incident or resulted from repetitive activities that resulted in an acute onset of low back symptoms. Notwithstanding, the evidence as a whole reflects that Petitioner did have an acute onset of certain symptoms while engaged in work-related activities that were not present before June 28, 2010.

An employee's injury is compensable under the Act only if it arises out of and in the course of the employment. 820 ILCS 305/2 (LEXIS 2003). The "in the course of employment" element refers to "[i]njuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work...." *Metropolitan Water Reclamation District of Greater Chicago v. IWCC*, 407 Ill. App. 3d 1010, 1013-14 (1st Dist. 2011). The "'arising out of' component refers to the origin or cause of the claimant's injury and requires that the risk be connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Metropolitan Water Reclamation District*, 407 Ill. App. 3d at 1013-14 (*citing Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (1989)). A claimant must prove both elements were present (i.e., that an injury arose out of and occurred in the course of his employment) to establish that his injury is compensable. *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006).

It is undisputed that Petitioner was at work on June 28, 2010. She reported an injury to one of Respondent's representatives on that date and completed a handwritten and detailed three-page injury report the following day describing her accident. Therein, Petitioner

The medical records, Petitioner's reports to Respondent's Section 12 examiner (Dr. Phillips) and Petitioner's written report also reflect somewhat differing reports about the mechanism of injury. However, the Arbitrator finds that these differences are *de minimus* when considering the record as a whole. Petitioner was physically engaged in scanning products on pallets when she felt an immediate onset of low back pain which she

immediately reported, for which she received evaluation and treatment soon thereafter, and which all of the medical records confirm were not present before her work activities on June 28, 2010. Based on the foregoing, the Arbitrator finds that Petitioner sustained a compensable injury to her low back on June 28, 2010.

In support of the Arbitrator's decision relating to Issue (F), whether the Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

The crux of the parties' dispute in this case is whether Petitioner developed anything other than a low back condition as a result of her accident at work. Petitioner testified about and the record reflects that she received medical treatment for myriad other reported symptoms resulting in other diagnoses, the most fervently debated of which is fibromyalgia. Based on a considered evaluation of the entirety of the evidence as delineated in the findings of fact above, the Arbitrator finds that Petitioner has failed to establish a causal connection between any alleged conditions other than her low back condition with radiculopathy and her accident at work.

To recover in a preexisting condition case, a claimant need only establish a causal connection between her work-related injury and claimed current condition of ill-being by showing that her injury aggravated or accelerated the preexisting disease. *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 204-206, (2003). It has long been held that an employer takes its employees as it finds them. *Sisbro*, 207 Ill. 2d at 205 (*citing Baggett v. Industrial Commission*, 201 Ill.2d 187, 199 (2003)). As in this case, even where an employee has a pre-existing condition that renders her more vulnerable to an 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." *See Sisbro*, 207 Ill. 2d at 205 (*citing Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d at 36; *Williams v. Industrial Commission*, 85 Ill. 2d 117, 122 (1981); *County of Cook v. Industrial Commission*, 69 Ill. 2d 10, 18 (1977)). All of Petitioner's treating physicians, second opinion doctors, and Dr. Phillips agree that Petitioner had pre-existing degeneration in the low back, and throughout the spine, at the time of her accident as evidenced by her July 2, 2010 lumbar MRI.

The Appellate Court's decision in *Waldorf Corp. v. Industrial Commission* is instructive in a case such as Petitioner's where a claim for compensation is based on a fibromyalgia diagnosis. *Waldorf Corp. v. Industrial Comm.*, 303 Ill. App. 3d 477 (1st Dist. 1999). In *Waldorf*, the Appellate Court acknowledged that finding causal connection between a fibromyalgia diagnosis and a claimed work injury was not precluded simply because the etiology of the disease was unclear. 303 Ill. App. 3d at 482-83. Since then, the medical community has continued to study the etiology of fibromyalgia as demonstrated in the disputed facts of Petitioner's case as well as Illinois Workers' Compensation Commission cases over decades.

Examining Petitioner's testimony, she contends that while she was diagnosed with various conditions post-accident stemming from the low back, she was searching for the correct diagnosis for her panoply of symptoms, ultimately being fibromyalgia. It is this condition to which she relates her pain and symptoms, and which she asserts resulted directly from her accident at work. Petitioner also maintains that, as a result of her accident and subsequent overall physical condition, she is permanently and totally disabled.

Petitioner's first orthopedic physician, Dr. Heim, gently noted that he was unable to explain Petitioner's subjective reports. As of November 2, 2010, he noted that he was "...not able to explain the degree of [Petitioner's] symptomatology nor relate them directly to her spine. It is not clear if any spine-related symptoms exist at this point." PX14. He also stated that he was "not able to describe any specific functional limitations regarding [Petitioner's] spine." *Id.* As of December 7, 2010, Dr. Heim maintained that "[a]t this point in time,

[he was] remain unable to explain the degree of [Petitioner's] symptomatology as related to her spine." *Id.* Petitioner did not return to see Dr. Heim after his inability or refusal to provide a causal connection opinion.

Petitioner then sought consultation at the Mayo Clinic and saw Dr. Inwards, a hematologist, who made diagnoses based on the records available to him and his examinations, but no opinion as to the etiology of Petitioner's herniated disc with back pain or any other condition. Petitioner then saw a second spine specialist, Dr. Nockels.

Dr. Nockels was also unable to explain Petitioner's subjectively reported symptoms from an orthopedic or neurosurgical perspective beyond finding that she was not a surgical candidate and needed conservative treatment with pain management and/or rheumatological care as directed by other physicians. As of March 17, 2011, Dr. Nockels reviewed the MRI of Petitioner's entire spine finding moderate disc bulges at C5-C6 and C6-C7 without significant cord compression, and a mild disc bulge at L4-L5 without significant cord compression or nerve root compression. He did not recommend any surgery and referred Petitioner for consultations with other specialists. As of on April 4, 2011, Dr. Nockels continued to note that he was "unable to get beyond the diagnostic phase for this patient. I am unable to determine a cause for her pain with certainty. She asked me to become involved in her work status, and – beyond accommodating her with off time during the required studies – I am unable to provide her with a definitive work status now or in the future." PX20.

Respondent also had Petitioner examined on three occasions by its own physician, Dr. Phillips, pursuant to Section 12 of the Act. Dr. Phillips agreed with the findings of Dr. Nockels insomuch as he was also unable to determine a cause for Petitioner's pain with certainty. At the time of her last evaluation, Dr. Phillips noted at least three positive Waddell signs on physical examination; signs of nonanatomic pain behavior or signs that did not fit with spinal anatomy. Petitioner exhibited walking with an abnormal gait, walking on her heels and toes causing excruciating back pain, tenderness to palpation with even the lightest palpation of the lumbar area, a normal neurologic exam of the lower extremities, and even less range of motion than at her last visit with only 10 degrees available in any direction.

Ultimately, Dr. Phillips maintained that Petitioner suffered a lumbar sprain/strain as it related to her accident. He testified that he did not have a specific diagnosis for her ongoing, fairly diffuse complaints other than fibromyalgia, which he testified that was "sort of a catch phrase for just muscle pain[,]" as diagnosed by other treating doctors. RX2 at 23-24. He acknowledged that, while he is not an expert in fibromyalgia, he treats patients with that diagnosis and he does believe that the condition exists. Notwithstanding, he explained that when he first saw Petitioner in July of 2010 she did not exhibit any symptoms of fibromyalgia. With regard to her sprain/strain, Dr. Phillips testified that this should have resolved by the beginning of November of 2012 and that Petitioner required no further medical care beyond that which he recommended and Petitioner underwent.

The Arbitrator finds the opinions of Respondent's Section 12 examiner, Dr. Phillips, to be persuasive given the totality of the evidence in this case; particularly in light of the medical records of Petitioner's own treating physicians. Both Dr. Heim and Dr. Nockels specifically declined to render causal connection opinions and noted that Petitioner's subjectively reported symptoms failed to correlate to their objective findings.

Although Petitioner asserts that she developed fibromyalgia after her low back injury—which would presumably explain Dr. Heim and Dr. Nockels' inability to determine a cause for her pain—the record as a whole reflects that they are not singular in their refusal to opine on causality or inability to clinically explain the source, location, or degree of her subjectively reported complaints as related to her accident, even in part. Thus, Petitioner relies on the diagnosis of Dr. Ostrowski, her first rheumatologist, but the opinions of her second

rheumatologist, Dr. Nayak. The Arbitrator does not find the opinions of Dr. Nayak to be persuasive in this case.

Dr. Ostrowski was the first physician to diagnose Petitioner with fibromyalgia. Her records reflect Petitioner's subjectively reported complaints and an accident at work occurring on June 28, 2010. However, Dr. Ostrowski did not opine that Petitioner's fibromyalgia was causally related to the accident at work. Petitioner eventually ceased treatment with Dr. Ostrowski. She testified that Dr. Ostrowski did not "listen" to her. Dr. Ostrowski's medical records paint a different picture.

Dr. Ostrowski saw Petitioner for the first time on March 25, 2011. She noted that Petitioner had been evaluated by neurosurgery and was not a surgical candidate. Dr. Ostrowski specifically noted that "[p]rior to her injury, [Petitioner] was running marathons and was very active. She had an injury 6/28/10. SHe is a shipping manager, and as she was bending and inspecting the packages (holding scanner), and then developed pain in her lower back. She has not had improvement in her back pain." PX20. After a physical examination noting 13 tender points and a normal neurological exam, Dr. Ostrowski found that Petitioner's generalized pain was most consistent with fibromyalgia. She also commented on the etiology of Petitioner's complaints.

Specifically, Dr. Ostrowski stated that "*[t]he etiology is unclear*, but lack of restorative sleep is associated with fibromyalgia, and patient states that she has not had more than 4-5 hours of sleep since she hurt her back. She will be seeing IR for facet injection for the back. … I recommend the above treatment options, which can be coordinated with patient's PCP and/or a psychiatrist if already involved. … *I have no other recommendations to offer from a Rheumatological/autoimmune perspective regarding fibromyalgia.* Patient is to return to clinic as needed." PX20 (*emphasis* added). Petitioner did return to see Dr. Ostrowski and on May 2, 2011 she noted Petitioner's request for off work notes. Dr. Ostrowski indicated that she did "not write notes for absence from work or for disability for the diagnosis of fibromyalgia." PX20. She also noted her discussion with Petitioner that she "did not routinely follow fibromyalgia as it is not a rheumatic autoimmune disease." PX20.

Petitioner's presentation at her last visit with Dr. Ostrowski on March 19, 2012 reflects that Petitioner was "tearful because she has not been able to go back to work due to her pain and has requested for my input regarding the causality of her fibromyalgia as a result of her work." PX20. Dr. Ostrowski noted her discussion with Petitioner "…that I *still* am not able to give opinion as to the causality for fibromyalgia being linked to her work, since we still do not understand the full etiology of fibromyalgia. However, I am able to provide records as needed which document my exam findings, etc. Pt agreeable." *Id.* (*emphasis* added). Petitioner did not return to see Dr. Ostrowski.

With regard to her fibromyalgia condition, Petitioner relies on a causal connection opinion that was offered by Dr. Nayak, her second rheumatologist. In the context of this record, it is significant that when Petitioner came to Dr. Nayak she already had a fibromyalgia diagnosis from Dr. Ostrowski; a rheumatologist who worked in conjunction with Petitioner's neurosurgeon and pain management doctor at Loyola (Dr. Nockels and Dr. Raghavendra) and who refused to give an opinion noting the relatedness, if any, of Petitioner's fibromyalgia to her accident at work. It is also significant that, despite two depositions, Dr. Nayak was unable to relate Petitioner's fibromyalgia to the accident at work with much confidence or understanding of the accident.

Petitioner first saw Dr. Nayak on June 26, 2012, almost exactly two years after her accident at work. Dr. Nayak noted Petitioner's presentation with "diffuse myalgias and arthralgias and dx of fibromyalgia w/ hx of work related injury on 6/28/10 resulting in severe low back pain and MRI noted for herniated disc and annular tear in lumbar region for which she has undergone extensive physical therapy and epidural/facet injections in summer 2010." PX23.

On December 4, 2012, Dr. Nayak authored a narrative report in which she stated that "Although [Petitioner] was not under my care prior to the work accident on June 28, 2010 and I had the opportunity to participate in her care one year after this incident,beginning June 26, 2012, after review of her medical records and after obtaining a complete medical history and performing a physical examination on [Petitioner], I believe that her symptoms of fibromyalgia may have been exacerbated by her work accident." PX30 (Dep. Exh. 2). Dr. Nayak did not note Petitioner's reported mechanism of injury at work. Moreover, Petitioner testified that she had no symptoms in the low back, or anywhere in her body, before her accident at work. It is unclear from the opinion contained in the narrative report if Dr. Nayak understood that Petitioner has some, or any, symptoms before June 28, 2010.

In any event, at a deposition Dr. Nayak testified that Petitioner's low back pain and fibromyalgia were exacerbated after the accident at work. PX30 at 29-30. She elaborated that it was very difficult for her or anyone to pinpoint the causes of fibromyalgia; "[w]e are not quite clear on that in general terms in terms of etiology for fibromyalgia. However, we do know that trauma can exacerbate it and *in this case it seems that it's very possible that trauma may have exacerbated her fibromyalgia.*" PX30 at 21-22 (*emphasis* added). She also explained that diagnosing fibromyalgia was "actually the exclusion of, you know, making sure that other tests are actually normal that's important to have while you're diagnosing -- making this diagnosis." PX30 at 36. Again, there is no indication from Dr. Nayak's records or testimony that she understood the mechanism of Petitioner's injury at work regardless of the slightly varied reports noted by other physicians or to which Petitioner testified at trial.

Dr. Nayak also conceded that fibromyalgia could occur with or without trauma. She explained that the patients she sees generally come to her with a diagnosis and symptoms that did not necessarily stem from a particular event exacerbating the condition. She explained generally that "[w]e look for certain exacerbating things *that might have brought on this process but sometimes we don't find anything, so it's very possible that it could be an etiology that we're unable to identify.*" PX30 at 36 (*emphasis* added). Ultimately, Dr. Nayak admitted that she did not know whether Petitioner's fibromyalgia did or did not result from her accident at work. She simply maintained that Petitioner's symptoms reportedly began after her accident at work.

"Expert opinions must be supported by facts and are only as valid as the facts underlying them." *Gross v. Ill. Workers' Comp. Comm'n*, 2011 IL App (4th) 100615WC, *16-17, 960 N.E.2d 587, 594 (4th Dist. 2011) (*citing In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003)). The Court went on to specify that such opinions are "only as valid as the reasons for the opinion." *Id.* (*citing Kleiss v. Cassida*, 297 Ill. App. 3d 165, 174, 696 N.E.2d 1271, 1277, 231 Ill. Dec. 700 (1998)).

Given the lack of understanding of the mechanism of injury, Petitioner's presentation to her with diffuse symptoms over two years after her accident, and the equivocal manner in which she testified about the possible etiology of Petitioner's fibromyalgia, the Arbitrator does not find Dr. Nayak's opinions to be persuasive. Moreover, the only two rheumatologists that evaluated Petitioner were her chosen treating physicians. They both diagnosed Petitioner with fibromyalgia and no contrary opinion was provided, but it is Petitioner's burden to show that her conditions of ill-being are somehow related to her accident. As explained above, Dr. Nayak's opinions taken alone are unpersuasive, but when considered in light of other treating physicians' inability to correlate the etiology of Petitioner's subjective complaints to her accident, those opinions are rendered even more so. Again, considering the sum of Petitioner's testimony she appears to assert that every symptom that she has experienced after June 28, 2010 is related to her accident at work. However, "[l]iability cannot be premised upon imagination, speculation or conjecture but must arise from facts established by a preponderance of the

evidence." Illinois Bell Tel. Co. v. Industrial Comm'n, 265 Ill. App. 3d 681, 685 (1st Dist. 1994). Petitioner must establish some causal link between the affected body part or condition and the accident at work.

There is also evidence in the record regarding Petitioner's claimed left hip condition and the relatedness, if any, to her accident at work. The record contains no indication that Petitioner had any symptoms or problems with her left hip before her accident at work. There is also no evidence that she had any hip complaints at or near the time of her accident. Petitioner testified that she did not have any type of accident involving her hip and she did not remember feeling hip pain right after her accident at work on June 28, 2010. These facts are uncontroverted. While Dr. Raghavendra treated Petitioner's subjective complaints, when examined closely, his opinions regarding the relatedness of her hip complaints to her accident are limited to Petitioner's fibromyalgia diagnosis and subsequent fall at home in 2014.

The medical records reflect that Petitioner's first specific complaint of hip pain is noted to stem from the low back and radiate into both hips by Dr. Abusharif at her last visit with him on September 2, 2010 two months after her accident. By November 13, 2012, Petitioner reported to Dr. Nayak that she had an exacerbation of left hip pain and persistent flu-like symptoms with fatigue and bruised feeling throughout her body with hand stiffness and paresthesias. As of December 26, 2012, Petitioner reported one month of worsening right-sided low back pain and left hip pain to Dr. Nockels. As of February 21, 2013, Petitioner saw Dr. Nayak reporting no benefit with her treatment at Loyola for persistent left-sided back pain radiating to the left lateral hip region. She continued to receive injections and treatment with Dr. Raghavendra, Dr. Nockels and Dr. Nayak for hip complaints through her fall at home in early 2014. She claims that this fall at home almost four years after her accident at work was caused by weakness in her legs during her treatment for fibromyalgia, a condition she claims resulted from her accident at work and has deteriorated her physical condition overall.

Petitioner's primary care physician, Dr. Wrona, opined in a letter written almost exactly four years after Petitioner's work accident that her "low back pain and hip bursitis could have contributed to her fall injury. It is unclear to me what role fibromyalgia plays to this situation." Dr. Raghavendra was asked about Petitioner's hip condition. He testified that Petitioner did not specifically indicate when her hip pain started and simply explained that it was a part of all her other pain complaints. Petitioner also offered the testimony of Dr. Nayak who equivocally explained that Petitioner's left hip bursitis could be associated with any number of things including her low back problems, her fibromyalgia, or simply be an isolated condition. But, she ultimately admitted that she could not opine whether Petitioner's left hip bursitis was related to her accident at work.

Petitioner also offered the testimony of Dr. Raghavendra, her pain management physician. He treated Petitioner's low back, left hip, and overall pain complaints. However he did not offer an opinion on Petitioner's fibromyalgia condition and his other opinions were limited. Dr. Raghavendra testified that he did not review Petitioner's treatment records from Dr. Ostrowski. With regard to her hip pain, he acknowledged that Petitioner did not specifically indicate when it started but also testified that Petitioner's hip bursitis was part of fibromyalgia also. He later acknowledged that he never diagnosed Petitioner with fibromyalgia, and merely noted that Petitioner showed signs of having the condition "[t]wo years later, not in the beginning visit." PX25 at 43. Dr. Raghavendra also testified that he could not opine whether Petitioner was able or unable to work at any level, and he had no opinion whether Petitioner had reached maximum medical improvement.

To the extent that Petitioner sustained a low back injury that resulted in any objectively supported radiating symptoms into or through the hips, such complaints are addressed in conjunction with Petitioner's low back injury. However, based on all of the foregoing, the Arbitrator finds that Petitioner has failed to establish a causal connection between any acute injury to the hip or symptoms in the left hip resulting from fibromyalgia.

Based on all of the foregoing, the Arbitrator finds that Petitioner has established causal connection between her low back and accident at work to the extent opined by Respondent's Section 12 examiner, Dr. Phillips, and further finds that Petitioner failed to establish that any other conditions are causally related to her accident.

In support of the Arbitrator's decision relating to Issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

"Under section 8(a) of the Act (820 ILCS 305/8(a) (West 2006)), a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of her employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury." *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 470 (4th Dist. 2011) (*citing University of Illinois v. Industrial Comm'n*, 232 Ill. App. 3d 154, 164 (1st Dist. 1992)). Whether a medical expense is either reasonable or necessary is a question of fact to be resolved by the Commission, and its determination will not be overturned on review unless it is against the manifest weight of the evidence. *F&B Manufacturing Co. v. Industrial Comm'n*, 325 Ill. App. 3d 527, 534 (1st Dist. 2001).

As explained more fully above, the Arbitrator finds that Petitioner has established causal connection with regard to her low back condition to the extent opined by Dr. Phillips. He last examined Petitioner on June 4, 2013. However, this was also the first time that he reviewed the majority of Petitioner's medical records. Indeed, Dr. Phillips, and Respondent, relied in part on the opinions of these doctors in arguing that Petitioner's condition is not as severe as she claims.

While Petitioner continued to receive medical treatment related to the low back beyond that recommended by Dr. Phillips, it was this very treatment and the observations of Petitioner's treating physicians that buttress Dr. Phillips' conclusions. Also, at least in part, Dr. Phillips as well as all of the treating physicians relied on Petitioner's subjective reports in diagnosing and treating her. This is reflected in the deposition testimony of the physicians involved in this case and Petitioner's treating medical records.

Thus, the Arbitrator awards the medical bills incurred by Petitioner related to the low back through June 4, 2013 as reflected in Petitioner's Exhibits that remain unpaid to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act. Petitioner's claim for payment of other medical bills is denied.

In support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

In light of the causal connection analysis explained above, the Arbitrator addresses Petitioner's claim that she is entitled to temporary total disability benefits for the disputed period beginning June 28, 2010 through June 4, 2015.

"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." *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 886 (2nd Dist. 1990). The dispositive test is whether the claimant's condition has stabilized, i.e., reached MMI. *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC at *28 (opinion filed June 26, 2014); *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003).

As explained above, the Arbitrator finds that Petitioner's current condition of ill-being in the lumbar spine is causally related to her injury at work to the extent opined by Dr. Phillips as of June 4, 2013. He maintained through that date that Petitioner reached maximum medical improvement as of November 7, 2010. Dr. Heim and Dr. Nockels did not place Petitioner off work at any point through June 4, 2013 as it related to her low back. Petitioner's other treating physicians who had her off work or in light duty status were treating wholly unrelated conditions, fibromyalgia, or pain related to these conditions.

Based on all of the foregoing, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from June 26, 2010 through November 7, 2010. Petitioner's claim for additional temporary total disability benefits is denied.

In support of the Arbitrator's decision relating to Issue (L), the nature and extent of Petitioner's injury, the Arbitrator finds the following:

Based on the record as a whole—which reflects that Petitioner sustained an aggravating injury to the low back resulting in extensive conservative medical care including injections to resolve pain and radiculopathy—the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 5% loss of use of the person as a whole pursuant to Section 8(d)(2).

In support of the Arbitrator's decision relating to Issue (M), whether penalties or fees should be imposed upon Respondent, the Arbitrator finds the following:

Based on the record as a whole, the Arbitrator finds that no penalties or attorney's fees should be imposed on Respondent. In so concluding, Section 19(k) of the Act provides in pertinent part:

> In case where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay, then the Commission may award compensation additional to that otherwise payable under the Act equal to 50% of the amount payable at the time of such award. Failure to pay compensation in accordance with the provisions of Section 8, paragraph (b) of this Act, shall be considered unreasonable delay. 820 ILCS 305/19(k) (Lexis 2010).

Section 19(l) provides in pertinent part:

> 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 the delay. In the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under Section 8.2(d). In case 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) (Lexis 2010).

Also, Section 16 of the Act provides for an award of attorney fees where an employer, its agent, or insurance carrier "has been guilty of delay or unfairness towards an employee in the adjustment, settlement or payment of benefits due such employee… or has been guilty of unreasonable or vexatious delay, intentional under-payment of compensation benefits, or has engaged in frivolous defenses which do not present a real controversy, within the purview of the provisions of paragraph (k) of Section 19 of this Act, the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier." 820 ILCS 305/16 (Lexis 2010).

Given the evidence, the Arbitrator finds that Respondent had a reasonable dispute as to whether Petitioner sustained a compensable injury at work given the variations in mechanism of injury reported by her. Respondent also had a reasonable dispute as to the conditions, if any, that were causally related to the claimed accident at work or the continuing physical symptoms allegedly involving the entire spine, arms, legs, left hip, and foot as well as the diagnosed fibromyalgia as alleged. Respondent's conduct was not unreasonable, vexatious and/or in bad faith.

Based on all of the foregoing and the totality of the evidence, the Arbitrator denies Petitioner's claim for penalties and fees under Sections 19(k), 19(l) or 16 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Santiago Alvarez,
Petitioner,

vs.

NO: 14WC 4281

Most Valuable Personnel , Visual Pack Co.,
Respondent,

16IWCC0749

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 16, 2015, is hereby affirmed and adopted.

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

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

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

DATED: NOV 21 2016
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CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

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

ALVAREZ, SANTIAGO
Employee/Petitioner

Case# **14WC004281**

MOST VALUABLE PERSONNEL VISUAL PACK CO
Employer/Respondent

16IWCC0749

On 9/16/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.26% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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STATE OF ILLINOIS)
)SS.
COUNTY OF Lake)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Santiago Alvarez
Employee/Petitioner

v.

Most Valuable Personnel, Visual Pack Co.
Employer/Respondent

Case # 14 WC 04281

Consolidated cases: N/A

16IWCC0749

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Rockford**, on **July 16, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0749

FINDINGS

On the date of accident, **January 20, 0214**, Respondent ***was*** operating under and subject 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 **$1,627.22**; the average weekly wage was **$271.22**.

On the date of accident, Petitioner was **32** years of age, ***single*** with **3** dependent children.

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

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

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

ORDER

BECAUSE PETITIONER HAS FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT HE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH RESPONDENT ON JANUARY 20, 2014, THE CLAIM FOR COMPENSATION IS DENIED.

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

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

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

Signature of Arbitrator

September 16, 2015
Date

ICArbDec19(b)

SEP 16 2015

Statement of Facts

Petitioner Santiago Alvarez testified that on January 20, 2014, he was employed by Respondent Most Valuable Personnel. Respondent was a staffing agency. Petitioner was working at Visual Pak. Petitioner testified that he had been working there for about six weeks on the assembly line. He was not working anywhere else at that time. He testified that his job consisted of stacking cases on the line onto pallets. There were two pallets on the ground near him. He would bend down to put the boxes onto the pallets.

Petitioner testified that on January 20, 2014, he started his shift at 3:00 PM. At about 4:30 PM, he was between two pallets and reached over to put a box down and could not straighten up. He felt a very strong pain on the right side of his low back and also pain in his neck. Petitioner denied any prior neck problem. He had a prior work related back injury in 2012. He testified the injury occurred on March 7, 2012 when he was lifting at work. Petitioner denied a further lifting injury on April 25, 2012. He treated with Greenleaf Orthopedics for that injury. He did not remember how long he treated. Petitioner testified he was released from care after that injury. His pain had resolved. He testified that he had no problems until January, 2014.

Contained in the New Life Medical Center records (PX 15) are records from Petitioner's treatment for his back at Greenleaf Orthopedics from March 19, 2012 through May 10, 2012. The records reflect a history of a lifting injury. Petitioner reports a previous onset of back pain a few years ago. Petitioner advanced complaints in the low back running down the left leg all the way to his to his foot with numbness and tingling. The records document a diagnosis of lumbago and sciatica. Petitioner began physical therapy. On April 30, 2012, Petitioner denied any radicular symptoms and had really no further complaints with respect to his back. Petitioner was still having abdominal discomfort. A CT of the pelvis was read as normal. Petitioner was released back to work full duty pending a release from his general surgeon related to this lower abdominal pain. Petitioner was discharged from physical therapy on May 10, 2012. He noted no further back pain, only some left hip pain when he first wakes up. Petitioner stated he did not think he could lift more than 20 pounds (PX 15).

On January 20, 2014, Petitioner continued to work until around 5:00 PM, when he went on his scheduled break. Petitioner testified that he approached a line manager, Abel Flores, to tell him that he had injured his lower back and needed to go home. Abel agreed that Petitioner could go home that day. Petitioner also spoke with a Carlos Bazan, Petitioner testified that he told Mr. Bazan that he hurt his back and needed to go home. Petitioner testified he told Mr. Bazan that he had hurt himself in 2012. He testified that he told him that he was going to try and see a local massage therapist.

Carlos Cardenas prepared an Incident Investigation Report on January 20, 2014 (RX 1). The report notes that Petitioner was working under the supervision of Abel Flores who had agreed he could go home for the day. The cause is listed as injury in a previous company and not here. Prevention includes that the previous injury was volunteered to the shift supervisor.

Mr. Bazan provided a statement on January 24, 2014 (RX 2). He reported that Petitioner approached him in his office at 5:15 PM to ask if he could go home. Petitioner reported he did not get injured here. He had this pain since he hurt himself at another company. He stated Petitioner was scheduled to work on January 21, 2014, but did not show up of call to say he was unable to come to work.

Carlos Bazan testified by evidence deposition taken July 10, 2015 (RX 6). He testified that he currently works as a supervisor for Most Valuable Personnel (MVP), which is a temporary employment agency. He has worked at MVP for more than 14 years and is currently working at Visual Pak. He was working at Visual Pak on January 20, 2014 when Petitioner approached him about two hours into the shift at 5:15 PM, requesting that he be allowed to go home. Carlos Bazan inquired as to why he wanted to go home and asked if he was okay. Petitioner indicated that he was feeling a little pain in his back and that he had had a previous injury at another company and he wanted to get massage therapy on his back from a massage therapist in his neighborhood. He testified that the massage therapist was someone that Petitioner had seen two weeks prior and that was the reason why his back was still warm. Petitioner testified that the massage therapist was a friend of his wife's family. He denied seeing him before.

Mr. Bazan testified that if someone reports a work related injury there is a procedure to follow. They would fill out a report and be offered medical treatment. Petitioner was scheduled to return to work on January 21, 2014 at 3:00 p.m. However, Petitioner was a no-show/no-call and Carlos Bazan never spoke or heard back from Santiago Alvarez again after January 20, 2014.

Petitioner testified that he did not call but sent a message. He waited a week for treatment because he was waiting for Josefa to call back. Petitioner testified he was never able to meet with her. He testified he went to the MVP office but the person in the office would not take the report. In the history provided to Dr. Graf, Petitioner states he spoke with Josefa on Friday who told him that Carlos did not report the accident. Petitioner was terminated on January 29, 2014 for failure to report to work or contact his supervisor on January 21, 2014 (PX 15).

Carlos Bazan testified that he sent an e-mail outlining the incident in which the Petitioner requested to go home to his supervisor at Visual Pak on January 24, 2014 (RX 2). He testified that Petitioner and Carlos Bazan spoke with Carlos Cardenas, a security employee at Most Valuable Personnel on January 20, 2014. Carlos Cardenas conducted an investigation and prepared the Most Valuable Personnel Incident Investigation Report (RX 1).

Petitioner first sought medical care with Dr. Barnabas on January 27, 2014. Dr. Barnabas' records from Herrin Medical Center were admitted as Petitioner's Exhibit 1. Petitioner provided a history that he was covering a pallet that he had been filling with boxes and felt a sudden pain in the back and couldn't move; he was stuck (PX 1, p 4). Petitioner complained of pain in his lower back which was radiating down both lower extremities as well as neck pain that was radiating down both arms. Following examination, Dr. Barnabas diagnosed cervicalgia, sprain of neck, thoracic or lumbosacral neuritis or radiculitis, lumbago, displacement of lumbar intervertebral disc without myelopathy and lumbar sprain. Dr. Barnabas ordered the Petitioner off of work and recommended physical therapy as well as an MRI of his lumbar spine (PX 1).

Petitioner underwent an MRI of his lumbar spine on January 27, 2014, at Delaware Place MRI. The radiologist's impression was disc herniations at L3-L4, L4-L5 and L5-S1 (PX 2). Petitioner also began physical therapy on January 29, 2014, at New Life Medical Center where he treated through April 21, 2014 (PX 15).

Petitioner was referred to Pain Care Specialists for pain management. Petitioner's initial visit was on February 10, 2014. Dr. Luz Rojas-Aguirre testified by evidence deposition on March 25, 2015 (RX 3). Dr. Aguirre testified that she had no independent recollection of the Petitioner and therefore testified from her report dated February 10, 2014. The report conveyed to her a December 20, 2013, accident date. The history of the

accident was consistent with the claimed injury. Petitioner complained of continuing low neck and back pain. The report states Petitioner had an MRI one week after, on December 27, 2013. Dr. Aguirre testified that examination revealed positive straight leg raise on both sides. Dr. Aguirre also testified that she reviewed the January 27, 2014 lumbar MRI. She diagnosed Petitioner with disc herniations at L3-L4, L4-L5 and L5-S1. Dr. Aguirre testified that she continued Petitioner's off work restrictions, recommended an MRI of his neck and ordered an epidural injection for his back (RX 3 and PX 4).

Petitioner testified that he provided Dr. Aguirre with the wrong date of accident of December 20, 2013, and that it was a mistake. He was not made aware of this until his attorney pointed it out to him while they began trial preparation.

Petitioner underwent an MRI of his cervical spine in February 11, 2014, at Lake Shore Open MRI. The impression was disc herniations at C3-C6 (PX 5). Petitioner also underwent an EMG on February 26, 2014, performed by Dr. Lenny Cohen, which evidenced moderate L5/S1 radiculopathy on the left, mild S1 on the right, as well as mild L4 radiculopathy on the left (PX 13). Petitioner underwent a series of epidural injections for both his neck and his back on March 21, 2014 and April 11, 2014, administered by Dr. Jain (PX 4). Dr. Jain took a history from Petitioner that he was injured when he lifted a heavy box and when he bent down; he felt pain on attempting to get up. Petitioner's history was that he was unable to move and was unable to get up (PX 4, p 4). Petitioner testified that while the injections did provide him with symptomatic relief, the benefits were only temporary and the pain returned.

On referral from Dr. Barnabas, Petitioner saw Dr. Malek for a neurosurgical consultation on April 25, 2014. Dr. Malek's records were admitted at Petitioner's Exhibit 8. On April 25, 2014, Petitioner provided a history of the January 20, 2014 work accident indicating that he had been packing for 4 days prior to the injury. He was moving small boxes weighing 5 pounds on the date of injury. He advised Dr. Malek of his prior work related back injury which he stated occurred two years ago and that he had done well since. Petitioner complained of radiating pain in both his neck and back (PX 8, p 5). Dr. Malek diagnosed bilateral cervical radiculopathy and left lumbar radiculopathy at the S1 level. Dr. Malek recommended an L5-S1 microdiscectomy for Petitioner's back and an epidural injection for his neck. Dr. Malek continued the Petitioner's off work restrictions pending surgery (PX 8, p 6-8). Respondent refused to authorize this treatment (PX 8, p 9). Petitioner followed up with Dr. Malek through July 18, 2014. Dr. Malek advised his patients on July 29, 2014 that he would be retiring from practicing medicine effective August 29, 2014 (PX 8, p 16).

Petitioner was also referred by Dr. Barnabas to Dr. Abdellatif at ProClinics, Pain Management. His records were admitted at Petitioner's Exhibits 10 and 11. Dr. Abdellatif administered facet injections on July 7, 2014, and July 23, 2014 (PX 11). After Dr. Malek's retirement, Petitioner had periodic visits with Dr. Barnabas though January 30, 2015. Dr. Barnabas notes the status of the legal proceedings and provided continued off work slips (PX 1, p 32-39).

Petitioner was seen by Dr. Carl Graf on April 13, 2015. Dr. Graf's records were admitted as Petitioner's Exhibit 14. Petitioner provided Dr. Graf with a history of lifting heavy boxes on Thursday and began to have back pain. The following Monday he was lifting similar boxes and stacking them on a pallet. Petitioner claims to have done this for 10 hours each of these days and began to have low back pain and could not get up. Petitioner complained of pain on the right side of his back underneath the belt line and in the middle of his chest. He has low back pain to the left leg and states his toes feel cold (PX 14).

Dr. Graf's physical examination of the cervical spine is unremarkable. He does note decreased sensation throughout the entire upper left extremity in no anatomic nerve distribution. The lumbar spine examination noted a normal neurological examination with negative straight leg raising producing back pain. Dr. Graf reviewed the MRI of the lumbar spine which he found to demonstrate degenerative disc changes with a right-sided L3-L4 disc herniation with a central disc bulge at L5. Dr. Graf recommended Petitioner undergo an updated lumbar MRI scan and return to him after that test (PX 14).

Petitioner testified that Respondent has refused to authorize that MRI and therefore he has not followed up with Dr. Graf. Petitioner testified that he has not received any temporary compensation. Petitioner testified that he recently found employment working for a blanket company. He worked for three weeks which ended on July 9, 2015. He testified that currently he is not working. Petitioner testified that he is still having pain in his lower back and that the injury has not improved. Petitioner testified that none of the medical bills stemming from his treatment have been paid by the Respondent (PX 16).

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, the Arbitrator finds as follows:

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the claimant's employment. Petitioner is alleging that he suffered injuries as a result of a lifting episode on January 20, 2014. Respondent has disputed that the injury occurred, submitting the testimony of Mr. Bazan, and the investigation records in which Petitioner initially reported he did not injury himself working for Respondent but was injured at a previous company.

The Arbitrator notes that the initial reporting was provided to Mr. Flores, Mr. Contreras and Mr. Bazan within hours of the alleged injury. At that time, all of the reporting documented that Petitioner had not injured himself at Respondent, but was suffering from a previous injury. This previous injury is documented in the records included from Greenleaf Orthopedics. The symptoms of back pain with radiation down the left leg are the same as the complaints advanced by Petitioner after January 20, 2014. Although Petitioner was released from care in May, 2012, his own statement at that time was that he did not think he could lift over 20 pounds.

Despite the dramatic event testified to by Petitioner, that he was "stuck" and could not straighten up, there was no reporting of the work accident at the time he left work on January 20, 2014. He sought no immediate medical treatment for this injury. He testified that he was only planning to seek massage therapy, despite having prior treatment at Greenleaf Orthopedics in Gurnee. Instead he sought no treatment for a week, yet Arbitrator's Exhibit 2 reflects that he sought legal counsel on January 22, 2014, before any claim of injury was reported. Petitioner's testimony that he was waiting for a call back from Respondent does not correspond with this timeframe. The Arbitrator notes that Petitioner's testimony with respect to the efforts to report the alleged accident does not agree with the explanation given to Dr. Graf.

The Arbitrator also notes many variations in the details of Petitioner's accident description. While the December 20, 2013 date given to Dr. Aguirre may be a mistake, given the concurrent statement that the January 27, 2014 MRI was performed on December 27, 2013, the other histories have multiple discrepancies. Petitioner testified to placing a heavy box on the pallet, yet told Dr. Malek he was moving small boxes

weighing 5 pounds on the date of injury.. He told Dr. Barnabas on January 27, 2014, he was covering a pallet when he felt pain. He told Dr. Jain he was lifting a heavy box. Petitioner provided Dr. Graf with a history of lifting heavy boxes on Thursday and began to have back pain. The following Monday he was lifting similar boxes and stacking them on a pallet.

The testimony and medical records also demonstrate that the medical was coordinated by Petitioner's counsel. Dr. Aguirre notes the referral to Dr. Barnabas not at Herrin Clinic but at Med Legal. Petitioner told Dr. Graf that he consulted Med Legal and was sent to Dr. Barnabas. The Arbitrator notes that despite Petitioner living in Waukegan and having previously treated at Greenleaf Orthopedics in Gurnee for a virtually identical condition, his treatment beginning after the date of his signature on the Application for Adjustment of Claim was with providers in downtown Chicago.

The Arbitrator also notes that Dr. Graf, despite Petitioner's presentation of severe subjective complaints including pain described as 10/10, recorded a physical examination with little in the way of objective findings. The loss of sensation in the upper extremity was not in an anatomic pattern. The remainder of the neurological examination was negative. Dr. Graf described the lumbar MRI as showing degenerative findings, other that a right sided herniation which would not account for alleged left leg complaints.

The Arbitrator had the opportunity to observe Petitioner's testimony to gauge his credibility. After observing this testimony and reviewing the documents and evidence submitted much of which is inconsistent with the described accident and complaints raised by Petitioner, the Arbitrator finds Respondent's version of the events of January 20, 2014 as documented by the testimony of Mr. Bazan and Respondent's exhibits more credible and persuasive.

Based upon the record as a whole including the testimony provided and the exhibits submitted, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he suffered an accidental injury arising out of or in the course of her employment with Respondent.

In support of the Arbitrator's decision with respect to (E) Notice, (F) Causal Connection, (J) Medical, (K) Prospective Medical, and (L) Temporary Compensation, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Accident, the issues of Notice, Causal Connection, Medical, Prospective Medical, and Temporary Compensation are Moot

Petitioner's claim for compensation is hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Soleill Ramirez,
Petitioner,

vs. NO: 13 WC 04617

United Airlines,
Respondent.

16IWCC0750

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of nature and extent of Petitoner's 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 August 13, 2015 is hereby affirmed and adopted.

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

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

16IWCC0750

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $15,100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 21 2016

o-11/16/16
jdl/wj
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Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RAMIREZ, SOLEILL
Employee/Petitioner

Case# **13WC004617**

UNITED AIRLINES
Employer/Respondent

16IWCC0750

On 8/13/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1836 RAYMOND M SIMARD PC
221 N LASALLE ST
SUITE 1410
CHICAGO, IL 60601

2461 NYHAN BAMBRICK KINZIE & LOWRY
LINDA ROBERTS
20 N CLARK ST SUITE 1000
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

Soleill Ramirez
Employee/Petitioner

v.

United Airlines
Employer/Respondent

Case # **13** WC **4617**

Consolidated cases:

16IWCC0750

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Ketki Steffen**, Arbitrator of the Commission, in the city of **Chicago IL**, on **06/03/2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

FINDINGS

On **November 2, 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 **$23,808.96**; the average weekly wage was **$523.19**.

On the date of accident, Petitioner was **24** years of age, ***married*** with **1** children under 18.

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

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

Respondent shall be given a credit of **$22,248.36** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$22,248.36**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $348.79/week for 63 5/7 intermittent weeks, as provided in Section 8(b) of the Act. The parties have stipulated that there was no overpayment or underpayment of TTD benefits.

Respondent has paid $22,248.36 in TTD benefits.

The Arbitrator declines to award the remaining balance of the bill from Dr. Gerald Cicero in the amount of $1,465.00.

Respondent shall pay Petitioner permanent partial disability benefits of $313.91/week for 47.30 weeks because the injuries sustained caused the 22% loss of use of the right leg as provided in section 8(e) of the Act.

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

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

the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Kelli Shroff Steffen
Signature of Arbitrator

8/13/15
Date

ICArbDec p. 2

AUG 13 2015

FACTUAL HISTORY

The Petitioner, Soleill Ramirez, is a lead customer service representative for the Respondent, United Airlines. The accident is uncontested. On November 2, 2012, the Petitioner was assigned to work in the lobby checking passengers in and weighing bags on the bag belt. Petitioner reported that she placed a bag on the belt when her foot got caught on a rubber mat causing instant pain. Petitioner testified that she heard a pop and felt pain in her right knee.

On November 2, 2012, Petitioner presented to Concentra at O'Hare Airport and reported that she was putting a bag on the belt when her foot got caught on the rubber mat and her knee popped. Petitioner was diagnosed with a right knee strain. Petitioner had full range of motion but had pain with full extension and decreased flexion due to pain. Petitioner was released to work with restrictions of wearing a knee brace at all times while at work. She was also advised to use her crutches for ambulation. Petitioner was restricted from no standing longer than 10 minutes. (Petitioner's Exhibit 1). Due to the nature of Petitioner job duties, Petitioner would have been confined to sedentary work and the Respondent could not accommodate the restrictions.

Petitioner returned to Concentra and reported significant right knee pain stating that she had a giving out feeling when she put her full weight on her right leg. Petitioner was off work at the time. Petitioner was diagnosed with a possible right medial meniscal tear and was referred to an orthopedic specialist Dr. Theodore Suchy. (Petitioner's Exhibit 1).

Petitioner presented to Dr. Suchy on November 13, 2012. Petitioner again reported that she went to lift a suitcase to put it on a moving rack when her right foot got caught in a mat causing her to twist her knee. Petitioner reported that she was unable

to put weight on her knee since then. Dr. Suchy noted joint effusion with pain and tenderness over the right medial joint line. The McMurray test was positive so the doctor suspected a tear of the medial meniscus. Petitioner was diagnosed with internal derangement of the right knee with probable displaced bucket handle tear of the medial meniscus. Petitioner was released to work with sit down work only. (Petitioner's Exhibit 2).

On December 4, 2012, Dr. Suchy prescribed an MRI of the knee. Dr. Suchy diagnosed the Petitioner with a torn medial meniscus with displacement. (Petitioner's Exhibit 2).

Petitioner underwent an MRI of the right knee on December 7, 2012 at Westbrook Open MRI. The MRI revealed suggestion of a mild chondral thinning of the patella. There was no evidence of acute intra-articular or bone injury. (Petitioner's Exhibit 2).

On December 11, 2012, Petitioner presented for a follow-up of the right knee with Dr. Suchy. The Petitioner was advised to return in 2-3 weeks and Dr. Suchy was hopeful that Petitioner would be back to regular duty at that time. (Petitioner's Exhibit 2).

Petitioner presented to Concentra for physical therapy on December 21, 2012. Petitioner had gait deficits and decrease heel to toe on the right extremity. Petitioner was diagnosed with a knee sprain. (Respondent's Exhibit 2).

On January 2, 2013, Dr. Suchy released the Petitioner to regular duty and discontinued formal therapy. (Petitioner's Exhibit 2).

The Petitioner then began treatment with Dr. Cicero of Chicago Neck and Back Institute. Petitioner presented to Dr. Cicero on January 25, 2013 with acute right knee

pain and swelling secondary to work injury. Dr. Cicero requested to review the MRI findings and recommended therapy for the Petitioner. Petitioner was authorized to return to work with restrictions of no lifting more than 10 pounds, no prolonged sitting, ground level work only, minimum bending or stooping, no over the shoulder work and was to wear the brace at all times.

Petitioner returned to Dr. Suchy on January 29, 2013. Petitioner complained that her knee locked in an extended position. She also reported increased pain and discomfort in the right knee. Dr. Suchy stated that he could not explain the Petitioner's subjective complaints or her locking. He released the Petitioner to regular activities without restrictions. He further stated Petitioner needed no further diagnostic studies or therapeutic modalities. (Petitioner's Exhibit 2)

Petitioner testified that she returned to work and noted increased pain and a 'giving out' of her right knee almost immediately.

On January 30, 2013, the Petitioner presented to Dr. Wilson for evaluation. Dr. Wilson noted that the Petitioner developed pain in the medial aspect of her knee. Petitioner had a negative straight leg raise. Dr. Wilson recommended a short steroid taper followed by Indocin 50 mg. He also recommended continuing therapy with Dr. Cicero. Petitioner continued with Dr. Cicero through February, 2013. Dr. Cicero then referred the Petitioner to Dr. Michael Collins at Hinsdale Orthopedics for a possible medial meniscal injury. (Petitioner's Exhibit 4).

Petitioner presented to Dr. Michael Collins on March 5, 2013 and reviewed the MRI films. Petitioner reported that she injured her right knee when her foot got stuck on a mat and her knee popped. Petitioner reported ongoing complaints of instability. Dr. Collins noted there was ligamentously laxity to valgus stress but there was no instability

to Lachman's or anterior Drawer test. Dr. Collins suspected a medial patella ligament or some chondral injury. (Petitioner's Exhibit 4). He recommended arthroscopic surgery of the right knee.

On April 16, 2013, the Petitioner presented to Dr. Collins for pre-surgical visit. Dr. Collins recommended a knee arthroscopy. He notes that Petitioner had markedly lax ligament and could easily bend the thumb down to touch the forearm. Petitioner did not have any instability of the patella. There was some tenderness over the anterior medial portion of the knee. (Petitioner's Exhibit 4).

On April 26, 2013 Petitioner underwent a diagnostic arthroscopy of the right knee at the Salt Creek Surgical Center (PX3). The arthroscopy revealed no significant subluxation or maltracking. There were no unusual SLAP lesions and no treatment was rendered to the patellofemoral joint. The medial compartment was intact and the anterior cruciate ligament was intact. (Petitioner's Exhibit 3). Petitioner had some Grade 1 softening of the patella.

When the Petitioner presented for her post-operative evaluation with Dr. Collins, Dr. Collins noted that the puncture sites were healing nicely and there was just trace effusion. Petitioner's arthroscopic findings were reviewed and there was some Grade 1 softening of the articular cartilage of the patella and Petitioner was advised that this was something that would heal at least to some extent with time. Petitioner was released to work to go back in a sedentary position. Petitioner then began a course of physical therapy at ATI Physical Therapy.

On July 9, 2013, Petitioner presented to Dr. Collins as an emergency. Petitioner stated that during work hardening she felt a crack when she had to put all her weight on

her right leg. Petitioner reported that her lower extremity was still painful while in work conditioning. Dr. Collins recommended another MRI. (Petitioner's Exhibit 4).

Petitioner underwent an MRI of the right knee which revealed no meniscal tear or ligament tear. There was minor chondral fissuring of the patella articulation without chondral defects. (Petitioner's Exhibit 4).

On July 19, 2013, Petitioner presented to the emergency room of Elmhurst Memorial Hospital complaining of instability. Petitioner was diagnosed with knee overuse.

On July 30, 2013, Petitioner returned to Dr. Collins. Petitioner stated that she was not doing well and that she had right knee pain which she attributed to work conditioning. Dr. Collins advised the Petitioner that he had no explanation for the severity of the Petitioner's symptoms and recommended a second opinion with Dr. Bush-Joseph at Rush. (Petitioner's Exhibit 4)

On September 23, 2013, Petitioner returned to Dr. Cicero for evaluation of her right knee. Petitioner began an exercise program to stabilize the knee.

The Petitioner presented to Dr. Bush-Joseph on September 24, 2013 for a second opinion. Petitioner was diagnosed with probable patellar subluxation, chondromalacia and moderate quadriceps hips and pelvic weakness. Dr. Bush-Joseph did not believe Petitioner was a surgical candidate and there was no evidence of arthrosis. He stated that Petitioner was able to work with restrictions and recommended aqua therapy to enhance quadriceps strength. (Petitioner's Exhibit 4).

On September 25, 2013, Petitioner presented to Dr. Wilson for evaluation of her right knee pain. Petitioner reported that she retro grasped while on therapy although she did not have any trauma or any new injury.

On October 17, 2013, Petitioner presented to Dr. Collins. Petitioner reported that she remained sore and had not been back to work. Petitioner was referred to physical therapy at Petitioner's request and was released to work with restrictions. (Petitioner's Exhibit 4)

When the Petitioner returned to Dr. Collins on November 25, 2013, Petitioner reported that her knee was feeling much better although she had some discomfort with it. Dr. Collins recommended that Petitioner finish up physical therapy for two more weeks and then go back to work. Dr. Collins released the Petitioner to work full duty. (Petitioner's Exhibit 4).

The Petitioner last saw Dr. Collins on December 3, 2014. Petitioner was prescribed a soft knee brace. Petitioner had not sought any treatment between November 25, 2013 and December 3, 2014.

Petitioner testified that she has no further appointments scheduled. She continues to work full duty without any lost time from work.

Analysis/Findings

In relation to (F) is the condition of ill-being related to the injury at work, the Arbitrator finds the following:

The Petitioner has testified credibly regarding the nature of her accident when she injured her right knee when her foot became caught on a mat while working for the Respondent. Petitioner received immediate treatment and gave a consistent account of her accident, injury and symptoms to all her medical providers. After preliminary exams and conservative care, Petitioner was diagnosed with a right knee strain and eventually underwent a diagnostic arthroscopic surgery. She appeared in court wearing a knee brace and testified to her current condition of pain and weakness in her right knee.

Dr. Bush-Joseph diagnosed the Petitioner with probable patellar subluxation, chondromalacia and moderate quadriceps hips and pelvic weakness. The Arbitrator finds that the Petitioner's current condition of ill-being is related to her work accident as there are no prior medical problems with her right knee, she was only 24 years of age and in good health at the time of the accident and her testimony and the mechanism of her accident are consistent and supported by the medical records.

The Respondent's payment ledger shows that the Respondent has paid Dr. Cicero for all dates of service. Dr. Cicero's bills are confusing as to what exactly is owed or unpaid. Section 8(a) allows for payment pursuant to the fee schedule or any agreement between the parties whichever is less. Furthermore, the Illinois Workers'

Compensation Act section 8.2(e) specifically prohibits the provider from seeking payment for balances from Petitioner after the Respondent has made payment. The bill presented by the Petitioner does not represent charges for unpaid services rather it is balance billing after Dr. Cicero accepted payment from the Respondent. Therefore the Arbitrator finds that the Respondent has paid for all reasonable and necessary medical charges and denies any further payments to Dr. Cicero.

J. MEDICAL EXPENSES

The Arbitrator finds that the medical services provided to the Petitioner were reasonable but that the outstanding bill from Dr. Cicero for $1,465.00 is not awarded and the Petitioner has failed to prove the nature of this outstanding bill.

The Petitioner seeks payment for an outstanding balance of $1,465.00 (PX7) on the bill of Dr. Gerald Cicero. Respondent objected as to reasonableness. The initial bill was adjusted to the fee schedule and the charges were supported by the records of Dr. Cicero. (PX2). The Respondent paid the bill. It is unclear from the evidence presented and the testimony what the outstanding balance is for. It appears to be more likely the amount left over after fee schedule adjustments. Section 8(a) allows for payment pursuant to the fee schedule or any agreement between the parties whichever is less. Furthermore, the Illinois Workers' Compensation Act section 8.2(e) specifically prohibits the provider from seeking payment for balances from Petitioner after the Respondent has made payment. The burden of proof to prove that the bill is for reasonable services rendered for the work related accident is upon the Petitioner. Respondent has

presented ledger evidence that it paid the bill for to Dr. Cicero subject to the fee schedule. Absent additional evidence to corroborate that the outstanding balance is an unpaid bill as opposed to the left-over amount after fee schedule adjustment, the Arbitrator declines to award the same.

(L) Nature and Extent of the Injuries

Accident is uncontested and the Petitioner suffered an injury to her right knee. Dr. Bush-Joseph diagnosed the Petitioner with probable patellar subluxation, chondromalacia and moderate quadriceps hips and pelvic weakness. Petitioner's MRI did not reveal any tears. The Petitioner after initial conservative case with continued complaints, underwent a diagnostic arthroscopic surgery. The diagnostic surgery did not reveal any tears or any objective findings. Both, Dr. Suchy and Dr. Dr. Bush-Joseph cannot clear explain Petitioner's current pain and weakness complaints in light of lack of acute objective findings.

The Petitioner has returned to full time, unrestricted work duties but has started using a knee brace since December 2014 due to instability while using the stairs. Dr. Collins has opined that Petitioner's diagnosis of subluxation of the knee would heal over time. Petitioner states she continued to suffer from right knee pain and weakness. She has no additional treatment pending or any appointments pending.

In regards to the nature and extent of Petitioner injuries, the Arbitrator notes that this is a post-AMA amendment case. This case arises out of a November 2, 2012 accident, a date after September 1, 2011 amendment of Worker's Compensation Act ("Act"). Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records.

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

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a customer service agent at the time of the accident and that she is able to return to full unrestricted duty after her treatment. The Arbitrator notes that she now uses a brace to avoid problems when using the stairs. The Arbitrator assigns moderate weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 24 years old at the time of the accident. Because Petitioner has over 40 years of labor market participation remaining, the Arbitrator therefore gives great weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner returned to the same job at the same rate of pay. There is no evidence of a compromise to the earning capacity so the arbitrator finds that this factor has a neutral effect on her decision.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner testified credibly that she experiences pain and weakness in her right knee. Such complaints have remained consistent from the date of accident to the date of arbitration. The treating records of Concentra, Dr. Cicero, Dr. Bach and Dr. Collins are all consistent with Petitioner's subjective complaints. Because of the fact that Petitioner is only 24 years old and will uses a knee brace to support her injured knee, the Arbitrator therefore gives moderate weight to this factor. The Arbitrator also gives some consideration to the fact that Petitioner has not returned for medical treatment for some time and that her subjective complaints are not necessarily supported by objective medical findings.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 22% loss of use of right leg pursuant to §8(e) of the Act.

Ketki Shroff Steffen
Signature of Arbitrator Ketki Shroff Steffen

8/12/15
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Thomas Phifer,
Petitioner,

vs. NO: 08 WC 38341

Premier Transport, Inc.,
Respondent.

16IWCC0751

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, employment relationship, and "all other evidentiary or procedural issues" and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 22, 2015 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: NOV 21 2016

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-11/16/16
jdl/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PHIFER, THOMAS E
Employee/Petitioner

Case# **08WC038341**

16IWCC0751

PREMIER TRANSPORT INC
Employer/Respondent

On 12/22/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.51% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLEN HASKINS NICHOLSON ET AL
DAVID B MENCHETTI
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0507 RUSIN & MACIOROWSKI LTD
KISA P STHANKIYA
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Thomas E. Phifer
Employee/Petitioner
v.
Premier Transport, Inc.
Employer/Respondent

Case # 08 WC 038341

16IWCC0751

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

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. 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. ☐ What were Petitioner's earnings?
H. ☐ What 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 _____

T. E. Phifer v. Premier Transport, Inc., 08 WC 038341

FINDINGS

On **August 5, 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 accident *was* given to Respondent.

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

In the year preceding the injury, Petitioner earned **$20,800.00**; the average weekly wage was **$400.00.**

On the date of accident, Petitioner was **52** years of age, *single* with **2** dependent children.

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

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

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

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

ORDER

Claim for compensation denied, Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on August 5, 2008 and failed to prove that he had an employee/employer Relationship with Respondent on said date.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 21, 2015
Date

ICArbDec p. 2

DEC 22 2015

FINDINGS OF FACT

Petitioner testified that he was employed by Respondent, beginning in about May of 2008. His job duties included delivery and moving and sales. They would move items store to store, deliver on a route and take items from a warehouse to a location and install or build up the items. Basically, Petitioner would load and unload furniture and household items. The job involved heavy lifting. Petitioner testified that his employment was terminated about 3 weeks after his alleged accident. Petitioner denied prior significant low back injuries. He was not under medical care on the date of the alleged accident.

Petitioner testified that he injured his low back and left foot (instep) on Tuesday, August 5, 2008, while working for Respondent. He was working with Johnell Lyes. Johnell was on the truck. Petitioner was on the ground. The surface that Petitioner was standing on was uneven. Johnell and Petitioner were moving office furniture (a desk or credenza) and Petitioner fell while carrying the furniture. He noticed pain in his instep and low back. Johnell asked Petitioner if he should call an ambulance, and Petitioner declined. Petitioner did not seek medical care after his shift was over. Petitioner continued to work for Respondent. After August 5, 2008, Petitioner had difficulty with his work tasks. He called Brian Caruthers of Respondent (Petitioner did not recall the exact date, but it was probably the Friday after the accident) and advised that he was not sure that he could return to work at Respondent. Petitioner testified that Caruthers told him that he was a valued employee, not to worry and focus on sales. Petitioner separated from Respondent a couple of weeks later. He noticed swelling in his left foot and leg and back pain at this time. Petitioner thought that he worked for Respondent after the accident on August 6, August 7 and perhaps August 8, 2008.

Respondent presented the testimony of Sam Dahleh, who was the owner of Respondent in 2008. He was familiar with Petitioner as a former employee of Respondent. Dahleh thought that Petitioner was hired for sales. Petitioner could have made deliveries, but not on Sundays. Petitioner's last day of work was July 24, 2008. He was terminated for three days no call/no show. (ResEx. 7) The termination was effective August 1, 2008. According to the wage audit, Petitioner's last day worked was August 1, 2008. (ResEx. 8) Petitioner did not work for Respondent during the time of August 1 through August 8, 2008. As far as Dahleh knew, Petitioner did not report an injury to Caruthers. The first notice of the injury that Respondent received was when the Application for adjustment of Claim was received. Petitioner was not working for Respondent on July 27, 2008, as it was a Sunday. Petitioner was not an employee of Respondent on August 5, 2008, as he had been terminated effective August 1, 2008.

Neither Party presented the testimony of Johnell Lyes or Brian Caruthers. Petitioner did not submit any documentation which refuted Dahleh's testimony regarding Petitioner's dates of employment.

The first medical care was at Holy Cross Hospital on August 19, 2008. Petitioner testified that he went to the ER because he could not get out of bed. The records of Holy Cross show that Petitioner arrived via CFD ambulance at 1:30 in the morning with11 out of 10 back pain, was moving an object from a transport truck. There was a history of low back pain and left ankle pain times 2 days, "lifts furniture at work". (PetEx. 1) The copy of the Holy Cross records that Respondent submitted show a history of low back pain and left ankle pain after a fall. The patient injured his back at work and re-injured himself trying to pick up a phone. Low back and left ankle x-rays were negative. The physical exam revealed bruising of the left lateral malleolus and point tenderness on the lumbar spine. The neurologic exam was negative. Petitioner was given medication and instructed to see his PCP. He was discharged ambulatory, with a slow and steady gait. The Holy Cross records also reveal that Petitioner was seen at the ER on January 7, 2013 (again arriving via CFD ambulance) for back pain, non-traumatic in origin. Petitioner gave a history of back pain in 2007, when he was diagnosed with degenerative disc disease and received a cortisone injection and an MRI. (ResEx. 6)

Petitioner next received treatment from Pain Net/Dr. Edward Herba, beginning on September 4, 2008. The history was of an injury on July 27, 2008, while working. Petitioner was standing on the ground, on uneven pavement, removing a couch from a truck. He slipped and the couch fell on him. He injured his left foot and low back, as a result of the fall and having the couch fall on him. He denied prior back problems. Petitioner testified that he did not give the date of July 27, 2008 to PainNet. A lumbar MRI was ordered, as well as an ankle x-ray. Petitioner was taken off work. On September 22, 2008, Dr. Herba charted that the ankle MRI (?, x-ray?) was normal and that clinically the swelling in the ankle had gone down. Perhaps the foot complaints were due to radicular symptoms. The MRI showed degenerative findings with some narrowing and stenosis. Petitioner underwent e-stim, therapy and range of motion exercises. He was last seen at PainNet on March 2, 2009. He was much improved and released from care, PRN. (PetEx. 2)

Petitioner was referred to Dr. Scott Glasser, a pain management physician. Dr. Glasser provided Petitioner with facet joint injections and bilateral facet joint injections. Petitioner treated with Dr. Glasser from October 29, 2008 through January 28, 2009. (PetEx. 3) Dr. Glasser testified via evidence deposition. He is board certified in anesthesiology, with a subspecialty certification in pain management. When Petitioner was first seen, the history was of an accident at work approximately 3 months before. He slipped on pavement carrying a couch and injured his ankle and low back. The date of injury was July 27, 2008. The physical exam revealed no neurologic deficit. Dr. Glasser did not review the MRI film when he was treating Petitioner. Dr. Glasser diagnosed lumbar radicular pain, most likely discogenic or fact joint pain. He thought that this condition was related to the accident because Petitioner denied prior back injuries and was not under treatment for back complaints until after the injury. (PetEx. 5)

Petitioner was kept off work by PainNet from September 4, 2008 through March 2, 2009. He has slower starts in the morning. He has to do exercises to be able to do his activities of daily living. He avoids lifting.

On cross-examination, Petitioner denied subsequent injuries, including an injury lifting a TV remote at home. He did have an increase in pain picking up a phone. Petitioner denied prior back injuries, but admitted that he filed a workers' compensation case for a 7/18/1996 back injury (No. 96 WC 40152), for which he received a 2% man as a whole settlement. He has had no treatment for his back since March of 2009. He is a full time student and seeks a sedentary job. He still participates in martial arts and dance, as is shown in his medical records. Petitioner could have participated in martial arts and dance from August 8, 2008 through September 4, 2008. Petitioner never provided Respondent with off work slips.

Petitioner's Bills Exhibit was Number 4. Respondent submitted Utilization Review (Prospective) regarding the Lumbar MRI (Non-cert, ResEx. 2), PT and modalities (Approved, ResEx. 3), and the ankle x-ray ordered by Dr. Herba (Non-cert, no rationale given, ResEx. 4).

Dr. Avi Bernstein's record review report was admitted as Respondent's Exhibit 5. Petitioner failed to appear for an exam by Dr. Bernstein, so only a record review was provided. Dr. Bernstein thought that if Petitioner had suffered a significant injury, he would have sought treatment earlier than 2 weeks after the injury. There was a question as to whether Petitioner suffered any back injury whatsoever. There was no evidence of a traumatically induced injury. The injections were unindicated, unnecessary and not causally related to any alleged August 5, 2008 injury. Dr. Bernstein did not think that there was any permanent disability associated with the injury and would have thought that Petitioner would be at MMI about 6 to 12 weeks after the injury. (ResEx. 5)

CONCLUSIONS OF LAW

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

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

The Arbitrator finds that Petitioner failed to prove that he was employed by Respondent on August 5, 2008. Petitioner's testimony regarding the date of the termination of his employment with Respondent was vague and not supported by any documentation. The testimony of Respondent's witness, Sam Dahleh, that Petitioner's last day worked for Respondent was July 24, 2008 was credible and supported by Respondent's Exhibits 7 and 8.

The Arbitrator further finds that Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on August 5, 2008. First, there was no employee/employer relationship on August 5, 2008. Second, Petitioner did not seek medical treatment until some 2 weeks after the alleged injury. Common sense and experience and Dr. Bernstein's persuasive opinion lead to the conclusion that if Petitioner sustained the injuries that he alleges on August 5, 2008, he would have sought medical treatment at a closer time to the injury. Finally, Petitioner did not provide the claimed date of injury to any of his medical providers, even those that he saw after he filed the Application with the claimed date of August 5, 2008.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Application was filed on August 29, 2008 and sent to Respondent on that date. Sam Dahleh sent communication regarding the claim on September 5, 2008. (ResEx. 7) Timely Notice was proven by Petitioner.

WITH RESPECT TO ISSUE (D), WHAT WAS THE DATE OF THE ACCIDENT, ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, AND ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

As the Arbitrator has found that Petitioner failed to prove that there was an employee/employer relationship between him and Respondent on the claimed accident date and failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on August 5, 2008, the Arbitrator needs not decide the above issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elinelec Cordero,
Petitioner,

vs.

NO: 13 WC 01468

16IWCC0752

Oak Park-River Forest High School,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary 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 May 20, 2016 is hereby affirmed and adopted.

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

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

16IWCC0752

The party commencing 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: NOV 21 2016

o-11/16/16
jdl/wj
68

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CORDERO, ELINELEC
Employee/Petitioner

Case# 13WC001468

OAK PARK & RIVER FOREST HIGH SCHOOL
Employer/Respondent

16IWCC0752

On 5/20/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.37% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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2461 NYHAN BAMBRICK KINZIE & LOWRY
LINDA A ROBERT
20 N CLARK ST SUITE 1000
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

ELIMELEC CORDERO,
Employee/Petitioner

Case # 13 WC 01468

v.

Consolidated cases:

OAK PARK & RIVER FOREST HIGH SCHOOL,
Employer/Respondent

16IWCC0752

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **GEORGE ANDROS**, Arbitrator of the Commission, in the city of **CHICAGO**, on **March 24, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On 8/4/2010, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $52,832; the average weekly wage was $1016.00.

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

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

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

Respondent shall be given a credit of $32,902.22 for TTD, $_____ for TPD, $____. for maintenance, and $ for other benefits, for a total credit of $32,902.22.

Respondent is entitled to a credit for all medical paid by group insurance under Section 8(j) of the Act.

ORDER

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $677.33/week for 9 6/7 weeks, commencing August 5, 2010 through October 13, 2010, as provided in Section 8(a) of the Act.

Respondent shall be given a credit of $32,902.22 for temporary total disability benefits that have been paid.

Permanent Partial Disability: Person as a whole
Respondent shall pay Petitioner permanent partial disability benefits of $609.60/week for 50 weeks, because the injuries sustained caused the10% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

George J. Andros
#001 Arb George J. Andros
Signature of Arbitrator

May 18,2016
Date

MAY 20 2016

16IWCC0752

CONCLUSIONS OF LAW 13 WC 01468

A. In relation to F, is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following.

The Petitioner sustained an undisputed accident on August 4, 2010. The medical records revealed that the Petitioner complained of pain radiating to the right buttock. The Petitioner underwent a course of conservative treatment and was released to work full duty on November 2, 2011 by his treating physician. Surgery was not recommended. In reviewing the Petitioner's medical records, the Arbitrator notes that the Petitioner was initially returned to work full duty in March 2011; however the Petitioner returned for additional treatment in April 2011 when he could not work full duty.

In contrast, after the Petitioner was release to work full duty in November 2011, Petitioner worked for a year full duty without any attempts to seek treatment or any reported complaints of pain. Petitioner acknowledged during the hearing he did not seek any treatment. Petitioner testified that he thought after the epidural injections and a change in his position at work, the symptoms would resolve.

A year later, on December 13, 2012, returned to Dr. Sokolowski complaining of pain radiating to the left buttock. His complaints were different than what he originally presented.The Petitioner returned to Dr. Sokolowski and again underwent conservative treatment.

The Petitioner then came under the care of Dr. Koutsky who opined that the Petitioner's treatment in 2012 and eventual need for surgery was causally related to the incident on August 4, 2010. Dr. Koutsky stated that the Petitioner did not treat for a year because the insurance company denied the Petitioner's treatment. The Petitioner never testified to this at hearing. In fact, the Arbirator's Exhibit 1 revealed that the Petitioner received benefits n 2012 and 2013. Benefits were only terminated after receiving Dr. Goldberg's report in October 2013. Dr. Koutsky did not begin treating the Petitioner

until December 2013. Dr. Koutsky seemed not aware of the change in Petitioner's complaints.

Therefore, the Arbitrator adopts the opinions of Dr. Goldberg and deems them most persuasive.

Based upon the totality of the evidence the Arbitrator finds as a matter of law and fact the Petitioner's medical treatment and lost time benefits subsequent to November 2, 2011 are not causally related to the accident in the case at bar.

B. In relation to 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 the following:

The Arbitrator finds that the Petitioner reached maximum medical improvement on November 2, 2011 for the lumbar spine strain he suffered on August 4, 2010. Therefore, the Arbitrator finds that all of the Petitioner's treatment subsequent to November 2, 2011 is not causally related to the Petitioner's injury of August 4, 2010. Arbitrator denies the Petitioner's request for medical benefits for treatment rendered subsequent to November 2, 2011.

C. In relation to K, what temporary benefits are in dispute, the Arbitrator finds the following:

The Petitioner was released to work full duty on November 2, 2011. The Petitioner was correctly paid TTD benefits through the date Petitioner returned to work light duty on October 13, 2010. The Arbitrator finds that the Petitioner's lost time beginning on May 8, 2013 through September 7, 2015 is not causally related. The Arbitrator finds that

the Petitioner is entitled to TTD benefits from August 5, 2010 through October 13, 2010 or 9 6/7 weeks for a total of $6,676.54. Respondent is entitled to a credit of $26,225.68.

D. In relation to L, what is the nature and extent of the injury, the Arbitrator finds the following:

The Arbitrator finds based on the evidence that the Petitioner sustained a protracted non-surgical condition to his lumbar spine. The diagnostics showed some pathology. The Arbitrator finds as a matter of law and fact that the Petitioner's need for fusion at L4-5 was not causally related to the accident of August 4, 2010. The Petitioner did work for a year full duty prior to his return for medical treatment. When the Petitioner did seek treatment in 2012, the Petitioner's symptoms had changed.

Therefore, the Arbitrator finds based on the totality of the evidence that the Petitioner sustained permanent partial disability under section 8(d)2 of the Act to the extent of Ten (10.%).

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WHITESIDE

☒ 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

William Cruse,
Petitioner,

vs. NO: 09 WC 28300

State of Illinois
Department of Central Management Services,
Respondent.

16IWCC0753

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 5, 2015 is hereby affirmed and adopted.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent and total disability benefits of $714.10/week for life, commencing February 1, 2012, as provided in Section 8(f) of the Act. Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in section 8(g) of the Act.

16IWCC0753

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: NOV 21 2016

o-11/16/16
jdl/wj
68

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CRUSE, WILLIAM
Employee/Petitioner

Case# **09WC028300**

STATE OF ILLINOIS/DEPT OF CMS
Employer/Respondent

16IWCC0753

On 10/5/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% 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:

0452 PIGNATELLI & ASSOCIATES
LOUIS F PIGNATELLI
102 E ROUTE 30
ROCK FALLS, IL 61071

4987 ASSISTANT ATTORNEY GENERAL
LAURA HARTIN
100 W. RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

0499 CMS RISK MANAGEMENT
301 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

OCT 5 - 2015

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WHITESIDE)

☐ Injured Workers' Benefit Fund (§4(d))
X Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

William Cruse
Employee/Petitioner
v.

Case # 09 WC 28300

16IWCC0753

State of Illinois/ Department of CMS
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 Falcioni**, Arbitrator of the Commission, in the city of **Rockford**, on **August 26, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 20, 2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$55,699.18**; the average weekly wage was **$1,071.15**.

On the date of accident, Petitioner was **61** years of age, ***married*** with **0** dependent children.

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

Respondent ***shall pay*** all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$119,011.84** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of $119,011.84.

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

ORDER

Temporary Total Disability
Respondent shall pay Petitioner Temporary Total Disability Benefits of $714.10/ week for 180 1/7 weeks, for the periods of time from 2/19/2008 – 8/01/2008 and 1/22/209 – 1/31/2009 as provided under Section 8(b) of the Act. In addition to the amounts paid which were calculated on an erroneous AWW of $990.95 and a TTD rate of $660.63, the parties agree the AWW to be $1,071.15 resulting in a TTD rate $714.10/ week. Owed for 180 1/7 weeks is the difference of $53.47/ week for a total of **$9,632.24**.

Medical benefits
Respondent shall pay all medical benefits that are yet unpaid and which are reasonable and casually related to Petitioner's June 20, 2007 accident as provided under Section 8(a) of the Act.

Permanent Total Disability
Respondent shall pay Petitioner Permanent Total Disability Benefits beginning 2/1/2012 in the amount of $714.10/ week for life as provided in Section 8(f) of the Act.

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

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

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

Signature of Arbitrator

September 30, 2015
Date

OCT 5 – 2015

BEFORE THE WORKERS' COMPENSATION COMMISSION
STATE OF ILLINOIS

WILLIAM CRUSE, Petitioner, vs. STATE OF ILLINOIS, Respondent.	)	Case No: 09 WC 28300 16IWCC0753

MEMORANDUM OF DECISION OFARBITRATOR

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

On the date of July 20th, 2007 while in the employment of Respondent as a traveling mechanic repairing large trucks, pieces of equipment and snow plows, Petitioner testified that he injured his right arm, shoulder and person as a whole while installing a starter on a truck. Timely notice was given to his employer of his injury.

Prior to this date, Petitioner testified he had no injury to his right shoulder or arm resulting in any permanency. He testified in 2002, 5 years prior to July 20th, 2007 he injured his right arm, saw a physician 1 time, missed no work, filed no claim and suffered no disability.

After his July 20th, 2007 injury on October 23, 2007, Dr. Hanlon ordered an MRI, without contrast, of Petitioner's shoulder that revealed an intra-substance tear of the supraspinatus tendon with the MRI unable to evaluate full thickness tears. *Petitioner's Exhibit 2 at page 125.*

Petitioner received a right shoulder injection on October 23, 2007 which gave him no relief. *Petitioner's Exhibit 2 at page 125.* Petitioner on the date of February 20th, 2008 was surgically treated by Dr. Shawn Hanlon and orthopedic surgeon who performed an arthroscopic subacromial decompression and open distal clavicle excision of the right shoulder. *Petitioner's Exhibit 2 at page 93.*

After a course of physical therapy from February 25, 2008 to July 23, 2008, Petitioner, on August 1, 2008 was released back to work to do what work he could do. Returning to work caused increased pain in his right shoulder for which he, on September 3rd, 2008, received an injection which gave only short term relief. *Petitioner's Exhibit 2 at page 112.*

On November 10, 2008 another MRI was performed, this time with contrast unlike the earlier MRI performed, and revealed a full thickness, severe rotator cuff injury with retraction of the supraspinatus tendon and associated partial tear of the infraspinatus. Also revealed was a compete tear of the long head of the biceps tendon with retraction. *Petitioner's Exhibit 2 at page 109.*

On January 22, 2009 Dr. Hanlon performed a second surgery, an open anterior acromioplasty of the right shoulder and the correction of impingement with repair of partial thickness tear and thinning of the supraspinatus and subscapularis tendon. *Petitioner's Exhibit 2, page 48*

Petitioner thereafter underwent courses of physical therapy from February 2, 2009 to June 19, 2009. *Petitioner's Exhibit 3, page 326.*

A functional capacity exam accomplished June 17th and 18th of 2009 revealed that the limitations of Petitioner's right shoulder resulting from his work injury did not allow his limited abilities to match his job duties as a truck mechanic. Prior to his injury Petitioner worked a heavy to very heavy job as a traveling truck mechanic. Recommended in the FCE were job modifications and alternate placement away from the heavy job duties. *Petitioner's Exhibit 4, page 4 of the FCE report.* The FCE reports Petitioner taking pain medication at his FCE when he experienced high pain levels. *Petitioner's Exhibit 4, page 9 of the FCE report, page 10 of Exhibit 4.* At the time of his FCE Petitioner was 63 years of age.

Petitioner was told by Respondent there were no modified jobs or alternative placements available to get him away from heavy job duties. He was offered no vocational rehabilitation.

On June 24th, 2009, Dr. Hanlon reviewed the FCE, the physical condition of Petitioner and charted Petitioner as being disabled from truck mechanic work. Dr. Hanlon instructed Petitioner, who was 63 years old, to return as needed. *Petitioner's Exhibit 2, page 62*

In a Vocational Evaluation Report of Petitioner by James Radke, MS, CRC, LCPC, dated November 11, 2013, Mr. Radke found Petitioner right hand dominant and having worked for the State of Illinois from 1986-2012 as a traveling mechanic where "he not only fixed trucks but snowplows, tractors, mowers, bulldozers, etc." *Petitioner's Exhibit 8, page 3.* "He (Petitioner) worked from a heavy to a very heavy level of physical exertion as defined by The United States Department of Labor." *Petitioner's Exhibit 8, page3.* Mr. Radke concluded with a reasonable degree of professional certainty as a Vocational expert that

> "Mr. Cruse does not have any transferable work skills that are consistent with his exertional capabilities and that Petitioner could not use his former skills in light of restrictions and limitations... the skills acquired in becoming an auto or truck mechanic are not applicable to Light or Sedentary work, especially when one considers reaching only to waist level. Therefore, due to these restrictions, Mr. Cruse is currently an unskilled worker... he is on Social Security Disability."

> "it is my opinion that Mr. Cruse does not have capability for employment at his former occupation (auto or truck mechanic) or any other skilled or semiskilled occupation at this point and is totally disabled from all work in his regional labor market. There is no reasonable stable labor market for Mr. Cruse." *Petitioner's Exhibit 8, page 3.*

In his evidence deposition Vocational Expert Radke described his extensive experience in attempting to get people back to work who have been on long term disability. *Petitioner's Exhibit 9, page 7.* From 1987 to the date of his deposition, May 30, 2014, he has worked through the organization Associates for Career Transition where he provides vocational rehabilitation services in the area of workers' compensation and long-term disability injuries. He also is a contractor with the Social Security Administration wherein he gave expert opinions in employability evaluations. He has been acknowledged in both Illinois state courts and in federal courts as an expert in the field of employability and the nature and extent of employability. *Petitioner's Exhibit 9, page 9*

Expert Radke found Petitioner experiencing ongoing pain and weakness in his right shoulder with a decreased range of motion. He was assessed right hand dominant. Mr. Radke found Petitioner's. "modality for learning things is not going to be through a standard classroom or typical teaching kind of thing. He was more

an observational learner his whole life." *Petitioner's Exhibit 9, page 15.* He concluded Petitioner to have no portability to his level of (workplace) functioning, especially with using his right arm. *Petitioner's Exhibit 9, 43.* With a reasonable degree of vocational and scientific certainty he concluded "that an unskilled person with lack of function in his right or dominant arm is not going to be able to find employment. There will be no employment that's going to work for this individual." *Petitioner's Exhibit 9, p 17.* Expert Radke testified he familiar with the labor markets in the entire northern Illinois area. *Petitioner's Exhibit 9, page 18.*

In describing Petitioner's failed attempt at using a computer to order parts while employed by the State of Illinois, Mr. Radke noted Petitioner was slow, didn't hit the keys very well and appeared not to have motor control of his upper extremity through his shoulders. *Petitioner's Exhibit 9, page 45.* His testimony was corroborated by Petitioner's testimony wherein he stated that he found it difficult to use the computer when he attempted the job in parts. He could not use the computer because of a lack of dexterity and familiarity. He was moved from the job after 5 weeks and positioned back to his job doing heavy to very heavy work as a traveling mechanic.

After his second surgery Petitioner testified he did attempt to become re-employed by the State of Illinois, initially, at any job after he was released by Dr. Hanlon, June 24th, 2009. There were no jobs for him because of his restrictions.

After being told he was unemployable by the State of Illinois and after his failed attempts at employment at Ace Hardware or fixing things for an insurance company, Petitioner retired to collect his pension to replace benefits he was no longer paid by CME Worker Compensation.

Petitioner testified further that after his worker compensation benefits stopped in February, 2012 and because of his need for income, Mr. Cruse applied for his CME pension. Mr. Cruse was one week short of being employed long enough to qualify for an additional $700/ monthly pension benefit. He attempted to become employed for that one more week. He was told to be present at a CME station in 2012. When the supervisors were asked whether they would employ him for just one more week, Petitioner's previous direct supervisor stated CME would not employ him any capacity for one more week because Petitioner was permanently disabled and not employable.

The State of Illinois, denied Petitioner re-employment in any capacity, and offered Petitioner no vocational training. Because of his physical limitations and his lack of experience, except in very heavy mechanic's work, CME would not employ him in any job.

Petitioner testified he tried getting a job in an ACE hardware store and where insurance repair work was done but was turned down because of right arm disability.

Petitioner testified from June 2009 until the time he testified at hearing on 8/26/2015 his uses greater amounts of narcotics in an attempt to control his increased shoulder pain. He testified he can feel his shoulder pop as many as 300 times a day.

On August 3, 2011 in completing a disability evaluation for State Retirement Systems, Dr. Hanlon declared Petitioner entitled to continuing disability benefits because of his rotator cuff tear resulting from the July 20th, 2007 accident. *Petitioner's Exhibit 1, page 8.*

Dr. Hanlon, on a 3/22/2013 off work slip, took Petitioner off work and "may not return (to work) until further notice" as a result of his right shoulder injury. *Petitioner's Exhibit 10.*

Petitioner testified the continuing shoulder symptoms which have kept him unemployed since his second surgery have worsened and become aggravated by the onset of rheumatoid arthritis and fibromyalgia. Petitioner's activities have been significantly limited. He is unable to put on his belt because of the reaching around his body and the lack of reach of his right arm around his waist. Hanging pictures causes pain in his right arm which, combined with the limitation of how high his right arm can reach, makes picture hanging impossible for him. An attempt to play catch with his grandson creates a directionless throw of the ball because of the popping and pulling of his right shoulder as his right hand moves the ball forward. He has weakness in his right arm and popping sometimes as much as hundreds of times a day. The sport of archery done frequently before the July 20, 2007 injury is limited by the lack of strength in attempting to pull back the bow string with the arrow.

Based on the record as a whole, the Arbitrator finds that Petitioner is permanently and totally disabled, said disablement commencing February 1st, 2012.and that Petitioner is entitled to PTD benefits from February 1st, 2012 and continuing for life with the benefit of $714.10/ week (calculated from the agreed upon AWW of $1071.15) as provided for under Section 8(f) of the Act and with supplementary benefits from the Rate Adjustment Fund provided in paragraph (f) of Section 7 of the Act, such supplementary benefits provided to be paid in paragraph (g) of Section 8 of the Act. Respondent shall pay all medical benefits incurred which are reasonable and causally related to Petitioner's July 20, 2007 accident as set forth under Section 8(a) of the Act as well as all medical benefits remaining yet unpaid that are reasonable and causally related to Petitioner's July 20, 2007 accident as provided for under Section 8(a) of the Act. The parties have agreed Petitioner's AWW to be $1,071.15 which calculates a TTD rate of $714.10. The erroneous AWW used by Respondent was $990.95/week and a TTD rate of $660.63. *Respondent's Exhibit 1, page 5.* Respondent paid Petitioner 180 1/7 weeks of benefits through the date of January 31st, 2012 at the erroneous reduced rate. *Respondent's Exhibit 2.* Owed Petitioner for 180 1/7th weeks is the difference between the TTD rate of $714.10 and the TTD of $660.63 paid him, or $53.47/week for a total of $9,632.24.

STATE OF ILLINOIS)
) SS.
COUNTY OF WHEATON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard Ellis,

Petitioner,

vs.

NO: 13 WC 16875

Grindal Co.,

16IWCC0754

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, extent of temporary total disability, wages/rate, medical expenses, prospective medical care, penalties under §19(k) and §19(l) and §16 attorneys' fees and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission corrects the clerical error of the date of accident listed on the face sheet from January 11, 2016, the date of the arbitration hearing, to February 25, 2013, the actual date of accident. The Commission affirms the Arbitrator's finding that Petitioner's current condition of ill-being is not causally related to the February 25, 2013 work accident, but rather is the result of a chronic, degenerative and inevitable process. Petitioner's pre-existing degenerative changes were not asymptomatic. Petitioner's report of having no symptoms and no treatment before February 25, 2013 are directly contradicted by the medical records. The Arbitrator found Petitioner sustained a right medial meniscal tear as a result of the February 25, 2013 accident, which was successfully repaired on June 26, 2013. The Arbitrator found Petitioner had reached maximum medical improvement as of August 19, 2013 as per treating Dr. Walsh. §12 Dr. Levin is the only doctor who had the full picture of Petitioner's situation, having reviewed the 2011

medical records as well as those since February 25, 2013. Petitioner failed to inform Dr. Silver of what his true condition was prior to the February 25, 2013 accident and therefore, Dr. Silver's causal connection opinion is not factually based and not credible.

The Commission modifies the Arbitrator's Decision finding that Petitioner's average weekly wage was $700.00, based on Petitioner's testimony of $17.50 per hour times 40 hours per week. The Commission notes that there was no wage statement in evidence. Overtime is not included as it was not mandatory or consistent. Furthermore, Petitioner failed to prove what his overtime actually was.

The Commission modifies the Arbitrator's Decision finding that Petitioner was temporarily totally disabled from February 26, 2013 through August 19, 2013, a period of 25 weeks at $466.66 per week (based on $700.00 average weekly wage); 25 weeks times $466.66 per week = $11,666.50. The Arbitrator did not award this period, but had given Respondent credit for same. There cannot be a credit against no award. The Commission affirms the Arbitrator's award of medical expenses through August 19, 2013, but not after that date. Petitioner had reached maximum medical improvement for the injury sustained on February 25, 2013 by August 19, 2013.

Regarding the amount of credit due Respondent, the Commission notes that on the Request for Hearing stipulation sheet, the parties agreed Respondent paid $18,888.64 in TTD benefits and a PPD advance of $8,884.80. Respondent also continued to pay TTD benefits from August 20, 2013 through October 24, 2014, a period of 61-4/7 weeks. Petitioner acknowledged he was paid TTD benefits through October 24, 2014. This was presumably paid at the TTD rate of $391.06 (average weekly wage of $586.58). From February 26, 2013 through October 24, 2014 is 86-4/7 weeks or 86.571. 86.571 times $391.06 = $33,854.46 TTD benefits paid. $33,854.46 TTD benefits paid + $8,884.80 PPD advance = $42,739.26 credit to Respondent. This results in an overpayment of compensation of $31,072.76 ($42,739.26 credit - $11,666.50 TTD awarded) and this amount is to be carried over and credited against an award of permanent disability, if any. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $466.66 per week for a period of 25 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the reasonable, necessary and related medical expenses under §8(a) of the Act, subject to the Medical Fee Schedule under §8.2 of the Act, through August 19, 2013, but not thereafter.

16IWCC0754

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes that Respondent paid $33,854.46 TTD benefits and $8,884.80 PPD advance for a total credit of $42,739.26. This results in an overpayment of compensation of $31,072.76 and this amount is to be carried over and credited against an award of permanent disability, if any.

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.

There is no bond for the removal of this cause to the Circuit Court by Respondent as there was an overpayment of compensation to Petitioner. The party commencing 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: NOV 23 2016
MB/maw
o10/27/16
43

Mario Basurto

Stephen J. Mathis

David L. Gore

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

ELLIS, RICHARD
Employee/Petitioner

Case# **13WC016875**

16IWCC0754

GRINDAL CO
Employer/Respondent

On 3/15/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.51% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5410 FRANKS & RECHENBERG
DAVID N RECHENBERG
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16IWCC0754

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

☐ 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)

Richard Ellis
Employee/Petitioner

v.

Grindal Co.
Employer/Respondent

Case # **13** WC **16875**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica A. Hegarty**, Arbitrator of the Commission, in the city of **Wheaton**, on **1-11-16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **1-11-16**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$30,502.16**; the average weekly wage was **$586.58**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of **$33,797.89** for TTD, $ for TPD, $ for maintenance, and **$8,884.80** for other benefits, for a total credit of **$42,686.53**.

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

ORDER

- The Arbitrator finds that Petitioner's current condition of ill-being is not causally connected to his work accident of February 25, 2013, but rather is the result of a chronic, degenerative and inevitable process.
- The Arbitrator finds that Petitioner sustained a medial meniscal tear as a result of the February 25, 2013 accident, which was successfully repaired on June 26, 2013.
- Petitioner was at MMI as of August 19, 2013 pursuant to the medical records of Dr. Walsh.
- Petitioner's claim for benefits is denied.

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

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

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

Jessica C. Myatt

Signature of Arbitrator

3/4/16

Date

ICArbDec19(b)

MAR 15 2016

16IWCC0754

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RICHARD ELLIS, Petitioner,	)	
v.	)	**Case No: 13 WC 16875** Wheaton
GRINDAL CO., Respondent,	)	

ADDENDUM TO THE DECISION OF THE ARBITRATOR

This case was tried before Arbitrator in Wheaton, Illinois pursuant to Section 19(b) and 8(a) of the Illinois Workers' Compensation Act on February 25, 2013. (Arb. Ex. 1) The following matters are in dispute between the parties:

- Causal Connection
- Average Weekly Wage
- Unpaid Medical
- TTD
- Prospective Medical (Right Knee Replacement Surgery)
- Penalties/Fees (Id.)

STATEMENT OF FACTS

It is undisputed that Petitioner, Richard Ellis was employed by Respondent, Grindal Company as a machine operator when he was involved in a work related accident on February 25, 2013. (Id.).

Petitioner's Right Knee Treatment Prior to the Date of Accident

Records from Elmhurst Memorial Clinic indicate Petitioner presented to Dr. Ninel Kandel, on January 21, 2011 with complaints of right knee pain, worse with walking. Dr. Kandel noted that Petitioner had been diagnosed with a torn meniscus and will need surgery. (Rx.5) He was referred to Dr. Vijay Thangamani, an orthopedic surgeon, regarding this pain.

At his initial evaluation with Dr. Thangamani, Petitioner reported that he was not sure what happened to cause his right knee pain, and that his knee would become very painful and swollen when playing sports. (Rx.6)

On February 15, 2011 an MRI of Petitioner's right knee indicated an oblique undersurface tear of the medial meniscus involving the posterior horn and body junction with horizontal component involving the body of the meniscus. (Px.2) The report further noted diffuse cartilage thinning in the anterior portion of the medial femoral condyle without full thickness cartilage loss. (Id.)

Petitioner underwent right knee arthroscopic surgery on February 28, 2011, including a right knee partial medial and lateral meniscectomy, and chondroplasties of the medial and lateral compartments. (Px.6) Post operatively, Dr. Thangamani diagnosed a right knee medial meniscal tear, lateral meniscal tear, and degenerative joint disease. (*Id*)

The operative report notes that Petitioner had medial compartment grade three chondral changes in addition to a degenerative medial meniscus tear. (*Id*)

Petitioner continued post-operative treatment with Dr. Thangamani through September 27, 2011. During this time, Petitioner reported little improvement in his right knee pain. Petitioner was prescribed Norco for pain and was administered several cortisone injections. On June 15, 2011, Petitioner reported to Dr. Thangamani that his pain was 7/10. Dr. Thangamani noted that Petitioner's continued pain was likely due to residual degenerative joint disease.

Petitioner continued to complain of severe knee pain on September 12, 2011. Dr. Thangamani reviewed the latest MRI of August 22, 2011, noting a small joint effusion and that the meniscus tear was no longer present. (*Id*) Petitioner was advised to wean off of narcotic medications and recommended occasional corticosteroid injections to manage his pain. (*Id*) Dr. Thangamani advised Petitioner that he would give him one more prescription for Norco but told him afterwards he could receive no more. (Id.)

Petitioner's family physician, Dr. Kandel noted that Petitioner had suffered intractable right knee pain with swelling since his surgery when she saw him on October 14, 2011. (Rx.5) Petitioner complained of pain with standing, bending, and walking. She referred Petitioner to orthopedic surgeon Dr. Jeffrey Meisles for a second opinion regarding his right knee. (*Id*)

Petitioner began treating at the Elmhurst Pain Clinic in October 14 2011. (Px.23; Rx.5) He was referred by Dr. Kandel and Dr. Thangamani for right knee pain. The records reflect that he completed intake forms in which he reported his right knee pain was worsened by "standing,

bending, and in general working". Petitioner noted that "when I sit down sometimes it is o.k. but even in bed it's hurting". He rated his present level of pain at a 7/10 and noted the duration of pain as continuous. (Id.) He reported taking Norco 5-6 times daily.

Petitioner was evaluated at Orthopedic Specialists on January 6, 2012. No doctor's name is evident in this record. (Rx.5) Petitioner reported to the physician that he was there for a second opinion regarding right knee pain, as he never felt a benefit after the surgery performed by Dr. Thangamani. (*Id*) He reported that he had undergone three injections since surgery that had not helped. Petitioner's examination was benign but for medial joint line pain. (*Id*) This doctor felt and advised Petitioner that he was too young to have a partial knee replacement and recommended Hyaluronic acid injections and continued treatment with Dr. Thangamani. (Rx.5)

Petitioner returned to the Elmhurst Pain Clinic on January 20, 2012, and again on April 17, 2012 where he reported continuous right knee pain at a 5/10. (Px.23Rx.5) He also continued to treat with Dr. Kandel, who provided a prescription for anti-inflammatory topical cream due to right knee pain on July 10, 2012. (*Id*) On July 30, 2012, August 24, 2012 and again on September 17, 2012 Petitioner was prescribed Percocet and Oxycontin for his right knee pain. (Rx.5)

Dr. Kandel provided a prescription to Petitioner on November 6, 2012 for a right knee brace for osteoarthritis. (Rx.5) Petitioner testified that he recalled receiving this prescription, but that he was not supposed to wear this brace at work. (Tr.74) Mr. Michael Kmiec, the operations and plant manager at Grindal, testified that Petitioner brought a knee brace to work one day prior to the February 2013 accident, but that he wore it only a couple of hours. (Tr.161) Mr. Erwin Cheves, a machine operator at Grindal, also testified that he saw Petitioner wear a brace at work on one occasion prior to February 2013, but that he did not wear it the whole day. (Tr.193) Ms. Janice Spooner, the owner and president of Grindal, testified that Petitioner told her he did not wear the brace because it was uncomfortable. (Tr.133)

Dr. Sloan wrote a prescription for Percocet on October 15, 2012, November 29, 2012. (Px. 23; Rx.5) Prescriptions for Oxycontin and Percocet were provided to Petitioner on December 15, 2012. (Id.) Dr. Sloan prescribed Percocet and Oxcycontin to Petitioner on January 9, 2013. (Id.)

February 25, 2013 work accident

It is uncontested that on February 25, 2013, Petitioner suffered a work place injury while moving a cart of parts when he slipped in a puddle of oil, twisting his knee. (Tr.9; Arb. 1)

Petitioner testified that he treated at the occupational health clinic at Alexian Brothers Medical Group initially, and was referred for an MRI. (Tr.12)

The right knee MRI, performed on March 16, 2013, revealed moderate degenerative changes in the medial femorotibial articulation with thinning and loss of cartilage, a moderate joint effusion, and a possible tear or sequelae of a prior meniscal surgery in the medial meniscus. (Px.1) He was then referred for an orthopedic consultation. (Id)

Petitioner began treatment with Dr. Kevin Walsh at DuPage Medical Group on April 22, 2013. Dr. Walsh noted a history of Petitioner injuring his right knee at work and that he had since undergone physical therapy, which had not been helpful. Petitioner reported to Dr. Walsh that he had undergone an arthroscopy on the right knee two years prior, but that he had been doing well for the past eight months. (Px.2) Dr. Walsh noted that the recent MRI report showed moderate degenerative changes in the medial compartment with subchondral bone marrow edema as well as a positive complex tear involving the posterior horn of the medial meniscus. (Id.) Dr. Walsh recommended a knee arthroscopy.

On June 26, 2013, Dr. Walsh performed a right knee arthroscopy with a partial medial meniscectomy, and chondroplasty of the medial femoral condyle, medial tibial plateau, and lateral tibial plateau. (Px.2) Dr. Walsh's post-operative diagnoses noted a torn medial meniscus, grade four chondromalacia of the medial femoral condyle and medial tibial plateau, and a large plica with grade two chondromalacia of the lateral tibial plateau. (*Id*)

In his surgical report, Dr. Walsh noted that there was very slight effusion in the right knee, a horizontal cleavage tear involving the posterior horn of the medial meniscus, and a degenerative tear at the junction of the middle and posterior third where the previous meniscectomy was done. He also documented a nickel-sized area of exposed bone along the medial tibial plateau and a larger area of exposed bone at the medial femoral condyle, about the size of a dollar. (*Id*)

Dr. Walsh wrote an addendum to his procedure report in which he noted that Petitioner has quite advanced arthritic changes in the medial compartment of his right knee given his relatively young age of 39. (Id.)

On July 2, 2013, Dr. Walsh noted that surgery revealed a degenerative tear involving the medial meniscal remnant, but that the grade four changes in the medial femoral condyle and medial tibial plateau were "more impressive findings". Due to significant degenerative changes in Petitioner's right knee, the doctor noted Petitioner would likely have problems in the future, and may require a partial knee replacement.

Dr. Walsh recommended physical therapy and noted Petitioner would likely be off work "probably for a month." (Id.)

On August 6, 2013, Petitioner presented to Dr. Walsh who again noted surgical findings consisting of significant degenerative changes, grade 4 changes involving the medial femoral condyle and medial tibial plateau as well as his torn meniscus. The doctor advised Petitioner that he was approaching maximum medical improvement with regard to the arthroscopy. He further noted that Petitioner would finish physical therapy and be released to work without restrictions as of August 19, 2013. The doctor advised against a work conditioning program given Petitioner's significant arthritis. He further noted the arthritis "will limit what he can do. If he is unable to perform his work duties, he knows he may end up with a knee replacement." (Id.)

On September 3, 2013, Dr Walsh noted that Petitioner reported ongoing symptoms, that he cannot stand longer than 1.5 to 2 hours, and cannot walk more than 30 minutes. The doctor noted "when he was released to work, he was promptly laid off by his employer." Dr. Walsh noted "I do think he is approaching MMI with regard to the knee scope. I think his ongoing pain is more related to his arthritis." The doctor recommended Naprosyn twice a day for a month and if no improvement possible corticosteroid injections. Dr. Walsh noted "I told him that even though he is young, if he continues to have pain, a knee replacement would probably be in his best interest." (Px.2)

Petitioner was last seen by Dr. Walsh on September 21, 2013. The doctor noted Petitioner's ongoing complaints of right knee pain. The doctor further noted a history of "no pain prior to this work injury". Petitioner reported to Dr. Walsh that the "work related injury may have aggravated his osteoarthritis". The doctor noted "there is no doubt that it aggravated his symptoms of osteoarthritis. He is more symptomatic now than he was prior to his work injury. He does have an attorney representing him for his injury."

The doctor further noted "I told the patient that we can certainly note in the medical record that his symptoms were aggravated by his work injury causing his condition to worsen." Follow-up in a month and continuation of physical therapy were recommended. (Id.)

Petitioner testified that he had treated at Elmhurst Pain Clinic since October 2012, but that he did not tell Dr. Walsh because it never came up. (Tr.80-81;72

Petitioner testified that he was notified by Respondent by letter of his termination on August 19, 2013. (Tr.35) He testified that at that time, he was still receiving TTD benefits and still had restrictions. (*Id*)

Petitioner later admitted that he did not recall whether Dr. Walsh had released him to work with or without restrictions, but that he would not dispute the contents of Dr. Walsh's records. (Id. at 81-82)

Petitioner did not attempt to find any other work after learning his position with Respondent was no longer available. (Id. at 83)

After his last appointment with Dr. Walsh, Petitioner began treating with Dr. Ronald Silver. Petitioner testified that he found Dr. Silver through internet research and through recommendations from friends and people they knew. (Tr.84)

Dr. Silver first saw Petitioner on November 21, 2013. Petitioner filled out an intake form on that date in which he noted that he does not require assistance with walking or transfers. Dr. Silver indicated that Petitioner had "basically lost the ability to walk more and can only walk a few blocks and is in constant pain" (Px.4) The doctor noted that "prior to his accident his right knee was normal without any previous symptoms or medical treatment." X-rays were at this exam showing complete loss of the medial joint space with bone-on-bone changes, a large spur near the trochlea of the femur and squaring off of the lateral femoral condyle. Dr. Silver felt that Petitioner had torn his medial meniscus as a result of the work injury, and had exacerbated and accelerated pre-existing asymptomatic degenerative changes in the right knee, resulting in loss of cartilage down to the bone. He recommended a total knee replacement, which he opined was due to the exacerbation and acceleration of his pre-existing asymptomatic changes. (*Id*)

Dr. Silver noted a causal relation between the work injury and the need for the total knee replacement was evidenced by the fact that Petitioner never had any symptoms in his knee prior to the injury, and that he was working full time without restriction. (Px.3) Dr. Silver placed Petitioner off work and indicated that he would be permanently disabled if he did not undergo the procedure. (*Id*)

Petitioner continued to follow up with Dr. Silver on a nearly monthly basis, from February 13, 2014 through October 9, 2014. (Px.4,7) Throughout these visits, Dr. Silver continued to note that Petitioner was

unable to return to work, and that he would be permanently disabled if he did not undergo the recommended procedure. (*Id*) He also consistently noted that Petitioner's condition was due to his work injury, as Petitioner was asymptomatic and capable of full duty work prior to the incident. (*Id*)

Petitioner underwent an Independent Medical Examination with Dr. Mark Levin on February 20, 2014. (Rx.4) Dr. Levin's report reflects that Petitioner reported undergoing six weeks of physical therapy after his February 2011 right knee surgery, after which the condition resolved. (*Id*) Petitioner testified that he does not recall reporting this to Dr. Levin, and that he disputes that he did so, though he admittedly could not recall what he told Dr. Levin. (Tr.91-92) Dr. Levin's report indicates that Petitioner denied any other problems with the right knee prior to the work injury. (Rx.4) On examination, Dr. Levin found no large effusion in the right knee, full extension and flexion, and medial joint line pain. X-rays were performed in Dr. Levin's office which revealed medial joint space narrowing on the right side with almost bone-on-bone touching apparent. (*Id*)

At the time of Dr. Levin's evaluation of Petitioner, he did not have a complete set of medical records. Based on the records he had, including Dr. Walsh's treatment notes and procedure report, Dr. Levin felt Petitioner's symptoms were related to medial compartment arthritis, but withheld forming an opinion regarding causation, further treatment, and the work injury prior to review of all records. (Rx.4,Resp.Exh.2)

Dr. Levin provided a brief addendum dated April 7, 2014, in which he indicated that Petitioner was capable of seated work, but could alternate between sitting and standing every 10 to 15 minutes. (Rx.4,Resp.Exh.3) The doctor testified that the restrictions he indicated were not related to the February 2013 accident, but rather are related to Petitioner's right knee medial compartment arthritis. (Rx.4,p50-51)

Dr. Levin compared the MRI of Petitioner's right knee dated February 15, 2011 to the post-accident x-rays and the March 2013 MRI report. He explained that chondromalacia is a term referring to the breakdown of chondral tissue, with zero being normal and Grade 3 being "right at the border where you're now starting to expose subchondral bone, and Grade 4 is just total bone on bone." The doctor testified that the pre-accident MRI films from February 2011 showed narrowing and "almost minimal joint space" in the medial side of Petitioner's right the knee. (Id. at 30-31) With respect to the surgical findings documented within the February 2011 report, Dr. Levin testified Petitioner was found to have severe Grade 3 chondomalacia on both sides of the joint (on the end of the femur and also on the tibia). (Id.) The doctor indicated:

> "[This] is a very bad prognostic finding, because now you have no cushioning...and the meniscus that he had which was the meniscal tear, was trimmed out. Now when you trim out the meniscal tear, you know you have the cushion between the bones, so just natural wear and tear is going to be rubbing those bones together." (Id.)

Dr. Levin further explained that "once you trim that meniscus out and trim the remnant cartilage, now the arthritis has no surface, so you've got a medial joint bone that is going to rub on bone with a progressive knee arthritis." (Id. at 34.) The doctor opined that Petitioner's condition, as revealed by the February, 2011 right knee MRI and arthroscopy, is an osteoarthritic condition that is degenerative in nature rather than traumatic. (Id. at 32-33)

Dr. Levin testified that, based on his review of Petitioner's medical records both before and after the February 2013 accident, his examination of Petitioner, and the findings indicated within the operative reports, x-rays, and MRIs, Petitioner's diagnosis is that of symptomatic medial compartment arthritis. He testified that there is no evidence that there was any change in Petitioner's condition following the February 2013 accident. (Rx.4,p43-46) He testified that Petitioner's right knee condition had clearly been symptomatic prior to the February 2013 accident, as Petitioner reported pain as severe as 8/10 and was using narcotic medications regularly and directly before the accident. (*Id*,p43) Dr. Levin testified that Petitioner did not require further treatment due to the February 2013 accident, but that his need for additional treatment was due to a preexisting condition that was present irrespective of the accident. (Id. at 48)

Dr. Ronald Silver testified in his evidence deposition on July 31, 2015. (Px.16 at 5.) Dr. Silver is a board certified orthopedic surgeon who began treating Petitioner on November 1, 2013. (Id.) X-rays taken at his office that day revealed Petitioner had a complete loss of cartilage in the medial compartment of his right knee with bone-on-bone changes, a spur on his trochlea and some squaring off of the lateral femoral compartment indicating damage to the cartilage in the lateral compartment (Id. At 8)

The doctor recommended a total knee replacement pursuant to the findings on x-ray. (Id. at 8-9) Dr. Silver testified that Petitioner could not return to work because his pain was too severe, he had no cartilage to stand on and he was taking narcotics on a daily basis. (Id. at 9) The doctor opined the need for the total knee replacement was caused or contributed to by the February 23, 2013 work accident based on his review of Dr. Walsh's records which included Petitioner's x-rays prior to his knee arthroscopy which were normal. (Id.) The doctor explained the

significance of normal x-rays meant that prior to the work accident, Petitioner had plenty of cartilage left. (Id. at 9-10) The doctor further explained that:

> "[E]ven if he had arthritis prior to the accident, it was so minimal it wasn't even noted on x-ray at that time. What that means then is that this new accident caused significant damage to the cartilage on the inside of his knee that took him from normal x-rays to a situation where the x-rays show bone on bone indicative of the fact that he damages so much cartilage with this fall that his need for knee replacement was obviously caused by the fall." (Id. at 10)

Dr. Silver testified that he had reviewed Dr. Walsh's records, which referred to x-rays predating his initial right knee procedure in 2011. Dr. Silver testified that these x-rays were normal, and that Petitioner had "plenty of cartilage left" after the first surgery. (Px.16 at 9-10) He testified that Petitioner had very mild degenerative changes in the right knee prior to the February 2013 accident, which was not detected on x-ray. (Id. at 10) He testified that the accident not only exacerbated and accelerated the degenerative changes, but that it caused damage to a point that were so severe that he had no cartilage left. (Id. at 10-11)

According to the doctor the work accident caused cracking and fragmentation which continued on until the point of his consultation when Petitioner no longer had cartilage. (Id. at 21.)

Dr. Silver disagreed with Dr. Levin's opinion that Petitioner needs only a partial knee replacement surgery because damaged cartilage exists in more than one compartment. (Id. 10-12) With respect to Dr. Levin's opinion contained in his October 6, 2014 report that Petitioner's work injury did not cause Petitioner's symptoms, Dr. Silver disagrees. (Id. at 27) Dr. Silver asserts that Petitioner's accident is a competent cause of the cartilage damage which is confirmed objectively on x-ray. (Id.)

The doctor further testified that he reviewed Dr. Walsh's. April 22, 2013 note in which Dr. Walsh discusses the results of an x-ray taken in 2011 after Petitioner's first surgery which showed that Petitioner had plenty of normal cartilage left. (Id. at 21)

Dr. Silver testified that he had initially misunderstood Petitioner's history regarding his right knee pain. Despite documenting that it was asymptomatic for a period of nearly a year, between November and October 2014, he testified that Petitioner actually reported that he had occasional pain that entire time, and that he clarified this in his medical note of November 13, 2014. (Id. at 23-24) The doctor further testified that his opinions remain unchanged given the fact that Petitioner was

taking pain medication and working full duty without restriction prior to the work accident. (Id. at 24)

Dr. Silver admitted that he did not review the operative report of February 2011, or any other record predating February 2013 other than Dr. Wasserman's January 6, 2012 medical note. (Px.16 at 17)

On cross-exam, Dr. Silver testified that Petitioner's right knee condition deteriorated to such a degree that in eight month's he went from almost normal cartilage to no cartilage. (Id. at 36)

Petitioner was treated at Elmhurst Clinic while he was treating with Dr. Walsh, on April 12, 2013. (Rx.5) Petitioner presented on that date for a quarterly evaluation for chronic maintenance of severe arthritis of the right knee, status-post right knee arthroscopy. This note is referring to the February 2011 surgery, as Petitioner had not yet undergone the surgery following his February 2013 accident. (*Id*) Petitioner is noted to have been advised by his prior surgeon, Dr. Thangamani, that he would likely require a total knee replacement within the next four to five years. (Id.)

Petitioner testified that he did not recall ever having discussed the possibility of a total knee replacement with any physician prior to the work injury. (Tr.100)

Petitioner maintained that he was working full time and full duty after the surgery in 2011. (Tr. 34-35;70) He testified that he stood for eight hours a day while working as a machine operator without difficulty prior to February 25, 2013, and that he performed his job duties without use of any accommodations typically provided to other employees. (Tr.34-35;78) Ms. Spooner testified that Petitioner requested a stool when he returned from his 2011 surgery, and that he used this stool frequently through February 25, 2013. (Tr.133-135) Mr. Kmiec also testified that Petitioner used a stool frequently, likely on a daily basis, after his return to work following the 2011 surgery. Mr. Kmiec observed Petitioner working on the machine directly in front of his office window, frequently using the stool rather than standing. (Tr.163-167) Mr. Cheves testified that he also observed Petitioner using the stool on a daily basis upon his return to work following the 2011 surgery. (Tr.193-194;198) Mr. Ampulski testified that he, too, witnessed Petitioner sitting at the machines frequently. (Tr.205)

Dr. Silver testified that he did not provide a prescription for a cane, crutches, or a wheelchair, but that Petitioner did walk with a limp. (Px.16,p32-33) Petitioner testified that he occasionally walked with a limp prior to February 2013. (Tr.24-25)

Petitioner testified that he never stopped using narcotic medications after his February 2011 surgery for more than a couple of days, and was using narcotic medications regularly throughout 2012. (Tr.66;68) According to Dr. Silver's June 9, 2015 medical note, however, Petitioner alleged that he was taking pain pills only occasionally discomfort prior to the work injury. (Px.8)

Dr. Levin testified that Petitioner's right knee condition was clearly symptomatic prior to the February 2013 accident, as evidenced in part by his continued use of narcotic medications. (Rx.4 at 43) Dr. Silver agreed that regular use of narcotic medications is an indication of symptoms including pain. (Px.16 at 37-38)

Petitioner testified that he occasionally had right knee pain prior to his work injury, but that this pain would occur occasionally throughout the week, but not necessarily every week. (Tr.65)

CONCLUSIONS OF LAW

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator makes the following findings and conclusions:

The Arbitrator finds that Petitioner has failed to prove that his current condition of ill-being is causally related to the accident alleged. The Arbitrator places significant weight on the treating medical records, including the objective diagnostic testing which reveals a significant pre-existing degenerative arthritic condition in Petitioner's right knee:

- On February 15, 2011 an MRI of Petitioner's right knee showed "*diffuse cartilage thinning in the anterior portion of the medial femoral condyle.*" (Id.)

- Dr. Thangamani's February 28, 2011, post-operative diagnoses were a right knee medial meniscal tear, lateral meniscal tear, and degenerative joint disease. (Rx.6) The operative report notes that Petitioner had *medial compartment Grade Three chondral changes* in addition to a degenerative medial meniscus tear. (*Id*)

- On March 14, 2013 Petitioner's right knee MRI showed "moderate degenerative changes in the medial femorotibial articulation with significant subchondral marrow edema in the medial femoral and tibial condyles. Possibility of impaction injury is there." With respect to cartilage/articular surfaces, the MRI found "moderate degenerative changes in the medial femorotibial articulation with

thinning and focal loss of cartilage with subchondral marrow edema. Lateral femorotibial and patellofemoral articulations are intact. (Id.)

- Dr. Walsh's June 26, 2013, post-operative diagnoses included a torn medial meniscus, grade four chondromalacia of the medial femoral condyle and medial tibial plateau, and a large plica with grade two chondromalacia of the lateral tibial plateau. (*Px.2*)

- Dr. Walsh's June 26, 2013 surgical report documents *a nickel-sized area of exposed bone along the medial tibial plateau and a larger area of exposed bone at the medial femoral condyle, about the size of a dollar.* (*Id*)

The Arbitrator notes the many inconsistencies in the record in Petitioner's testimony and within the medical records. The Arbitrator is not persuaded by the testimony of Dr. Silver or the opinion of Dr. Walsh that Petitioner solicited at his last exam. The Arbitrator finds Dr. Walsh's opinion is predicated on Petitioner's statement that he had "no pain prior to this work injury". The treating records and prescription refill records prior to Dr. Walsh's involvement clearly belie that statement. Further, Dr. Walsh did not have the advantage of reviewing Petitioner's prior medical records prior to forming his "opinion".

The Arbitrator further finds Dr. Walsh's opinion inadmissible as a statement made specifically for the purposes of litigation as evidenced by his September 21, 2013 record in which Petitioner reported to the doctor that the "work related injury may have aggravated his osteoarthritis". Dr. Walsh documented that Petitioner had an attorney "representing him for his injury" and further noted, "I told the patient that we can certainly note in the medical record that his symptoms were aggravated by his work injury causing his condition to worsen." It is clear to this Arbitrator that Petitioner solicited this opinion from the doctor in an effort to strengthen the causation prong of this case.

With respect Dr. Silver, the Arbitrator places significantly less weight on his opinions as he did not review any records predating February 2013 other than Dr. Wasserman's January 6, 2012 medical note. (Px.16 at 17)

Dr. Silver's testimony that Petitioner "had plenty of cartilage" in February of 2011 was apparently based on review of Dr. Walsh's records which included Petitioner's x-rays prior to his knee arthroscopy which were normal. Dr. Silver further testified that "even if he had arthritis prior to the accident, it was so minimal it wasn't even noted on x-ray at that time" is contradicted by the pre-accident surgical report which reveals

advanced right knee arthritis. Specifically, the surgeon visualized grade 3 chondral changes in the medial and lateral compartments of Petitioner's right knee two years prior to the work accident at issue. (Rx.5) The Arbitrator notes that Petitioner not only did not present this to Dr. Silver for review but did not admit this report into evidence.

Dr. Silver's explanation regarding the clarification he provided in his November 13, 2014 medical note is not believable. The Arbitrator notes that Dr. Silver did not amend his records until Dr. Levin's final IME report of October 6, 2014, documenting Petitioner's vast treatment to the right knee prior to the accident. His testimony that he simply misunderstood Petitioner for a period of nearly one year of treatment is not credible.

In this case, Petitioner was examined by one non-treating physician, Dr. Levin. Dr. Levin, however, was provided Petitioner's medical records and MRI and x-ray films from both before and after the accident. He is the only physician to have done so. He testified that Petitioner's records predating the February 2013 accident clearly document ongoing complaints of severe right knee pain, severe arthritis in the medial compartment, recommendations for injections, prescriptions for a knee brace, regular use of narcotic pain medications between 2011 and two weeks prior to the accident, and the recommendation for a future total knee replacement.

Dr. Levin felt Petitioner is capable of working in a seated position, or with accommodations of alternating between sitting and standing. He was working within those restrictions upon his return to work in 2011 after his first right knee surgery, and was capable of returning to those restrictions by August 19, 2013. The Arbitrator notes the treating surgeons August 6, 2013, note in which he advised Petitioner that he was approaching maximum medical improvement with regard to the arthroscopy. He further noted that Petitioner would finish physical therapy and he would release him to work without restrictions as of August 19, 2013.

However, upon learning that his position was no longer available, Petitioner elected to treat with Dr. Silver rather than returning to Dr. Walsh and searching for another job. Dr. Silver immediately placed Petitioner off work, indicating that Petitioner could barely walk. There is no indication in the records, or through Petitioner's testimony, that he was incapable of returning to work as he previously performed it; alternating between sitting and standing. Petitioner admitted that he walked from the train station to Dr. Silver's office for the deposition in July 2015. He was ambulatory during the trial, and sat through several hours of testimony without apparent distress.

The Arbitrator further notes inconsistencies between Petitioner's testimony (and his position with respect to causation) and the medical records. Petitioner testified that his knee was more painful since the work accident, and that he was unable to do things he had previously been capable of doing. The records predating his accident, however, reveal that Petitioner had longstanding complaints of right knee pain which was worsened by prolonged standing, walking, and bending. These are exactly the activities that Petitioner alleges now aggravate his right knee. Petitioner admitted that he failed to disclose to Dr. Walsh that he had been treating at Elmhurst Pain Clinic before the work injury, though he testified that he was also truthful and honest with Dr. Walsh. (Tr.79) He also failed to report to Dr. Walsh that he was receiving prescriptions for narcotic pain medications on a monthly basis from this clinic, and had been using narcotic medications for right knee pain on a monthly basis since 2011. (Tr.72;97)

The medical records establish that Petitioner failed to disclose the extent of his right knee treatment prior to February 2013 as well as his regular use of narcotic medications. Because Petitioner was not forthcoming with Dr. Walsh, Dr. Silver, or Dr. Levin. The Arbitrator gives Petitioner's testimony little weight.

The Arbitrator is persuaded by Dr. Levin's opinions of significant pre-existing arthritis prior to the February 25, 2013 accident, which is based on Petitioner's medical records and objective findings. The Arbitrator also notes that prior to the work accident, two orthopedic doctor's records mention the inevitability of right knee replacement for Petitioner.

The Arbitrator finds that Petitioner's current condition of ill-being is not causally connected to his work accident of February 25, 2013, but rather is the result of a chronic, degenerative and inevitable process.

The Arbitrator finds that Petitioner sustained a medial meniscal tear as a result of the February 25, 2013 accident, which was successfully repaired on June 26, 2013. Dr. Walsh released Petitioner to full duty work as of August 19, 2013, noting that Petitioner was approaching MMI with regard to his work injury, and that his persistent pain was related to his arthritis. Petitioner's claim for benefits is denied.

In support of the Arbitrator's decision with respect to (G) Wages, the Arbitrator makes the following findings and conclusions:

Petitioner alleges an annual salary of $41,964.00, and an average weekly wage of $807.00, which includes consideration of overtime hours. The

Arbitrator notes that Petitioner admitted that he did not work overtime every week, and that he was not required to if there was a conflict with his personal schedule. Ms. Spooner confirmed that employees were encouraged to work overtime, but not required to. Overtime hours were not offered every week, and Petitioner frequently did not work overtime hours when they were offered. This is neither mandatory nor consistent overtime. Therefore, the Arbitrator finds that Petitioner did not work mandatory and consistent overtime. His salary, without consideration of overtime, totaled $30,502.16, and his average weekly wage is therefore $586.58.

In support of the Arbitrator's decision with respect to (J) Medical Expenses, the Arbitrator makes the following findings and conclusions:

The Arbitrator finds that Petitioner has undergone medical care following his release to full duty work from Dr. Walsh with Dr. Silver which is unrelated to the February 2013 accident. Petitioner has been under active medical care with a pain management specialist since October 2011, and recommendations for a total knee replacement were noted in Petitioner's records well before the February 2013 accident.

The Arbitrator finds that any and all treatment Petitioner has undergone with Dr. Silver has been unnecessary and unreasonable as it relates to the February 25, 2013 accident. Any treatment beyond September 27, 2013, after Petitioner's last date of treatment with Dr. Walsh, was unreasonable and unnecessary. As such, Respondent is not liable for any medical services provided to Petitioner beyond that date.

The Arbitrator further notes that Petitioner has been prescribed Norco on a monthly basis since 2011, and that his current prescription for pain medications is therefore unrelated to the February 2013 accident, but is rather a continuation of the medications he previously used.

The Arbitrator further finds that the charges for narcotic medications from Dr. Silver's office, totaling $43,127.97, and $2,152.10, are unreasonable. Petitioner admitted that he did not pay this much for narcotic medications between 2011 and 2013 despite getting monthly refills. There is no reasonable justification for charging such a fee for the same medications as of November 2013.

In support of the Arbitrator's decision with respect to (K) Prospective Medical Care, the Arbitrator makes the following findings and conclusions:

The Arbitrator finds that Petitioner is not entitled to prospective medical care, specifically the surgical procedure recommended by Dr. Silver on November 21, 2013, as Petitioner's current condition of ill-being is not causally related to his alleged accident.

Petitioner's subjective complaints after the June 26, 2013 surgery are consistent with his complaints after the surgery of February 2011, indicating that Petitioner's work injury consisted only of a medial meniscal tear, which was repaired successfully, and that Petitioner was returned to his pre-accident condition as of August 19, 2013.

In support of the Arbitrator's decision with respect to (L) TTD benefits, the Arbitrator makes the following findings and decisions:

As the Arbitrator finds that Petitioner has failed to prove that his current condition of ill-being is causally related to the accident alleged, she awards no TTD to Petitioner. Petitioner was released to full duty work by Dr. Walsh as of August 19, 2013. Petitioner did not return to work only because there was no position available at the time of his release. He admittedly did not seek employment elsewhere. Petitioner was found by Dr. Levin to be capable of performing seated work, with the option to alternate sitting and standing. This is exactly as Petitioner performed his work for Respondent prior to the accident. Therefore, Petitioner had returned to his pre-accident condition by August 19, 2013. As such, no TTD benefits are awarded since that date.

Despite this, Petitioner testified that he received TTD benefits through October 24, 2014, after receiving the IME addendum of Dr. Levin. Respondent is therefore entitled to a credit for all TTD benefits paid after August 19, 2013.

In support of the Arbitrator's decision with respect to (M) Penalties and Fees, the Arbitrator makes the following findings and conclusions:

Petitioner has requested that penalties and fees be assessed on Respondent under sections 19(k), 19(l), and 16 of the Act. As Petitioner's current condition of ill-being is not causally connected to his alleged accident, Petitioner has not been awarded any lost time benefits. As the Respondent is not liable for payment of any benefits to Petitioner, Petitioner is not entitled to penalties in this matter. Moreover, the evidence is overwhelming that Respondent's actions in this matter have been reasonable.

In support of the Arbitrator's decision with respect to (N) a credit to Respondent, the Arbitrator makes the following findings and conclusions:

Petitioner testified that he received TTD benefits through October 24, 2014. He was released to full duty work as of August 19, 2013 by Dr. Walsh. Petitioner's current condition of ill-being is not related to the February 2013 accident, but rather is due to his pre-existing condition, and his off-work status from Dr. Silver is unrelated to the work accident. Therefore, Respondent is entitled to a credit for an overpayment of TTD benefits for the period of August 19, 2013 through October 24, 2014, totaling $24,077.51.

The Arbitrator also notes that Petitioner received an advance from Respondent totaling $8,884.80, as stipulated to by the parties. Respondent is therefore entitled to a total credit of $32,962.31.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Laurie Laidlow,

Petitioner,

vs.

NO: 13 WC 20261

Paramount Staffing,

16IWCC0755

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 25, 2016 is hereby affirmed and adopted.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 2 3 2016

MB/mam
o:10/27/16
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LAIDLOW, LAURIE
Employee/Petitioner

Case# **13WC020261**

16IWCC0755

PARAMOUNT STAFFING
Employer/Respondent

On 4/25/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.35% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0123 COHN & COHN
ERWIN COHN
77 W WASHINGTON ST SUITE 1422
CHICAGO, IL 60602

4866 KNELL O'CONNOR & DANIELEWICZ
MICHAEL J DANIELEWICZ
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

16IWCC0755

STATE OF ILLINOIS)
)SS.
COUNTY OF Lake)

- [ ] 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

Laurie Laidlow
Employee/Petitioner

v.

Paramount Staffing
Employer/Respondent

Case # 13 WC 20261

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 **Andros**, Arbitrator of the Commission, in the city of **Waukegan**, on **February 27, 2015 and November 18, 2015 & after reopening proofs on February 24th , 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. [x] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **March 23, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

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

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

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

ORDER

Petitioner is not entitled to benefits under the Act as no incident occurred which arose out of and in the course of Petitioner's employment with Respondent.

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

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

#001 Arb. George J. Andros, April 23rd, 2016

Signature of Arbitrator — Date

APR 25 2016

ISSUES IN DISPUTE 13 WC 20261

The case at issue is 13 WC 20261 with an a alleged date of injury by Petitioner of March 23, 2013. Issues in dispute are accident/date of alleged incident, causal connection, medical expenses, temporary total disability (hereafter "TTD"), and nature and extent of the injury. Arb.Ex. 1.

STATEMENT OF FACTS &CONCLUSIONS OF LAW 13 WC 20261

Regarding Issue "C," did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

The Arbitrator concludes based upon the totality of the evidence that the alleged incident did not arise out of and in the course of Petitioner's employment by Respondent. The Arbitrator cites the following reasons for his finding:

A March 27, 2013 visit note from Lake County Health Department cites that Petitioner experiences right lateral thigh pain after banging his right knee. *Rx.* 3. The note states that there is no swelling to Petitioner's right knee. *Rx.* 3. The note does not state where the injury took place. *Rx.* 3.

An April 12, 2013 visit note from Vista Medical Center East states that on March 23, Petitioner was injured at home after running into a wall with his right knee. *Rx.* 2. There is no explanation for this inherent contradiction with other records and pleadings. The Arbitrator is concerned that the note states the incident occurred at home while running into a wall. In Petitioner's testimony, he indicates that he never informed the physicians at Vista that he was injured at home. *Tr.* 100. The Arbitrator finds this testimony not consistent, yet given histories do vary it was conceivable a work door was later confused with an entrance door at work.

Petitioner's 8(a) Petition filed July 2, 2013 cites that Petitioner's alleged incident occurred as a result of a not properly latched door which hit Petitioner's right knee. *Rx.* 5. This statement is reiterated in Petitioner's Application for Adjustment of claim filed July 2, 2013. *Rx.* 5. It is confirmed once more in Petitioner's 8(a) Petition filed September 27, 2013. *Rx.* 5. Photos of the door involved show that the door has a door closer mechanism located at the top of the door. *Rx.* 16C.

According to testimony provided by Respondent's witness, this mechanism provides resistance when the door is being opened so that the door cannot be swung open. *Tr(2).* 27-29. This Arbitrator finds that the photos provided directly contradict Petitioner's assertion that the door in question can be swung open with the force necessary to cause the alleged injury. Further, Respondent's witness testified that nothing had been done to the doors since the date of alleged incident. *Tr(2).* 28.

An April 11, 2013 Accident Investigation Form filled out by Respondent indicates that Petitioner was late for his shift and as he was entering the building hit his right leg with the door. *Rx.* 8.

This Arbitrator finds that in light of the records provided and the conflicting testimonies that Petitioner's history is not persuasive. The door involved in the alleged work incident cannot feasibly be swung open in the manner which Petitioner describes. Photos of the door confirm this. The company witness so testified.

Further, the Arbitrator finds as matter of fact the worker did not sustain a compensable accident while entering the premises of the borrowing employer.

Therefore, as a matter of law the in respect to Issue "C," the Arbitrator concludes that the alleged incident did not arise out of and in the course of Petitioner's employment with Respondent.

Regarding Issue "D," what was the date of the incident, the Arbitrator finds the following:

The Arbitrator concludes after examining the evidence, notwithstanding the Arbitrator's findings on issues C, F, J, K, and L, that the alleged date of incident by Petitioner of March 21, 2013 is incorrect. The Arbitrator concludes that the incident date in question is March 23, 2013. The Arbitrator cites the following reasons for his finding:

A March 27, 2013 visit note from Lake County Health Department cites that Petitioner's alleged incident occurred on March 21, 2013. *Rx.* 3.

A March 10, 2014 visit note from Associated Medical Centers of Illinois cites that Petitioner's alleged incident occurred on March 23, 2013. *Rx.* 1. A April 12, 2013 visit note from Vista Medical Center – East cites that Petitioner's alleged incident occurred on April 11, 2013 and on March 23, 2013. *Rx.* 2.

Petitioner's 8(a) Petition filed July 2, 2013 cites that Petitioner's alleged incident occurred on March 23, 2013. *Rx.* 5. This statement is reiterated in Petitioner's Application for Adjustment of claim filed July 2, 2013. *Rx.* 5. It is confirmed once more in Petitioner's 8(a) Petition filed September 27, 2013. *Rx.* 5. An April 11, 2013 Accident Investigation Form filled out by Respondent based upon the Petitioner's assertion an accident took place so indicates that the incident in question took place on March 23, 2013. *Rx.* 8. An email from Respondent's witness Margarita Mercado to Little Lady Foods was sent on March 23, 2013 indicating that during second shift Petitioner reported an incident to Ms. Mercado. *Rx.* 9.

A First Aid/Incident Only Report signed by Petitioner and prepared by Respondent on March 23, 2013 indicated that on said date Petitioner's alleged incident occurred. *Rx.* 11. A Waiver of Medical Treatment form signed by Petitioner on March 23, 2013 indicated that on said date an incident occurred for which Petitioner was offered medical treatment, and that he declined said offer. *Rx.* 12. Petitioner's timecard report from March 21, 2013 indicated that he checked in for second shift at 3:30 pm on Thursday and checked out at 1:00 am on Friday the 22. *Rx.* 13. The timecard further shows that on March 23, 2013 Petitioner checked in at 3:30 pm and checked out at 5 pm that same day. *Rx.* 13.

On August 22, 2014, Petitioner filed an Amended Application for Adjustment of claim in which for the first time he alleges that the incident in question occurred on March 21, 2013. *Rx.* 7.

First the Arbitrator notes that all of Respondent's records and testimony indicate that the alleged incident reportedly occurred on March 23, 2013. This appears to be corroborated by Petitioner's timecard. Petitioner's timecard for March 21, 2013 indicated that Petitioner worked a full shift; however, Petitioner's timecard for March 23, 2013 indicated that Petitioner worked only an hour and a half. The Arbitrator finds it more likely that, of it occurred at all , the alleged incident occurred on March 23, 2013 given that Petitioner's time for that day was only an hour and a half. This Arbitrator will not address the allegations made by Petitioner at trial that Respondent actively changes timecards in their system to discredit their employees.

Second the Arbitrator notes that Petitioner signed a medical waiver on March 23, 2013 in which was indicated an incident occurred on that date for which he was offered medical treatment that he denied. The Arbitrator concludes that even if a bump on the knee occurred, not all incidents rise to the level of single trauma to be deemed an accident under the law.

Third Petitioner's pleadings all resolutely state that the alleged incident occurred on March 23, 2013 with the exception of Petitioner's August 22, 2014 Amended Application for Adjustment of Claim. Petitioner filed several pleadings over a lengthy time span prior to said application, and all of said pleadings indicate an alleged incident date of March 23, 2013.

Finally the Arbitrator addresses the dates noted in the medical records. To avoid needless misinterpretations the Arbitrator will assume that each physician reported an alleged date of incident as provided to them by Petitioner.

Petitioner's Lake County visit note is the only record provided by either party that comports Petitioner's alleged date of incident. *Rx.* 3. Although this visit note corresponds to the alleged date of incident by Petitioner at hearing. Although one would assume that six days after an incident Petitioner should remember the date of the incident, the Arbitrator finds that this is incorrect. Given Petitioner's testimony at trial, the Arbitrator finds that Petitioner is not the best historian and that his testimony on the date of incident is not credible. All other medical records, reports, and testimony, provided by Respondent's witness, indicate that Petitioner's alleged incident occurred on March 23, 2013.

Therefore, in respect to Issue "D," the Arbitrator concludes that the alleged date of incident is in fact March 23, 2013 and not March 21, 2013. Said determination does not impact the conclusion of law that no accident occurred arising out of and in the course of the employment at bar.

Regarding Issue "F," whether Petitioner's current condition of ill-being is causally related to an accident which arose out of Petitioner's employment with Respondent, the Arbitrator finds the following:

In light of the Arbitrator's findings on Issue "C," this Arbitrator finds that Petitioner's current condition of ill-being is not causally related to an accident which arose out of Petitioner's employment with Respondent. Nevertheless, the Petitioner complained of thigh pain and received an ultrasound. The poor handwriting can be made out to read that they were checking for a thrombus , not a knee injury. The report of a doctor about one year after the accident stating the door hitting was a cause of a horizontal tear of the meniscus is not at all persuasive.

Regarding Issue "J," whether the medical services provided to Petitioner were reasonable and necessary and whether Respondent has paid all appropriate charges for reasonable and necessary medical services, the Arbitrator finds the following:

Regarding Issue "K," whether Petitioner is entitled to any additional TTD benefits, the Arbitrator finds the following:

Regarding Issue "L," what is the nature and extent of the injury, the Arbitrator finds the following:

In light of the Arbitrator's findings on Issues of accident and even causation, the Arbitrator finds that Petitioner is not entitled to payment of any section 8 benefits from Respondent at bar.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stuart Whitson,

Petitioner,

vs.

NO: 10 WC 44094

16IWCC0756

State of Illinois/
Secretary of State,

Respondent.

DECISION AND OPINION ON REVIEW

Respondent appeals the Decision of Arbitrator Lindsay finding that as a result of repetitive trauma accidental injuries arising out of and in the course of his employment manifesting on September 20, 2010, Petitioner was temporarily totally disabled from May 24, 2012 through July 21, 2012, a period of 8-3/7 weeks at $533.39 per week, that he was entitled to reasonable and necessary medical expenses of $625.00 and ordered Respondent to also reimburse Petitioner for his out-of-pocket payments to Dr. Watson and Prairie Surgery Center and that Petitioner is permanently partially disabled to the extent of 7.5% loss of use of his right hand and 10% loss of use of his left hand, a total period of 35.875 weeks at $480.53 per week. The issues on Review are whether Petitioner sustained repetitive trauma accidental injuries arising out of and in the course of his employment manifesting on September 20, 2010, whether a causal relationship exists between those injuries and Petitioner's current condition of ill-being and if so, the extent of temporary total disability, the amount of medical expenses and the nature and extent of permanent disability. The Commission, after reviewing the entire record, reverses the Decision of the Arbitrator finding that Petitioner failed to prove he sustained repetitive trauma accidental injuries arising out of and in the course of his employment manifesting on September 20, 2010 and failed to prove a causal relationship exists and denies Petitioner's claim for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a 56 year old motor vehicle regulation Tech II on September 20, 2010, testified he is currently 61 years old and is retired from the Secretary of State (Tr 12). Petitioner has a 12th grade education and went to an adult education school to learn how to type (Tr 12). His work experience prior to working at the Secretary of State was at a gas station, a mattress factory and at a Juicy Ridge Juice outlet (Tr 12). Petitioner was employed with the Secretary of State for 30 years, but was given credit for 27 years and either 4 or 6 months (Tr 13). He retired from the Secretary of State at the end of 2013 (Tr 13).

Petitioner started as a data input operator at the Howlett Building in Springfield, Illinois and worked in this capacity for 17 years (Tr 13). He was then transferred to the Emissions Program at Dirksen (Tr 13). Petitioner later was promoted to Tech II, the facility assistance hotline and that is where he remained until retirement (Tr 13).

In his position as data input operator, Petitioner worked the 3 to 11 shift for 17 years (Tr 14). Petitioner explained his job duties: "We typed in batches of 100 either title and registration, title and transfer, title only, we had junking certificates, salvage certificates also, and that's basically all it was. It was just constant typing." (Tr 14). He typed on a Honeywell 6, a very old fashioned computer system that feeds into a main computer and stores everything (Tr 14). Petitioner would type for his entire shift (Tr 16). Usually there was a 10 hour a week mandatory overtime. At the very minimum he worked 8 hours per day. During his shift he got two 15-minute breaks and a half hour lunch; he could not work over 4 hours without a 15-minute break (Tr 16). Petitioner did strictly typing and did not multi-task (Tr 17). His work station consisted of a desk with drawers (Tr 18). Petitioner usually put his hand on the edge of the keyboard to type (Tr 18). Dividers and new desks were brought in and new computers were brought in after he had been transferred to Dirksen (Tr 19).

At the Dirksen facility, Petitioner did, "Basically the same thing only there were – we were looking up – it was emissions, people who had failed – there is like 7 cities in Illinois where it's mandatory that they have their cars emissions tested." His main job duty there was primarily data entry; it was searching up and making certain that all vehicle identification numbers matched as well as addresses (Tr 19). Petitioner worked the day shift and the same amount of hours (Tr 20). He would get a one hour lunch break and two 15-minute breaks during a shift (Tr 20).

Petitioner was promoted up to the facility assistance hotline. He spent 10 to 11 years in this job (Tr 20). This was a multi-tasking job. Petitioner explained, "You answered the phone which we had head phones and if the phone rang you just pushed the button and talked to them while you got printouts and looked at the screen to read the driver's abstract and find out if they

had stops on there that they needed to go to the County and pay fines or reinstatement fees for being suspended for not paying fines." (Tr 21). This job required use of the telephone and data entry (Tr 21). Petitioner stated, "...you also had to write up everything that was done for the record; and then get an after image printout and clip them together and prepare them to be microfiched after that." (Tr 21). Petitioner worked the same amount of hours and had the same breaks (Tr 21-22). When he started complaining about his hands, they gave him a slide out keyboard from underneath the table that he used; "That gave me quite a bit of relief." (Tr 22).

At some point, Petitioner started having problems with his hands; they were getting numb and he was having a hard time hitting the right keys; they were painful at times (Tr 23). He started noticing symptoms and he would say it got worse between 2009 until he got them fixed (Tr 23). Petitioner talked to his supervisor, Kris Minor, about his symptoms (Tr 23). He told Ms. Minor that he felt his symptoms were related to his job activities (Tr 23-24). Ms. Minor had him fill out an accident report at that time (Tr 24).

After he reported these symptoms to his supervisor, Petitioner sought medical treatment (Tr 24). Petitioner first saw his primary care physician Dr. McKay and let him know his situation. Dr. McKay referred Petitioner to Dr. Fortin, a neurologist at Springfield Clinic (Tr 24-25). Petitioner saw Dr. Fortin and complained of symptoms of numbness and tingling in his hands (Tr 25). Based on his clinical examination, Dr. Fortin diagnosed bilateral carpal tunnel syndrome (Tr 25). Dr. Fortin then referred him for an EMG/NCV. When Petitioner got the results of the EMG/NCV, Dr. Fortin referred him to Dr. Wottowa at Springfield Clinic (Tr 26). Petitioner saw Dr. Wottowa and complained of the same symptoms (Tr 26). Dr. Wottowa recommended bilateral carpal tunnel releases, but he did not perform them. Petitioner did not really recall that Dr. Wottowa did not perform the release surgeries because workers' compensation did not approve them (Tr 26). Petitioner asked primary care physician Dr. McKay to refer him to Dr. Watson of Watson Orthopedics, which he did (Tr 27). Petitioner saw Dr. Watson and told him about his same symptoms (Tr 27). Dr. Watson agreed with Dr. Wottowa that the carpal tunnel releases should be done (Tr 27-28). On May 24, 2012, Dr. Watson performed a left carpal tunnel release. On June 21, 2012, Dr. Watson performed a right carpal tunnel release (Tr 28). Dr. Watson kept Petitioner off work from May 24, 2012 until he released him to return to work at full duty on July 21, 2012 (Tr 28). Petitioner did not return to work at that time as he was treating for a hip problem (Tr 28-29).

At Respondent's request, Petitioner saw Dr. Williams of Midwest Orthopedics in Peoria for an independent medical evaluation (Tr 29). The examination with Dr. Williams took about an hour and a half (Tr 29). Petitioner was shown Px9, medical bill list (Tr 29). Petitioner stated that it looked as though all his medical bills had been paid (Tr 30). Petitioner paid a co-pay and his group health insurance covered the rest (Tr 30). Petitioner currently noticed that he is happy with his wrists and arms. He has good sensitivity. He only has problems opening bottles now and then, opening jars and things like that (Tr 30). Petitioner has never been diagnosed with any thyroid disorder or diabetes (Tr 31).

On cross-examination, Petitioner testified that when he saw Dr. Wottowa for his hands on September 20, 2010, he had him fill out a questionnaire and he answered those questions truthfully and to the best of his ability (Tr 31). Petitioner wrote that by 2010, he had smoked for 40 years (Tr 32). He also wrote that he had smoked approximately 1½ packs per day during that 40 year smoking history (Tr 32). Petitioner started smoking when he was approximately 16 years old (Tr 32). He quit smoking about a year before this hearing (Tr 32-33). Petitioner saw Dr. Wottowa once for his hands (Tr 33). Dr. Wottowa asked about his job and Petitioner told him he worked for the State and used a keyboard (Tr 33). That was really about the only discussion he had with Dr. Wottowa concerning his job (Tr 33). Petitioner did not recall if he told Dr. Wottowa that he also answered telephones (Tr 34). It sounded accurate that Petitioner saw Dr. Williams at Respondent's request on April 13, 2011. Dr. Williams asked Petitioner questions about his job and he answered all his questions truthfully and to the best of his ability (Tr 34). Petitioner acknowledged he mentioned to Dr. Williams that he enjoyed woodworking (Tr 34). Petitioner stated that he really did not have any tools to do much woodworking (Tr 34). He did tell Dr. Williams that he engaged in that activity when he had the opportunity (Tr 34-35). Petitioner also conveyed to Dr. Williams that he does home improvement, painting and stuff like that (Tr 35). Dr. Wottowa did not ask Petitioner about his activities outside of work, about woodworking and things of that nature (Tr 35). Petititioner saw Dr. Wottowa in September 2010 and saw Dr. Watson in April 2012 (Tr 35). There were so many things happening between those times and Petitioner stated he gets fuddled on dates, times and stuff (Tr 36).

Petitioner was off work around the same time for a hip replacement (Tr 36). He had surgery on his left hand in May 2012 and he was really happy with the results of that surgery (Tr 36). Approximately a week later, Petitioner went back to Dr. Watson and said that all his symptoms had essentially resolved. This was a pretty quick recovery from the surgery (Tr 36). The same can be said with the right hand and Petitioner had good results with that as well (Tr 36). Petitioner is very happy with the outcome of the surgeries with both his right and left hands (Tr 37). He has all his sensitivity back (Tr 37). Dr. Watson had Petitioner fill out a form as to what he believed was causing his symptoms and Petitioner wrote, "28 years of typing" (Tr 37). On July 21, 2012, Dr. Watson returned Petitioner to work without any restrictions (Tr 37). Petitioner worked without restrictions on his hands up until the time he retired (Tr 37). Petitioner did not seek treatment after he last saw Dr. Watson as his therapy was over and he was satisfied (Tr 37). Petitioner thinks he received the same salary when he returned to work (Tr 38). Petitioner believed he received the same salary after the surgery as he did before the surgery (Tr 38). He worked his last job with Respondent for almost 11 years (Tr 38). He might have retired in December 2012, not 2013 (Tr 38). Petitioner had that last job from around 2000/2001 until he retired (Tr 38). He had some problems with his hands before 2009, but they got much more noticeable in 2009 (Tr 39). He started to notice it more in 2009 (Tr 39). That was during his last job with Respondent (Tr 39).

There were supposed to be 4 people at the phone bank (Tr 40). They had a hard time keeping people there; generally there were 3 and sometimes only 2 people there (Tr 40). Generally when Petitioner received these phone calls and had to type on the computer, then the

information he typed in was a driver's license number consisting of 13 keystrokes (Tr 41). If he had to correct something, he had to go in and delete and reload; it is much more than another 12 or 15 additional keystrokes (Tr 41). It was a whole line of abstract or driving record (Tr 41). Sometimes they would get 70, 80 calls a day (Tr 41-42). Petitioner would spend less than 5 minutes per call (Tr 42). Some of the time he could just type in a driver's license number; when the record came up if it did not pertain to something he would fix, then he would try to get to the area where it could be fixed (Tr 42). Less than half the calls or 40% of the calls he would just have to type in the 13 digit driver's license number to resolve the issue of the phone call (Tr 43). Petitioner started his shift at 8:00 a.m. and would take a break about 11:00 a.m.; he then stated he would take his break between 9:00 a.m. and 10:00 a.m., about the middle of his work between the time he started and lunch (Tr 44). It was the same for afternoon (Tr 45). Petitioner got an hour for lunch at Dirksen and got off work at 4:30 p.m. (Tr 45). It is a fair statement that the most he could be typing at any one time without a break would be a couple of hours (Tr 45). Petitioner also had to write what he had done to the record (Tr 45). He is left hand dominant and he writes with his left hand (Tr 46). Petitioner uses a cane and has so for over 20 years (Tr 46). Petitioner has a bad left leg and uses the cane with his right hand (Tr 47). He wears a brace on his left ankle (Tr 47). He uses a cane in his right hand everywhere he goes, unless he is shopping and using a grocery cart (Tr 47).

On re-direct examination, Petitioner testified that his father was a carpenter all his life. As a child, Petitioner studied to be a carpenter until he got hurt at 17 years old (Tr 48). He went to the vocational school in Springfield and finished 11th and 12th grade and they considered that 2 years of carpentry apprenticeship (Tr 48). Petitioner's father told him that he could not be a carpenter after his accident because they could not insure him on a ladder (Tr 49). Woodworking was kind of a hobby (Tr 49). Petitioner stated, "I didn't really bust my fanny at it like you would if you were a carpenter." (Tr 49). He did not have the money or time to do any woodworking when he was 17 years old (Tr 49). Petitioner started woodworking when he bought his house in August 1999 (Tr 50). What he called woodworking entailed a little trim work, painting and just decorating because he bought a fixer upper (Tr 50). The tools he used were paint rollers, paint brushes and a miter box for cutting angles (Tr 50). Petitioner would work on these projects on the weekends; not every weekend, maybe one weekend a month (Tr 50). Whether he would spend both days of a weekend working on this project depended on the size of the room he was painting (Tr 51). Petitioner had his kitchen and bathroom remodeled and had to pay for that (Tr 51). That was a home improvement project and different from a woodworking project (Tr 51). Woodworking was a hobby only when he first bought the house for the first year (Tr 52). Woodworking is not something that he did as a side job or anything like that (Tr 53). When multi-tasking in his last job at the assistance hotline, when he answered the telephones he was also simultaneously doing data entry (Tr 53). He was talking on the phone and keying at the same time a lot of times (Tr 53). Then he would write everything up (Tr 54). He did not just sit for 15 to 20 minutes between calls. When no phones were ringing, Petitioner went over everything he had done to make sure he did not make a mistake (Tr 54).

2. Tina Mikeworth testified that she is currently employed with the Secretary of State, Department of Personnel, and is the Workers' Compensation Coordinator (Tr 56). Through time management, she has access to the employee records (Tr 56). Ms. Mikeworth acknowledged that Respondent's attorney had asked her to access Petitioner's employee attendance records for 2009, 2010 and 2011, which she did (Tr 56). She pulled those records and they were admitted into evidence (Tr 56). She determined if Petitioner took time off (Tr 56). If Petitioner worked a full day, it would be noted as "ED" on the attendance records (Tr 57). From the attendance records, Ms. Mikeworth calculated Petitioner's absences for 2009: he used 86.75 hours of sick leave; he had 18 hours of un-excused absences; he had 19 hours of personal leave; he used 151.75 hours of vacation; he used 14.75 hours of comp time and he was tardy for an hour. The total hours absent from work in 2009 were 291.25 hours, which is 38.83 days. Petitioner worked 7.5 hour days. In addition, he had 12 days off with holiday pay. For the total 52 weeks of the year, Petitioner only had 8 weeks where he was present Monday through Friday for 5 days.

On cross-examination, Ms. Mikeworth looked at Petitioner's records starting in 2009; she did not look at years before 2009 (Tr 58). Sick time has to be documented. Personal time is something the Secretary of State grants and is given so much per year. Regarding un-excused absences, many times employees are given un-excused absences if they run out of time and do not have any time to take (Tr 59). Regarding comp time, maybe Petitioner worked a Saturday or sometimes if an employee works overtime or on a Saturday out of their regular hours, they are given comp time hours that they can use (Tr 59).

3. Kris Minor testified that she has been employed with the Secretary of State for 28 years (Tr 60). She is familiar with Petitioner (Tr 60-61). Petitioner used to work in the phone bank for facility calls and she was his immediate supervisor (Tr 61). When Petitioner was working, four people were assigned to the phone bank (Tr 61). As an employee at the phone bank, Petitioner received phone calls from Secretary of State facilities throughout Illinois (Tr 61). When receiving a call, Petitioner would have to enter the driver's license number of 13 digits; he would have to put in a format and then a back slash and then the driver's license number of 13 digits and then a period and then enter (Tr 62). After that, the screen would populate with information he would need (Tr 62). Then Petitioner would respond to inquiries from the telephone based upon the information conveyed on the screen (Tr 62). Petitioner would need to type more characters if he was going to make a correction to do something, maybe delete something off the record and reload something in its place or possibly remove the header, the driver's license (Tr 63). Petitioner did more of just inputting the driver's license number. Her best guess was maybe 60% of his time he would just have to input the 13 characters (Tr 63). Doing the addition keystrokes would be the other 40% of the time (Tr 63). She would say approximately 20 additional letters inputted, depending on what he would be doing to the file, whether deleting something off or adding; probably closer to 30 characters to maybe put in something correct (Tr 64). Each phone call lasted about 5 minutes (Tr 64). So Petitioner was entering on his keyboard during a 5 minute period of time at the most 45 characters (Tr 64-65). But 60% of the time he would only be entering 13 characters (Tr 65).

On cross-examination, Ms. Mikeworth testified that 40% of the time Petitioner was making corrections and he would have to type in additional keystrokes (Tr 65). That is tracked and a report is kicked out each morning for the previous day on who had done something to that particular record (Tr 66). The only time someone would be shown that report is if there was something done incorrectly and to let them know the correct way to do it (Tr 66). Ms. Mikeworth did not review Petitioner's reports on the percentage of corrections versus regular entries. It is fair to say that the percentage she provided was speculation (Tr 66).

On re-direct examination, Ms. Mikeworth testified she has been supervisor of the phone bank for 7 or 8 years (Tr 67). She has a pretty good idea about how many corrections they do during the course of a day (Tr 67). She reviewed those corrections only if they have a problem with it and it is brought to herself or someone else in upper management to help get it done correctly. The phone banks are located about 10 feet from her office (Tr 67).

On re-cross examination, Ms. Mikeworth agreed that Petitioner retired about the end of 2012 (Tr 68). The reports are received by her electronically and she can go back to that time period (Tr 68). She is speaking in general about the corrections made, not Petitioner in particular (Tr 68). She did not know specifically how many corrections were made by Petitioner (Tr 68).

On re-direct examination, Ms. Mikeworth testified that if Petitioner made a correction, it would be on a particular phone call and she talked about the number of characters he would have to type in for the corrections (Tr 69).

4. Petitioner was recalled in rebuttal and testified that he had heard Ms. Mikeworth's testimony. Petitioner did not think he ever had 86 hours of sick leave in one year, but if so, he must have been off having surgery or something (Tr 70). In 2008, Petitioner thinks he had surgery on his hip and possibly his neck as he had 4 discs removed in his neck and also maybe his gallbladder (Tr 70-71).

5. According to the medical records from Springfield Clinic, Px3, on a Patient History form dated September 20, 2010, under Injury Petitioner wrote, "27 years on a keyboard." Petitioner saw Dr. Wottowa that day, who noted he was there for a new problem. Dr. Wottowa noted that Petitioner had tennis elbow in the past and was injected and that had gone away. Dr. Wottowa noted, "He now has numbness and tingling involving both his hands. It has been present for about a year, maybe longer. He associates this with activities at work. He works for the state and uses a keyboard. It is involving the entire hand, mostly the thumbs. He does not think one side is affected worse than the other." Petitioner complained of near constant pain and constant numbness for 3 months. The thumb bothered him during the daytime with his typing activities, sometimes with driving. There were not a lot of night symptoms. On examination, Dr. Wottowa found full range of motion of both elbows, forearms, wrists and fingers; normal 2-point discrimination in all fingertips; mildly positive Phalen's bilaterally; mildly positive Tinel's bilaterally; negative Phalen's and negative Tinel's at the elbows; all the symptoms with all the provocative testing are present at the wrists. Dr. Wottowa noted that the EMG/NCV done by

Dr. Fortin on July 2, 2010 demonstrated a distal motor latency on the left at 5.6 milliseconds and on the right at 4.8 milliseconds and Dr. Fortin thought Petitioner had evidence of bilateral carpal tunnel syndrome. Dr. Fortin noted he did not find any cervical nerve root irritation, which was good news for Petitioner as he had 3 cervical discs treated in the past. Dr. Wottowa's impression was bilateral carpal tunnel syndrome. Dr. Wottowa opined that Petitioner had classic symptoms of carpal tunnel syndrome and now had constant symptoms in his thumbs. Dr. Wottowa recommended surgical releases two weeks apart. Petitioner informed Dr. Wottowa that he was filing a workers' compensation claim for this and would not do anything until approval was received.

6. CMS Workers' Compensation Employee's Notice of Injury dated September 24, 2010 was admitted into evidence as Rx2. The date of injury was listed as September 20, 2010. Under how the injury occurred, it was noted, "27 years of typing." Petitioner noted, "I work on a keyboard. Carpal tunnel is a common problem for some. I have done production in data entry and used a keyboard all day with this job too. I have been working on keyboards since I started working for the Secretary of State since Dec-16-1983."

7. Petitioner saw his primary care physician Dr. McKay at Springfield Clinic on October 25, 2010. Dr. McKay noted that Petitioner complained of numbness and pain in his upper extremities, particularly his hands. Dr. McKay was aware that Petitioner had a job where he did a lot of keyboarding. Dr. McKay noted that the previous EMG/NCV showed bilateral carpal tunnel syndrome and that Petitioner saw Dr. Wottowa, who recommended surgical releases. Petitioner was there to discuss this. Petitioner reported that the previous night he had severe pain down into his wrist and severe numb-type of pain in his left wrist. Petitioner was not using night splints. On examination, Dr. McKay found a positive Tinel's bilaterally, normal thenar strength bilaterally and sensation was relatively normal. Dr. McKay's assessment was carpal tunnel syndrome. Dr. McKay agreed with Dr. Wottowa that surgery was the best option. Petitioner was to try nocturnal splints. Dr. McKay noted, "I explained to him that I think more likely this is a work comp type of situation given the type of work that he does."

On November 12, 2010, Dr. McKay noted he saw Petitioner and he was doing okay. Dr. McKay noted Petitioner was waiting to have his carpal tunnel surgery. Dr. McKay changed his prescribed medications and Petitioner was seen for other things. (Px3).

8. Petitioner admitted into evidence a Job Description form signed by him and dated November 5, 2010, Px2. Petitioner described his job duties with Respondent as mostly typing and writing. When asked on the form what activities in his opinion caused or contributed to his condition, Petitioner wrote, "27 years as of Dec 16, 2010 typing." Under estimate the approximate number of repetitions he used for his hands and arms, Petitioner wrote, "I don't know how to count keystrokes." Petitioner noted he started working for Respondent on December 16, 1983 at the Howlett Building.

9. On November 15, 2010, Petitioner, through his attorney, filed an Application for Adjustment of Claim. The date of accident was listed as September 20, 2010 with repetitive trauma listed as the accident and both hands and arms affected. The Application for Adjustment of Claim was admitted into evidence as Px1.

10. At Respondent's request, Petitioner saw Dr. Williams on April 13, 2011 for a §12 evaluation. In his report of that date, Rx3, Dr. Williams noted, "As you know, Stuart is a 57 year-old left-hand dominant gentleman who works for the Secretary of State in Motor Vehicle Regulations as a Technician II. Stuart has worked for the Secretary of State since 12/16/83, for over 27 years. He states his job requires him to work 7½ hours a day, Monday through Friday. On Monday's he works 8:30 a.m. until 5:00 p.m. Tuesday through Friday he works 8:00 a.m. to 4:30 p.m. He gets two 15 minute breaks and a one hour lunch break. Stuart is responsible for 130 driver facilities in Illinois. If they have problems they call him. He reads abstract and he helps with reinstatement fees and he fixes problems with data entry." Petitioner's chief complaints were discomfort, problems keying, weakness, stiffness and numbness. He had problems at night. Pain at night was rated at 5/10 and 8/10 with activity. Medications helped. Dr. Williams noted, "He says that all day he answers phones, types and writes." Splinting at night helped. Dr. Williams noted, "He says that he has been a data entry operator for 17 years for the State of Illinois and for the last 10 years he has been a Regulation Technician." Petitioner reported that he smoked a pack and a half of cigarettes a day for the past 40 years. Dr. Williams noted, "He does woodworking at home and he does home improvement projects on his home." Petitioner was still working.

Dr. Williams noted he reviewed the medical records provided to him. Dr. Williams also noted he reviewed a job description prepared by Kristine Minor on September 27, 2010 in detail with Petitioner and he found no discrepancies with the job demand analysis. On examination, Dr. Williams found full range of motion of the wrists bilaterally, full strength of his wrist flexion and extension, positive Tinel's and positive Phalen's bilaterally and a positive median nerve compression test bilaterally. Dr. Williams' impression was bilateral carpal tunnel syndrome, left worse than right. Dr. Williams opined, "I do not believe this condition is secondary to his employment and the typing he does. This patient also does woodwork and works on his house which would be more likely to be contributory to carpal tunnel syndrome than would be his keyboarding activities." Dr. Williams opined Petitioner's smoking could have also contributed to his carpal tunnel syndrome. Dr. Williams opined Petitioner would benefit from carpal tunnel release surgeries.

11. In his September 28, 2011 deposition, Rx6, Dr. Williams testified he is a board certified orthopedic surgeon who also is certified in hand surgery. Dr. Williams recited from his report, noted above. Dr. Williams opined that Petitioner's work activities did not contribute, aggravate or cause the development of Petitioner's carpal tunnel syndrome (Dp 13). Dr. Williams noted Petitioner performed various tasks, including answering the phones, typing and writing. Dr. Williams noted that Petitioner's data entry consisted of entering numbers and names and that he was not doing transcription where he was writing reports or taking dictation, which is constant

writing. Petitioner's job was more intermittent-type work (Dp 13-14). Dr. Williams opined that smoking and woodworking could be more contributory to Petitioner's carpal tunnel syndrome than his job would be (Dp 14). Dr. Williams noted that Petitioner had explained to him that his woodworking involved the use of hammers, which obviously would involve some type of impact or vibratory activity, which is something which has definitely been linked to the development of carpal tunnel syndrome. Dr. Williams opined that keyboarding has not been linked to carpal tunnel syndrome (Dp 14). Dr. Williams opined that Petitioner's carpal tunnel syndrome could also be idiopathic and the cause is unknown (Dp 16).

On cross-examination, Dr. Williams testified that during his evaluation, he met with Petitioner for approximately 45 minutes to an hour (Dp 17). Dr. Williams spent 30 to 40 minutes before the evaluation reviewing medical records and another 45 minutes after the evaluation compiling his report. Dr. Williams noted Petitioner's job duties (Dp 18-19). Dr. Williams stated it would change his opinion if Petitioner was typing constantly for 6 hours a day or greater (Dp 19-20). Dr. Williams stated that literature documented that keyboarding has not been linked to the development of carpal tunnel syndrome (Dp 20). A Mayo Clinic article documented that people that keyboarded had no higher incidence of carpal tunnel syndrome than the general population (Dp 20). Dr. Williams testified that the types of activities that cause carpal tunnel syndrome are vibratory activities, impact activities, jack hammering, grinding and construction activities (Dp 22). He noted other factors (Dp 22). Dr. Williams would include on that list 6 hours of continuous typing with no breaks (Dp 23). Dr. Williams opined Petitioner would benefit from carpal tunnel release surgery (Dp 27). Petitioner told him he did woodworking as a hobby and did not say how often he did that or work on his house (Dp 28).

On re-direct examination, Dr. Williams testified he had mentioned the 6 hour typing threshold. Petitioner did report to him that he gets an hour lunch and two 15 minute breaks (Dp 30). Petitioner does not type for 6 hours a day, based on his history to him (Dp 30). Dr. Williams noted Petitioner's entering data is not constant typing and his activities varied throughout the day (Dp 30).

12. In his October 31, 2011 deposition, Px8, Dr. Wottowa testified he is a board certified orthopedic surgeon and also hand specialty. Dr. Wottowa recited from his records, which are noted above. Dr. Wottowa first saw Petitioner on July 16, 2007 at the request of Dr. McKay for his shoulder and elbow and not related to hands. Dr. Wottowa first saw Petitioner for complaints of his hands on September 20, 2010 on referral from Dr. Fortin. His next visit with Petitioner was on March 9, 2011. On that date, on examination Dr. Wottowa found Petitioner still had positive Phalen's and Tinel's. Given Petitioner's reported constant symptoms, Dr. Wottowa recommended carpal tunnel releases (Dp 13). Petitioner wanted to wait until there was approval from the workers' compensation insurer (Dp 13). In a hypothetical, Dr. Wottowa was asked to assume that Petitioner worked for Respondent for over 27 years and that his job required him to type for 7.5 hours a day Monday through Friday, a total of 37.5 hours a week (Dp 14). Dr. Wottowa opined that Petitioner's condition of ill-being is not causally related to his repetitive typing activities (Dp 15). "For carpal tunnel I very rarely say causally related unless I have a

direct blow or some sort of trauma that does it. It may have been aggravated by his symptoms – by his activities at work, but there's no direct data linking keyboard use to the etiology of carpal tunnel syndrome that I know of." (Dp 15). Dr. Wottowa opined that Petitioner's symptoms may have been aggravated by his activities by his own description (Dp 16). Dr. Wottowa opined that there is no data linking the use of a keyboard to carpal tunnel as an etiology (Dp 17). Dr. Wottowa opined, "It's my own clinical impression that people who do spend eight continuous hours or more doing the same thing tend to have more aggravation of their carpal tunnel than the patients who don't." (Dp 17-18). His treatment of Petitioner was reasonable and necessary (Dp 18). His charges were reasonable and customary to the best of his knowledge (Dp 18). Dr. Wottowa opined Petitioner may have some problems if he does not get this addressed in a timely fashion (Dp 19). Dr. Wottowa opined, "But activities that include a forced grip through an extreme position of flexion or extension are aggravating factors for carpal tunnel syndrome. Typically typing is not included in that." (Dp 20).

On cross-examination, Dr. Wottowa opined that typing might have aggravated Petitioner's carpal tunnel syndrome condition (Dp 26). In rendering this opinion Dr. Wottowa relied on Petitioner's conveying to him that when he types at work that causes him pain and symptoms (Dp 26-27). In addition to that it is his understanding that Petitioner typed all day (Dp 27). Dr. Wottowa did not know what Petitioner's work station looked like, how many hours a day he spent working or any overtime hours worked (Dp 27). His opinion could change if in fact Petitioner did not type all day or a significant portion of his work day (Dp 27). Dr. Wottowa opined that smoking is a contributing factor to carpal tunnel syndrome (Dp 27). Smoking affects blood flow and nicotine causes damage and vasal constriction to small vessels; it decreases the amount of oxygen or blood flow and decreased blood flow to the nerve can aggravate carpal tunnel syndrome (Dp 28). In his patient history, Petitioner indicated that he had smoked 1½ packs of cigarettes a day for 40 years (Dp 28-29). When Dr. Wottowa saw Petitioner, he was on a smoking cessation program (Dp 29). Dr. Wottowa had no history of Petitioner's woodworking at home (Dp 30). Woodworking can be a fairly hand intensive activity (Dp 31). Dr. Wottowa opined that woodworking might or could also contribute to Petitioner's carpal tunnel syndrome, but he would have to know how much and how often (Dp 31). Dr. Wottowa did not receive a job description from Respondent (Dp 31).

13. According to the medical records from Watson Orthopedics, Px4, Petitioner saw Dr. Watson on April 17, 2012. Dr. Watson noted the following history, "Stuart is a 58-year-old gentleman complaining of bilateral hand pain with numbness and tingling. He has been diagnosed with carpal tunnel syndrome and surgery has been recommended in the past for both hands. He has not had surgery however." Petitioner described his symptoms as numbness and tingling, particularly in the thumb, index and long fingers. His dominant left hand symptoms were worse. He wore night splints and was awakened at night. Dr. Watson noted, "He attributes these symptoms to the work that he does at the Secretary of State office. He works as a motor vehicle regulation technician. He explains that he spends 6-1/2 hours per day keyboarding and answering the telephone. He has been doing this for 28 years. He first reported the symptoms to his supervisor in 2010 but feels that the symptoms were present years before this." Dr. Watson

noted there was no history of diabetes, thyroid disorder or rheumatoid disease. Petitioner quit smoking in January 2012 when he had his right hip replaced by another orthopedic surgeon. Dr. Watson noted Petitioner was currently off work for his hip replacement. On examination, Dr. Watson found diminished sensation in the median nerve distribution, Tinel's was positive bilaterally, Phalen's was positive bilaterally and there was mild thenar atrophy on the left. Dr. Watson noted that a prior EMG/NCV revealed bilateral carpal tunnel syndrome. Dr. Watson's impression was bilateral carpal tunnel syndrome. Dr. Watson opined Petitioner was a candidate for surgical releases. Dr. Watson noted that Petitioner would like to file this as workers' compensation and gave him the appropriate paperwork to do so. Dr. Watson held Petitioner off work.

On May 8, 2012, Petitioner returned to Dr. Watson with persistent bilateral carpal tunnel syndrome symptoms. His complaints and examination findings were essentially unchanged. Petitioner reported he had been denied workers' compensation coverage. Petitioner was ready to schedule surgery. Dr. Watson noted the left wrist would be done first and the right wrist done several weeks later. Primary care physician Dr. McKay was to do the pre-operative examination.

In his May 24, 2012 Operative Report, Dr. Watson noted a pre-operative diagnosis of left carpal tunnel syndrome and left index finger foreign body. Dr. Watson performed an open left carpal tunnel release and foreign body excision. This was performed at Prairie Surgery Center. On May 30, 2012, Dr. Watson noted that the sutures were removed. Petitioner reported his neurologic symptoms had resolved. Petitioner wanted to schedule the right carpal tunnel release and this was done. (Px5, Px6).

In his June 21, 2012 Operative Report, Dr. Watson noted a pre-operative diagnosis of right carpal tunnel syndrome. Dr. Watson performed an open right carpal tunnel release. This was performed at Prairie Surgery Center. On June 27, 2012, Dr. Watson noted that the sutures were removed. Petitioner reported his neurologic symptoms had resolved. Dr. Watson ordered physical therapy and Petitioner was to follow-up in one month. Dr. Watson anticipated Petitioner would return to work on approximately July 21, 2012. (Px5, Px7).

14. Petitioner admitted into evidence medical bills as Px9. Respondent admitted the following into evidence: Petitioner's wage statement (Rx1); Demands of Job: use of hands for fine manipulation (typing, good finger dexterity) for 4 to 6 hours per day (Rx4); Position Description (Rx5); Petitioner's attendance records (Rx7).

Based on the record as a whole, the Commission reverses the Decision of the Arbitrator finding that Petitioner failed to prove he sustained repetitive trauma accidental injuries arising out of and in the course of his employment manifesting on September 20, 2010 and failed to prove a causal relationship exists. The Commission denies Petitioner's claim.

16IWCC0756

The Commission notes that nowhere in the transcript is it mentioned how Petitioner held his hands when he typed at work. For the last 10 or 11 years of his employment, Petitioner was to answer a phone every 5 minutes, type a 13 character driver's license number and at times change the data in the system, which required an additional typing of 45 characters. The Commission finds that this was not constant typing, it was intermittent. The Commission also notes that no doctor opined causal connection. Dr. Wottowa opined that Petitioner's condition of ill-being is not causally related to his repetitive typing activities, but that those activities could have aggravated his symptoms if continuous during his workday, which was his understanding. Dr. Wottowa opined that there is no data linking the use of a keyboard to carpal tunnel as an etiology. On cross-examination, Dr. Wottowa indicated his opinion regarding aggravation of Petitioner's condition could change if in fact Petitioner did not type all day or a significant portion of his work day. §12 Dr. Williams opined there was no causal connection and no aggravation. Dr. Williams' opinions were based on what Petitioner actually did at work. Treating Dr. Watson made no opinion in his records. Primary care physician Dr. McKay noted, "I explained to him that I think more likely this is a work comp type of situation given the type of work that he does." The Commission finds that Dr. McKay's opinion was a generalization and not based on any real knowledge of what Petitioner's actual duties were or how he performed those duties.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove that he sustained repetitive trauma accidental injuries arising out of and in the course of his employment manifesting on September 20, 2010 and failed to prove a causal relationship exists, his claim for compensation and medical expenses is hereby denied.

DATED: NOV 2 3 2016
MB/maw
o10/06/16
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Mario Basurto

Stephen J. Mathis

David L. Gore

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

Michael Williams, Sr.,
Petitioner,

vs.
State of Illinois-IYC St. Charles,
Respondent,

NO: 11 WC 04576
16IWCC0757

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 7, 2016 is hereby affirmed and adopted.

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

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

No bond or summons required for State of Illinois cases.

DATED: NOV 23 2016

MB/mam
o:10/27/16
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS SR, MICHAEL
Employee/Petitioner

Case# **11WC004576**

16IWCC0757

STATE OF ILLINOIS - IYC-ST CHARLES
Employer/Respondent

On 3/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% 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:

0787 MEYERS & FLOWERS
JOHN N HARP III
3 N SECOND ST SUITE 300
ST CHARLES, IL 60174

5204 ASSISTANT ATTORNEY GENERAL
CHRISTOPHER R FLETCHER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

MAR 7 - 2016

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

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE

16IWCC0757

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

MICHAEL WILLIAMS, SR.
Employee/Petitioner

v.

STATE OF ILLINOIS - IYC ST. CHARLES
Employer/Respondent

Case # 11 WC 4576

Consolidated cases: ___

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Geneva**, on **February 17, 2016**. By stipulation, the parties agree:

On the date of accident, **September 20, 2010**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$61,680.32**, and the average weekly wage was **$1186.16**.

At the time of injury, Petitioner was **42** years of age, ***married*** with **1** dependent children.

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

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

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

16IWCC0757

The Petitioner is employed by the State of Illinois as a Juvenile Justice Specialist at the Illinois Youth Center in St. Charles, Illinois. On September 20, 2010, he suffered a lumbar strain with radiculopathy as the result of breaking up a fight between inmates at the Illinois Youth Center. He sought medical care with Dr. Bhagavatal Morker of the DeKalb Clinic for injuries to his low back. He was taken off of work from September 22 through October 4, 2010. On October 4, 2010, Dr. Morker released the Petitioner to return to work full duty with instructions to continue his home exercise plan and take over the counter anti-inflammatories as needed. The medical evidence shows that Petitioner suffered an undisputed lumbar strain requiring medical care including prescription of pain relieving, muscle relaxers and NSAID medication. He testified credibly at trial that he continues to have spasms and pain in his lower back after performing physical labor. As a result of his injury, Petitioner had to change his workout routine to a less strenuous regime in which he now only lifts 345 lbs three times per week. The Petitioner's testimony is supported by the medical records admitted into evidence. (PX 1). As such, the Arbitrator finds that Petitioner has suffered permanent partial disability to the extent of the 0.5% man as a whole pursuant to Section 8(d)2 of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $669.64/week for 2.5 weeks, because the injuries sustained caused the 0.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

3/13/16
Date

MAR 7 - 2016

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

Tina M. Johnson,

Petitioner,

vs.

NO: 13 WC 38413

Innovative Staffing Solutions, Inc.,

16IWCC0758

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 27, 2016 is hereby affirmed and adopted.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 23 2016

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:11/3/16
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JOHNSON, TINA M
Employee/Petitioner

Case# **13WC038413**

16IWCC0758

INNOVATIVE STAFFING SOLUTIONS INC
Employer/Respondent

On 4/27/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.40% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0834 KANOSKI BRESNEY
CHARLES N EDISTON
129 S CONGRESS
RUSHVILLE, IL 62681

0522 THOMAS MAMER & HAUGHEY LLP
ERIC S CHOVANEC
30 MAIN ST SUITE 500
CHAMPAIGN, IL 61824-0560

16IWCC0758

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

Tina M. Johnson
Employee/Petitioner

v.

Innovative Staffing Solutions, Inc.
Employer/Respondent

Case # 13 WC 38413

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 **Mt. Vernon**, on **September 2, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0758

FINDINGS

On **August 16, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did 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 **$17,680.00**; the average weekly wage was **$340.00**.

On the date of accident, Petitioner was **44** years of age, *single* with **1** dependent children.

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

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

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

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

ORDER

Because Petitioner failed to prove by a preponderance of the evidence that she suffered accidental injuries which arose out of and in the course of her employment, and that her condition of ill-being is causally related to the injury, benefits are denied.

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

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

Michael K. Nowak, Arbitrator — **3/31/16** Date

ICArbDec p. 2

APR 27 2016

FINDINGS OF FACT

Petitioner claimed that she sustained a repetitive trauma injury to both hands that manifested itself on August 16, 2013. Petitioner worked for Respondent as a temporary employee at Quad Graphics in Effingham, Illinois. Petitioner worked at Quad Graphics from August 11, 2013, through August 16, 2013, a total of six days.

Petitioner testified that her work at Quad Graphics required her to repetitively grasp bundles of newspapers or other printed products and either move them to pallets or put them in boxes. Petitioner said that she had to perform her tasks at a very fast pace to keep up with the printed materials that were being produced.

After working at Quad Graphics for several days, Petitioner said that she began to experience pain, numbness and swelling in both of her hands. The numbness was primarily in the thumb, index and middle fingers of both hands. Petitioner testified that when she worked on the I–Press machine that she had to repetitively and rapidly grasp bundles of newspapers and that this was especially aggravating of the pain and numbness. The machine printed newspapers and Petitioner would pick them up, turn around and place them on a pallet. She worked on this specific machine for at least two of the six days that she worked for Respondent. There was no testimony regarding the weight of the newspapers or the amount of force required to move them.

Respondent tendered into evidence a video of an individual packing printed materials in boxes (Respondent's Exhibit 3). Petitioner said that it excluded the more strenuous work she had to perform on the I–Press machine. She also noted that the individual observed in the video was working in a much slower pace than what she was required to work at.

Petitioner first sought medical care from Dr. Thomas Bilyeu, her family physician, on August 19, 2013. Petitioner informed Dr. Bilyeu that she had started a job and had worked six or seven days doing long hours of pulling, wrapping and using both hands. Petitioner complained of pain, swelling and numbness. Dr. Bilyeu opined that Petitioner had acute carpal tunnel syndrome, post traumatic (PX1).

Dr. Bilyeu saw Petitioner in September, 2013. On September 20, 2013, he opined that Petitioner had bilateral carpal tunnel syndrome, left worse than right. He gave Petitioner a steroid injection. Petitioner's condition did not improve so Dr. Bilyeu ordered EMG/nerve conduction studies (PX1).

Petitioner had EMG/nerve conduction studies performed on October 1, 2013, by Dr. Douglas Dove. The tests were normal and not indicative of carpal tunnel syndrome (PX3).

Dr. Bilyeu saw Petitioner on October 4, 2013, and reviewed the test results. Petitioner still had bilateral hand symptoms and Dr. Bilyeu again noted his diagnosis of bilateral carpal tunnel syndrome, left worse than right. He stated he was going to refer Petitioner for a surgical evaluation (PX1).

Petitioner was seen by Dr. Jacob Sams, an orthopedic surgeon, on October 8, 2013. Petitioner informed him that she had a sudden onset of numbness and tingling in her hands while at work. Dr. Sams noted that Petitioner had equivocal signs of carpal tunnel on examination. Dr. Sams subsequently reviewed the EMG/nerve conduction studies and saw Petitioner on November 19, 2013. Dr. Sams could not determine the

source of Petitioner's pain and discomfort. He recommended Petitioner be seen by Dr. Michael Neumeister (PX2).

On December 13, 2013, Petitioner was seen by Bethany Tschantz, a Physician's Assistant in Dr. Neumeister's office. Petitioner informed PA Tschantz that she had an onset of hand symptoms while performing repetitive work at Quad Graphics. On examination, PA Tschantz was unable to elicit a positive Tinel's or provocative compression test at the median nerve bilaterally (PX4).

Petitioner was seen by Dr. Neumeister on January 16, 2014. On examination, Dr. Neumeister found swelling throughout both hands; however, the compression test at the carpal tunnel and Tinel's sign were both negative bilaterally. He opined that there was nothing surgically that would alleviate Petitioner's symptoms and recommended referral to a rheumatologist (PX4).

Petitioner was seen by Dr. Sriya Ranatunga, a rheumatologist, on January 22, 2014. He opined that Petitioner did not have a typical presentation of rheumatoid arthritis, but ordered some tests (PX4).

Dr. Neumeister saw Petitioner on February 17, 2014, and he noted that Petitioner had been seen by a rheumatologist and that the workup was negative for any rheumatological disease. He opined that Petitioner had bilateral carpal tunnel syndrome and stated he was going to perform a left carpal tunnel release surgery (PX4).

Dr. Neumeister performed left and right carpal tunnel release surgeries on March 4 and April 15, 2014, respectively. Dr. Neumeister saw Petitioner following surgery. When he saw Petitioner on May 29, 2014, Petitioner had no complaints in regard to her carpal tunnel surgeries, but still had some PIP joint swelling and pain (PX4).

Respondent had Petitioner examined by Dr. R. Evan Crandall, a plastic surgeon, on March 11, 2015. Dr. Crandall reviewed Petitioner's treatment records and the video. He opined that a person could not develop carpal tunnel syndrome from a six to eight day work exposure. Further, he opined that it was not established that Petitioner, in fact, had carpal tunnel syndrome and referenced the fact that the nerve conduction studies were normal (RX1).

Dr. Neumeister's deposition was taken on May 20, 2015. In respect to his diagnosis and treatment of Petitioner, his testimony was consistent with his medical records. In regard to causality, Dr. Neumeister stated "There are many causes of carpal tunnel, so I don't know exactly what caused her carpal tunnel. I think if the work she was doing aggravated those symptoms or brought those symptoms on, it probably aggravated the condition, yes." (PX6; p 19).

On cross-examination, Dr. Neumeister stated that there was not a minimal amount of exposure an individual could have before developing carpal tunnel syndrome. He testified that:

> For aggravating the symptoms I think there are a number of causes of things that may be developing at the time. There may be one single thing that actually brings on the symptoms that, or aggravates the condition. So as I mentioned before, with all the various causes I don't know what caused this, but there may be, there's not a set number of activities that are required to actually suddenly bring something on. (PX6; p 34).

Petitioner testified that her symptoms of numbness and tingling had resolved. She still has some occasional aching and a lack of grip strength in both hands.

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 is causally related to the injury?

Petitioner only worked for Respondent for six days and stated that she began to experience symptoms in both hands after working for several days.

While Petitioner testified that she had to repetitively grasp bundles of newspapers, there was very little evidence as to how repetitive and stressful the work was. There was no evidence as to either the amount of force required to perform Petitioner's job duties or the weight of the newspapers and other printed documents that she was required to handle.

Petitioner had complaints consistent with bilateral carpal tunnel syndrome; however, various physical examinations revealed a negative Tinel's and compression test. Further, the EMG/nerve conduction studies that were performed were normal.

Dr. Neumeister testified that he did not know the cause of Petitioner's carpal tunnel syndrome, but that the work activity aggravated it.

Dr. Crandall opined that an individual would not develop carpal tunnel syndrome after such a short exposure and that it was not even established that Petitioner, in fact, had carpal tunnel syndrome.

The Arbitrator finds the opinion of Dr. Crandall to be more persuasive than that of Dr. Neumeister.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner failed to sustain her burden of proof that she sustained an accidental injury arising out of and in the course of her employment for Respondent and that her current condition of ill-being is causally related to her work.

Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
Issue (K): What temporary benefits are in dispute?
Issue (L): What is the nature and extent of the injury?

Based upon the Arbitrator's conclusions with regard to issues (C) and (F), benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF Mc LEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Margaret Nelson,

Petitioner,

vs. NO. 14WC033121

Illinois State University,

16IWCC0759

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 notice, temporary total disability, medical expenses, 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 January 4, 2016 is hereby affirmed and adopted.

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

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

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: NOV 2 3 2016
SJM/sj
o-11/3/2016
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NELSON, MARGARET
Employee/Petitioner

Case# **14WC033121**

SOI/ILLINOIS STATE UNIVERSITY
Employer/Respondent

16IWCC0759

On 1/4/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.55% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
JEAN A SWEE
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

4138 ASSISTANT ATTORNEY GENERAL
WARREN WILKE
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 4 = 2016

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

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

16IWCC0759

☐ 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

Margaret Nelson
Employee/Petitioner

v.

State of Illinois/Illinois State University
Employer/Respondent

Case # **14** WC **33121**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Bloomington, Illinois**, on **11-23-15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **7-3-14**, 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 **$58,583.90**; the average weekly wage was **$1126.57**.

On the date of accident, Petitioner was **55** years of age, ***single*** with **0** dependent children.

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

Respondent ***has 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 **$1776.19** under Section 8(j) of the Act. Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $751.05/week for 8-1/7 weeks, commencing 9-12-14 through 10-5-14 and 10-24-14 through 11-25-14, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $3698 to Dr. Edward Trudeau, $794.49 to Memorial Medical Center, $18,390.95 to Orthopedic and Shoulder Center, $10,029.91 to Ireland Grove Center for Surgery, and $3360.44 to Prescription Partners, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $675.94/week for 52.25 weeks, because the injuries sustained caused the 15% loss of the right hand (28.5) and 12.5% loss of the left hand (23.75), as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

1/2/2016
Date

JAN 4 - 2016

FINDINGS OF FACT:

Petitioner, a 56-year-old, testified that she had worked for Respondent, Illinois State University, since August, 1992. Petitioner worked as a business manager processing utility bills for Respondent from 2008 through the date of arbitration. Petitioner testified that during that period, she used a computer and mouse 7.5 hours each day typing e-mails, paying utility bills, performing financial transactions, and developing Excel sheets. Prior to July 3, 2014, Petitioner worked on a keyboard which was set on top of a large desk. Petitioner provided that the chair was not at an appropriate height and she used the keyboard with her wrists angled up at approximately 60 degrees while typing.

Petitioner testified that she began experiencing some intermittent numbness and tingling in her hands beginning in 2012. In April and May of 2014, she noticed increasing numbness and tingling in her hands. Petitioner said that she noticed the symptoms the most when she was typing and mousing and that she began to take breaks from work to shake her hands in an effort to alleviate the pain. Petitioner said that her hand pain would diminish on the week-end off from work, and that it would increase by the end of a work week. Petitioner said that she felt the pain and numbness the most while she was at work.

Petitioner testified that her symptoms worsened and as a result she consulted with her family physician, Dr. Joseph Lui, on July 3, 2014. Dr. Liu recorded a history from Petitioner that she had numbness in both hands, more on the right, for a couple of years. Dr. Liu noted that the pain radiates up her arm and wakes her up in the night. Dr. Liu stated that Petitioner would shake the hand to try to make it better. Dr. Liu stated that Petitioner works on a computer all day and that she uses a mouse a lot. Dr. Liu diagnosed carpal tunnel syndrome on the right, ordered a brace, and referred Petitioner to OSF Physical Medicine. (PX 3)

Petitioner testified that prior to Dr. Liu's July 3, 2014 visit she was not aware that her diagnoses was carpal tunnel and that it was likely work related. Petitioner indicated she "thought maybe arthritis." Upon learning the possible connection, Petitioner informed her employer and completed the Tristar Workers' Compensation Notice of Injury form, on July 20, 2014. Petitioner listed an accident date of July 3, 2014. She noted that she had right and left hand pain and that she had treated with Dr. Liu on July 3, 2014. (RX 4) Petitioner's supervisor, Sheila Taylor, completed a Supervisor's Report of Injury or Illness form on July 10, 2014 describing Petitioner's accident as "carpal tunnel injury due to repetitive computer/typing input and daily filing/sorting/processing of multiple invoices." (RX 5) Also, on July 10, 2014, Respondent filed a Form 45 listing an accident date of July 3, 2014 as a result of Petitioner claiming carpal tunnel syndrome from repetitive motion at work. The Form 45, signed by Samantha Carmona, states that Petitioner had some symptoms for about two months, that Petitioner had treated with Dr. Liu on July 3, 2014 and that the doctor referred Petitioner to OSF Physical Medicine as well as Physiatry. (PX 3)

On July 29, 2014, Petitioner presented to Dr. Lawrence Liu, an orthopedic surgeon, who had treated her for a prior knee condition. Dr. Li took a history that Petitioner sustained an accident on July 3, 2014. Dr. Li recorded that Petitioner had been having numbness and tingling in her bilateral hands, with her right worse than her left. Dr. Li stated that Petitioner uses a keyboard and mouse all day long and, because her desk is higher than what it should be, she has to have her wrists in a more extended position while she is typing. Dr. Li stated that this activity brought Petitioner's symptoms on. Dr. Li performed an examination which showed positive Tinel's and Phalen's bilaterally with decreased sensation in the median nerve distribution on the right. Dr. Li diagnosed bilateral carpal tunnel syndrome from working in an awkward position at work. An EMG was ordered. (PX 4)

On September 4, 2014, Dr. Edward Trudeau performed an EMG. Dr. Trudeau took a history that Petitioner performed repetitive duties at work and that she had increased symptomatology in her hands at work. Dr. Trudeau stated that when Petitioner is not working, her symptoms got better. Dr. Trudeau stated that, although Petitioner had some symptoms for approximately two years, she treated with her family physician on July 3, 2014 and learned that this was a work related condition. Dr. Trudeau performed the EMG and interpreted same as bilateral median neuropathies at the wrist, moderately severe on the right and mild on the left. (PX 5)

Dr. Li performed an open right carpal tunnel release on September 12, 2014. Dr. Li subsequently performed an open left carpal tunnel release on October 24, 2014. (PX 7, PX 8)

At Petitioner's request, Respondent performed an ergonomics study on September 16, 2014. (PX 11) Petitioner testified that after the assessment, Respondent installed a keyboard tray to avoid wrist extension and forward reaching.

Petitioner underwent physical therapy at Dr. Li's office through November 17, 2014. On said date, the physical therapist, Jason Richards, noted that Petitioner was progressing well. The therapist added that that after Dr. Li's follow-up appointment on November 26, 2014, Petitioner should be discharged to a home exercise program. (PX 10)

Petitioner last saw Dr. Li on November 26, 2014. At that visit Dr. Li noted that Petitioner's numbness and tingling had resolved, but she continued to have pillar pain. Dr. Li prescribed Mobic 7.5 mg, and Protonix 20 mg BID. The doctor also continued her home exercise program and provided that she could advance activities as tolerated. (PX 10)

On February 2, 2015, Dr. Li authored a narrative stating, "[Petitioner had] bilateral carpal tunnel syndrome due to an ergonomic position at work, which causes her to place her wrists in an extended position beyond 40 degrees when she uses her keyboard and mouse all day. This is the ergonomic cause of her developing carpal tunnel syndrome and needing bilateral carpal tunnel releases..." Dr. Li added that the surgery successfully relieved the numbness and tingling, but that as of November 26, 2014, she still had pillar pain in both wrists. (PX 1)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. James Williams on March 11, 2015. Dr. Williams took a history of Petitioner's work activities with Respondent. Dr. Williams stated that, at the time of his examination, Petitioner had minimal numbness and tingling on both sides with some intermittent numbness and tingling in her thumb, index, and middle finger on the right and some intermittent pain on the left. Dr. Williams stated that Petitioner gave a history of weakness with both hands and that she is still sore and tender around the thumbs. Dr. Williams stated that Petitioner reported that her grasp was not as good and that it was hard opening things. Dr. Williams stated that Petitioner had improved post-operatively, but that she still had some weakness which he thought would resolve with time. Dr. Williams concluded that Petitioner was at MMI and that she could continue to work without restrictions. Dr. Williams opined that Petitioner was honest and forthcoming and that, if she was performing her work duties in the type of non-ergonomic fashion as described, he thought that the work resulted in at least an aggravation, if not the direct cause, of her carpal tunnel syndrome. (PX 2, RX 2)

On November 12, 2015, Dr. Williams rendered an impairment rating. Dr. Williams stated that using the measurements taken during his March 2015 Section 12 examination and the 6th Edition AMA Guides to Partial Permanent Impairment, Petitioner's final UEI is 3%. (RX 1)

Petitioner testified that she continues to work in her capacity as a Business Manager and that her earnings have not been effected. Petitioner stated that currently, she experiences some ongoing numbness and tingling with the right hand being worse than the left, she has loss of grip, loss of strength, and some difficulties opening jars with both hands.

With respect to (E) Was Timely Notice of the Accident Given to Respondent, the Arbitrator finds as follows:

Petitioner credibly testified that she began experiencing some intermittent numbness and tingling in her hands beginning in 2012. In April and May of 2014, she noticed increasing numbness and tingling in her hands. Petitioner said that she noticed the symptoms the most when she was typing and mousing and that she began to take breaks from work to shake her hands in an effort to alleviate the pain. Her hand pain would diminish on the week-end off from work, and that it would increase by the end of a work week. Petitioner continued to work while noting increased pain and numbness. As her symptoms worsened, she consulted with her family physician, Dr. Joseph Lui, on July 3, 2014. Dr. Liu recorded a history from Petitioner that she had had numbness in both hands, more on the right, for a couple of years. Dr. Liu noted that the pain radiates up her arm and wakes her up in the night. Dr. Liu stated that Petitioner would shake the hand to try to make it better and that she worked on a computer all day using a mouse a lot. Dr. Liu diagnosed carpal tunnel syndrome on the right.

Petitioner credibly testified that prior to Dr. Liu's July 3, 2014 visit she was not aware that her diagnoses was carpal tunnel and that it was likely work related. Petitioner indicated she "thought maybe arthritis." Upon learning the possible connection, Petitioner informed her employer on July 10, 2014. Petitioner listed an accident date of July 3, 2014. She noted that she had right and left hand pain and that she had treated with Dr. Liu on July 3, 2014.

The parties stipulated and the Arbitrator finds that Petitioner's date of accident was July 3, 2014. On July 3, 2014, Petitioner's physical condition worsened to the point that she sought medical care and learned of the likely diagnosis and causal relationship of her injury to her employment. By July 10, 2014, Respondent was notified that Petitioner was claiming an accident which manifested itself on July 3, 2014.

Based on the above, the Arbitrator finds that Petitioner provided timely notice to Respondent as prescribed by the Workers' Compensation Act.

With respect to (J) Were the Medical Services That Were Provided to Petitioner Reasonable and Necessary? Has Respondent Paid All Appropriate Charges for Reasonable and Necessary Medical Services, the Arbitrator finds as follows:

Respondent stipulated that it was responsible for reasonable and necessary medical bills if the Arbitrator finds that Petitioner provided timely notice within the terms of the Workers' Compensation Act.

Having found that Petitioner gave notice within 45 days, the Arbitrator finds that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $3,698 to Dr. Trudeau, $794.49 to Memorial Medical Center, $18,390.95 to Orthopedic and Shoulder Center, $10,029.91 to Ireland Grove Center for Surgery, and $3,360.44 to Prescription Partners, as provided in Sections 8(a) and 8.2 of the Act.

The Arbitrator also finds that Respondent shall be given credit of $1,776.19 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to (K) What Temporary Benefits (TTD) Are in Dispute, the Arbitrator finds as follows:

Respondent's quarrel regarding temporary total disability stems from its dispute as to whether Petitioner provided timely notice of accident. Having found that Petitioner provided timely notice of accident, the Arbitrator finds Petitioner was temporarily totally disabled from September 12, 2014 through October 5, 2014 and from October 24, 2014 through November 25, 2014, or a period of 8-1/7 weeks.

With respect to (L) What Is the Nature and Extent of the Injury, the Arbitrator finds as follows:

In determining the level of permanent partial disability for injuries that occur on or after September 1, 2011, the Commission shall base its determination on the following factors:

(i) the reported level of impairment pursuant to most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment";
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity;
(v) evidence of disability corroborated by the treating medical records. (820 ILCS 305/8.1b)

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that Dr. Williams determined Petitioner had a Partial Permanent Impairment of 3%. The Arbitrator 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 as a business manager for Respondent and continued in that occupation post-accident. The Arbitrator gives no weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 55 years old at the time of the accident. Because of the length of time Petitioner will live with her permanent disabilities, the Arbitrator gives little weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no evidence was presented to show the impact on Petitioner's future earnings capacity. 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 credibly testified that she has some ongoing numbness and tingling with the right hand being worse than the left, she has loss of grip, loss of strength, and some difficulties opening jars with both hands. Petitioner's complaints are corroborated by the medical records. On November 26, 2014, Dr. Li noted ongoing bilateral pillar pain. Dr. Williams found that Petitioner was at MMI as of March 11, 2015 and that she still had some ongoing weakness with both hands, reduced grasp, and difficulty opening things. Dr. Williams also noted that Petitioner experienced achiness and soreness as well as some intermittent numbness in the thumb, index and middle finger on the right. The Arbitrator gives weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 15% loss of use of the right hand and 12.5% loss of use of the left hand pursuant to §8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jody Klopp,

Petitioner,

vs. NO. 14WC039886

City of Batavia,

16IWCC0760

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of permanent 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 1, 2016 is hereby affirmed and adopted.

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

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

16IWCC0760

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: NOV 2 3 2016
SJM/sj
o-11/17/2016
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KLOPP, JODY
Employee/Petitioner

Case# **14WC039886**

16IWCC0760

CITY OF BATAVIA
Employer/Respondent

On 6/1/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0787 MEYERS & FLOWERS LLC
RYAN THERIAULT ESQ
3 N 2ND ST SUITE 300
ST CHARLES, IL 60174

0481 MACIOROWSKI SACKMAN & ULRICH
ROBERT T NEWMAN
105 W ADAMS ST SUITE2200
CHICAGO, IL 60603

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

16IWCC0760

JODY KLOPP
Employee/Petitioner

v.

CITY OF BATAVIA
Employer/Respondent

Case # **14** WC **39886**

Consolidated cases: **NONE**

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 **Gerald Granada**, Arbitrator of the Commission, in the city of **Geneva**, on **May 9, 2016**. By stipulation, the parties agree:

On the date of accident, **July 17, 2013**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**105,059.53**, and the average weekly wage was $**2,020.37**.

At the time of injury, Petitioner was **50** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**26,914.44** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**26,914.44**.

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.

16IWCC0760

ORDER

Respondent shall pay Petitioner the sum of **$712.55**/week for a further period of **100** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **20% loss of use of the person as a whole.**

Respondent shall pay Petitioner all compensation that has accrued.

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

5/27/16
Date

JUN 1 - 2016

16IWCC0760

FINDINGS OF FACT

Petitioner is a now 52 year old male who was working for Respondent as a journeyman electric lineman on July 17, 2013, when he felt a pop in his back while hand digging a hole in the ground in furtherance of his job duties. He was 50 years old on the date of the undisputed work accident.

As a journeyman electric lineman, the Petitioner's job was to maintain the electric distribution system operated by the City of Batavia which provides electric power to residences and businesses within the City boundaries. The work involves upgrades of the existing structures, responding to power outages and installing new service to new houses or buildings, and maintaining street lighting. Electric line workers are required to lift 50 pounds regularly and 100 pounds occasionally. Electric line workers use bucket lift trucks to access overhead lines and also have to climb power poles using spikes and safety belts. In addition, electric line workers operate equipment, including such heavy equipment as a backhoe, end loaders and other equipment for digging trenches to repair or install underground lines. (RX. 8)

On the date of the accident, Petitioner testified that he was manually digging a hole to locate a gas line during a directional boring project. In the process of doing so, he felt a pop in his back and experienced immediate pain. The Petitioner reported the work accident to his immediate boss, Brian Bettin. Respondent did not dispute that a work accident occurred in the manner described by Petitioner.

After the work accident, the Petitioner was sent by his employer to Tyler Medical Clinic for initial treatment. At Tyler Medical, the Petitioner was diagnosed with a lumbar strain. He was prescribed medication for the pain, placed on work restrictions, and advised to follow up in a couple of days. (PX. 4)

The Petitioner had no pre-accident complaints with respect to his lumbar spine.

Tyler Clinic continued to treat the Petitioner with medications and physical therapy over the course of about four weeks' time. (PX. 4)

The Petitioner underwent an MRI on August 13, 2013 showed, and L4-5 disc herniation. (PX. 4)

Petitioner eventually came under the care of Dr. Matthew Ross, a neurosurgeon, who administered an epidural steroid injection on August 28, 2013. (PX. 2) Ultimately, after attempts at conservative treatment failed, on October 7, 2013, Dr. Ross performed a right sided L4-L5 hemilaminotomy, microdiscectomy and foraminotomy to treat Petitioner's herniated disc. (PX. 2)
The Petitioner had a course of physical therapy in November and December of 2013, along with a course of work conditioning in January of 2014. (PX. 1)

After full compliance with all of his medical care, the Petitioner was returned to a trial return to full duty work on February 6, 2014. (PX. 2) On September 3, 2014, Dr. Ross placed Petitioner at MMI with no further formal medical treatment required at that time. (PX. 2)

The Petitioner testified that he experiences continued pain as the result of the undisputed work accident. On a 1 to 10 scale, with 10 being the worst, he stated his daily back pain ranges from a 2 or 3 at the least and as high as a seven. He testified that he frequently relies upon over the counter pain medication to treat his symptoms. He testified that he is required stand, walk, sit, climb or balance, stoop, kneel, crouch, and crawl, all of which cause him some degree of

discomfort. He also testified that operating heavy equipment causes back pain as it is a very bumpy, and not smooth ride. This fact was corroborated by Petitioner's supervisor, Brian Bettin, on cross-examination.

Dr. Steven Mash completed an AMA rating Examination of the Petitioner on August 25, 2015. In his report, Dr. Mash concluded that the Petitioner is considered to have 7% impairment of the whole person, as defined by the AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition. Dr. Mash also agreed with the diagnosis of Dr. Ross and found Petitioner's injuries to be causally connected to Petitioner's undisputed work accident. (PX. 5)

CONCLUSIONS OF LAW

Pursuant to Section 8.1b of the Act, for accidental injuries occurring after September 1, 2011, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. Per 820 ILCS 305/8.1b(b), the criteria to be considered are as follows: (i) the reported level of impairment pursuant to subsection (a) [AMA "Guides to the Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. Those factors will be addressed below.

(i) Impairment Level. The only rating presented at trial was that of Dr. Steven Mash, which found 7% impairment of the whole person. Of note, the pain Disability Questionnaire considered by Dr. Mash in his report, reflects Petitioner's current and ongoing pain and difficulties with performing both work tasks and activities of daily living. Additionally, Dr. Mash confirmed that Petitioner is at four times greater risk to suffer subsequent difficulty down the road at some time, either at the same level or an adjacent level." (See PX 5, Page 35). The Arbitrator gives considerable weight to this factor.

(ii) Occupation. The Petitioner is currently a journeyman electric lineman and acting crew chief in the electric distribution system operated by the City of Batavia. Petitioner has been released to return to his previous employment, and has been able to do the work he performed prior to his injury. However, he gets help with some of his duties that involve heavy lifting, digging or other activities that cause him pain. He has recently been made a crew leader who manages a number of employees, but he continues to do some of the labor despite his supervisory position. The Arbitrator gives great weight to this factor.

(iii) Age. Petitioner was 50 years old at the time of the injury and was 52 years old at the time of the hearing. The Arbitrator gives some weight to this factor.

(iv) Future Earning Capacity. There was no evidence presented regarding the Petitioner's future earning capacity, and therefore the Arbitrator gives no weight to this factor.

(v) Evidence of Disability. There was evidence of disability corroborated by the treating medical records, which show that the Petitioner sustained a disc herniation at L4-5, resulting in Petitioner undergoing surgical intervention involving a right sided L4-L5 hemilaminotomy, microdiscectomy and foraminotomy, followed by physical therapy and work hardening. Petitioner credibly testified to ongoing complaints of pain and difficulties with performing work activities and activities of daily living – which was supported by the evaluation of Respondent's expert, Dr. Mash. The Arbitrator gives significant weight to this factor.

Base on these factors, the Arbitrator finds that as a result of his July 17, 2013 accident, Petitioner sustained a 20% loss of use to his person as a whole.

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

Crystal Quandt,

Petitioner,

vs.

NO. 11WC008596

State of Illinois/Murray Center,

16IWCC0761

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 8, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

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

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: NOV 2 3 2016
SJM/sj
o-11/3/2016
44

Stephen J. Mathis

David L. Gore

Mario Basurto

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

QUANDT, CRYSTAL
Employee/Petitioner

Case# **11WC008596**

14WC033491

SOI/MURRAY CENTER
Employer/Respondent

16IWCC0761

On 10/8/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 THOMAS C RICH PC
6 EXECUTIVE DR
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FAIRVIEW HTS, IL 62208

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

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

OCT 8 - 2015

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

16IWCC0761

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)

Crystal Quandt
Employee/Petitioner

v.

State of Illinois/Murray Center
Employer/Respondent

Case # **11** WC **08596**

Consolidated cases: **14 WC 33491**

An *Application for Adjustment 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 7, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **February 4, 2011** Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being, except for her right knee, *is* causally related to the accident. Petitioner's current condition of ill-being in her right knee *is not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$36,145.72**; the average weekly wage was **$695.11**.

On **February 4, 2011**, 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 regarding Petitioner's right knee. Respondent agreed it has, or will pay, all reasonable and necessary medical services regarding Petitioner's cervical and lumbar conditions.

All temporary total disability benefits with respect to Petitioner's causally connected injuries have been paid. Petitioner has not claimed any temporary total disability or lost time with respect to her right knee.

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

Petitioner failed to prove that her current condition of ill-being in her right knee is causally related to her accident of February 4, 2011. No benefits are awarded with regard to Petitioner's right knee claim. Petitioner's current condition of ill-being is otherwise causally related to the accident of February 4, 2011; however, Petitioner only sought benefits in this proceeding with regard to her right knee. No benefits are awarded with regard to Petitioner's right knee.

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.

Kevin Lindsay
Signature of Arbitrator

October 5, 2015
Date

ICArbDec19(b)

OCT 8 2015

STATE OF ILLINOIS)
) SS
COUNTY OF JEFFERSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CRYSTAL QUANDT
Employee/Petitioner

v. Case # 11 WC 08596

STATE OF ILLINOIS/MURRAY CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT and CONCLUSIONS OF LAW

The Parties stipulated that on February 4, 2011 (11 WC 08596) and August 11, 2014 (14 WC 33491), Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent. Both cases were consolidated solely for the purposes of conducting the 19(b) hearing. Two decisions will issue. At the time of arbitration in both cases Respondent only disputed causal connection, liability for medical expenses, and liability for prospective medical care pertaining to Petitioner's right knee injury.

Issue (F): Is Petitioner's current condition of ill-being causally related to the accident of February 4, 2011?

Respondent stipulated that Petitioner's current condition of ill-being, except for her right knee condition, was causally connected to her accident of February 4, 2011. Petitioner failed to prove that her current condition of ill-being in her right knee is causally connected to her accident of February 4, 2011. In support thereof the Arbitrator finds as follows:

Petitioner is a Mental Health Technician for Respondent. On February 4, 2011, Petitioner was involved in an undisputed accident. The incident report reflects that Petitioner was struck in the face and pushed into the railing and wall. (RX2).

As shown in RX 2, Petitioner only reported neck and upper back pain complaints at the time of her February 4, 2011 accident.

Petitioner was seen at St. Mary's Hospital on February 8, 2011. Nothing therein suggests a right knee injury. (PX 3)

Petitioner treated with Dr. Michael Bowman, a chiropractor, from February 11, 2011 through July 6, 2011. There is no reference to a right knee injury. There is a reference on April 6, 2011 to Petitioner's low back with the doctor noting, "lower back still very sore into right knee." (PX 4)

Petitioner saw Dr. Rubio on February 15, 2011. There is no mention of a right knee injury or complaints. (PX 5)

Petitioner treated with Dr. Gornet from February 24, 2011 through December 8, 2011. On the December 8, 2011 visit Dr. Gornet noted some "isolated knee pain" which he felt was related to a knee problem itself and nothing referred from her back condition. No knee complaints were noted when he re-examined Petitioner on January 19, 2012. Dr. Gornet did note swelling in Petitioner's right knee on April 23, 2012 and reported "she feels [it] began after her altercation in February of 2011." She was referred to Dr. Paletta. Dr. Gornet never opined that Petitioner's right knee symptoms were causally connected to her work accident on February 4, 2011. (PX 6)

Petitioner underwent a lumbar spine MRI on July 11, 2011 due to low back pain radiating to her right buttocks and leg behind her knee. (PX 7)

Petitioner was examined by Dr. Grandberg on July 20, 2011 through August 10, 2011. No right knee complaints or injuries were noted. On August 10, 2011 he noted mid-back pain radiating down into Petitioner's right knee. (PX 8)

Petitioner presented to Dr. Paletta on April 23, 2012. Dr. George Paletta took the following history:

> This is the first visit for this 46-year-old white female who presents for evaluation of a chief complaint of right knee pain and swelling. She presents for consultation at the request of Dr. Matthew Gornet. She works as a medical care technician at the Murray Center. This is essentially equivalent to a CAN [sic-CNA] –type job. She was injured in February 2011. She was seated at her desk. She was apparently attacked or hit by a male patient where [sic] she estimates weighed about 180 or 190 pounds. The patient came out from the right side and hit her from the anterolateral aspect. She suffered multiple injuries including low back and knee. Most of the attention so far has been directed to the low back, which was the more significant of the issues. However, she has had persistent pain and swelling in the knee since the initial injury. . . (PX11, 4/23/12).

Petitioner gave a further history of persistent swelling, believing her knee was swollen that day although not as bad as it sometimes was. She reported diffuse pain behind her knee, especially the knee cap but no radiating pain or associated complaints. She denied prior surgery on her knee or problems predating her work incident.

Dr. Paletta's physical examination of Petitioner's right knee demonstrated "obvious soft tissue swelling with large area of fluctuance at the superolateral corner of the patella just anterior to the iliotibial band." (PX11, 4/23/12). He also noted moderate tenderness, 1+ effusion, tenderness along the medial joint line, particularly in the mid axillary line and posterior region, and some medial retinacular tenderness. *Id.* Dr. Paletta suspected a tear of Petitioner's medial meniscus and recommended an MRI. *Id.* Dr. Paletta believed that Petitioner's right knee problems were the result of the February 2011 work incident. *Id.*

Petitioner underwent a right knee MRI on July 6, 2012. It revealed a tear of the posterior horn of the lateral meniscus with abnormal configuration and a linear signal with distortion of the shape of the medial meniscus suggestive of a meniscal tear as well, but that may have been an older process, diffuse articular thinning with a focal deep fissure in the weight bearing aspect of the tibial plateau, degenerative bone marrow change in the fibular head, large joint effusion without evidence of a loose body, and a large lobulated and probably septated Baker's Cyst. (PX 7)

Dr. Paletta reviewed the MRI documenting his impression of a meniscus tear within the setting of early degenerative joint disease. He also noted the scan demonstrated findings consistent with a tear of the posterior horn of the lateral meniscus and a "probable" meniscus tear. Petitioner's MRI also showed some articular cartilage thinning involving the tibial plateau and a large joint effusion with an associated multifocal Baker's cyst. He recommended arthroscopic debridement and partial meniscectomy. (PX 11, 7/10/12 scan review)

Respondent had Petitioner examined by Dr. Timothy Farley on August 28, 2012. (RX3). Dr. Farley agreed with the diagnosis of medial and lateral meniscus tears, but did not believe that these were the source of Petitioner's swelling. *Id.* He did not believe that Petitioner's described knee pain was in any related to the February 4, 2011 incident. *Id.* Despite Petitioner's lack of a history of right knee problems, he indicated that he did not believe Petitioner sustained any injury, and opined that the majority of the pathology within her knee was attributable to non-work-related conditions. *Id.*

Dr. Farley testified by way of deposition on February 12, 2013. Dr. Farley testified that he did not believe any of Petitioner's diagnoses were traumatic in nature. (RX4, p.9, 10). He believed that Petitioner's first complaints of knee pain occurred 10 months later on December 8, 2011. (RX4, p.8). He acknowledged that Petitioner sustained no prior right knee injuries. *Id.* at 14. He acknowledged that there was nothing in the records to indicate that Petitioner had any prior right knee complaints. *Id.* at 14. Dr. Farley also acknowledged that there was no evidence of any intervening trauma contained in the medical records or by way of history. *Id.* at 16. He testified that he did not have any of Petitioner's treatment records beyond July 9, 2012. *Id.* at 23.

Dr. Paletta testified by way of deposition on April 17, 2014. (PX12). Dr. Paletta confirmed that Petitioner had no intervening accidents between February 4, 2011, and the time he saw her in 2012. (PX12, p.7). With regard to causation, he testified:

> Q: . . .Given, Sir, the history of overriding low back/spine complaints, Number One, assuming knee complaints following the injury, do you have an opinion, sir, within a reasonable degree of medical certainty, as to whether her pathology was caused by the accident that she complained of?
> A: Yes, sir, I do.
> Q: And what would that be, please?
> A: If her history is accurate and she had pain in the knee as a result of that incident, it's my opinion that her meniscus tear is related to that incident. *Id.* at 7.

Petitioner sought no further care for her right knee until she sustained her second accidental injury on August 11, 2014, when a resident kicked an end table into her leg while she was attempting to keep him seated. Petitioner reported to the St. Mary's Hospital emergency room on August 13, 2014, with significant swelling, pain and difficulty bearing weight and came under the care of Dr. Jha. (PX3, 8/13/14; PX12). X-rays were taken and the impression noted "large knee joint effusion." *Id.* Dr. Jha referred Petitioner to Dr. Houle, who noted on August 18, 2014 that Petitioner's right knee complaints now consisted of sharp, aching, stabbing and burning pain, and swelling accompanied with giving way. (PX12; PX13). Dr. Houle's physical examination noted severe effusion and limited range of motion. (PX13). Dr. Houle recommended a new MRI to assess suspected internal derangement and prescribed Mobic and meloxicam to reduce Petitioner's inflammation. *Id.*

Petitioner returned to Dr. Paletta on November 3, 2014, at which time Dr. Paletta noted that Petitioner had sustained a new injury when a resident pushed a table into her knee. (PX11, 11/3/14). He noted that Petitioner experienced immediate pain and that her symptoms persisted despite the non-steroidal anti-inflammatory medication prescribed by Dr. Houle. Petitioner initially worked light duty (essentially seated duty). She complained of pain both at rest and with activity. Her swelling "waxed and waned." Her knee felt unstable and she experienced stiffness after long periods of sitting. Stairs were particularly difficult but she denied any true give away.. Physical examination showed marked joint line tenderness and significant effusion. *Id.*

Dr. Paletta ordered x-rays. His impression was effusion of the right knee and a possible meniscus tear. She had significant effusion and marked joint line tenderness. Dr. Paletta recommended that Petitioner "aggressively" ice her knee, undergo a new MRI, and try a Medrol Dosepak and non-steroidal anti-inflammatory medication. He concurred with ongoing restrictions of light duty/seated work. He further stated that Petitioner's current right knee condition was caused by the work incident that occurred on August 11, 2014. *Id.* Dr. Paletta further noted:

> As noted previously, I had seen Crystal back in 2012 for problems related to the right knee. At that time, she was diagnosed with a meniscus tear. Recommendation was made for arthroscopy and partial meniscectomy. Crystal states that she did not pursue that because work comp would not approve it. She was never seen back after completion of the MRI scan and the recommendation for surgery. She states that she effectively babied the knee and was able to get by but that the knee was never back to 100%; however, since this injury in August, things have been significantly worse with dramatically more swelling and pain as documented in the note above. *Id.*

Petitioner's new MRI of November 3, 2014 showed a large joint effusion and large Baker's cyst with multiple loose bodies and debris. Clinical correlation was recommended. There was also evidence of an abnormal menisci with abnormal configuration and size, particularly in the posterior horns. In the absence of surgery the radiologist felt the findings were consistent with meniscal tearing. The radiologist could not tell if Petitioner had undergone previous surgery or if she had a meniscal tear with some degenerative change. The lateral meniscus was also noted to be abnormal. (PX 7) Dr. Paletta reviewed the MRI scan noting it "once again shows evidence of a medial meniscus tear." He also noted that Petitioner now appeared to have synovial

chondromatosis with multiple intraarticular small loose bodies and a "persistent" large effusion. Dr. Paletta recommended arthroscopic debridement, chondroplasty, removal of loose bodies, and partial medial meniscectomy. (PX 11).

Respondent had Petitioner examined by Dr. Farley a second time on February 2, 2015. (RX8). Dr. Farley reviewed Petitioner's most recent radiographs and his physical examination also demonstrated tenderness over the medial and lateral joint lines. *Id.* Dr. Farley believed that the August 2014 injury had no discernible impact on Petitioner's knee condition, and believed that Petitioner reached maximum medical improvement regarding any pretibial contusions that occurred as a result of the incident. *Id.* He did believe, however, that Petitioner's subjective complaints were supported by the pathology depicted on her radiographs. *Id.*

Petitioner returned to see Dr. Paletta on February 23, 2015 reporting that her claim had been denied and she couldn't afford to take an unpaid leave to have her knee treated under her personal health insurance. She reported that her knee was about the same and that she was also having right-sided low back and hip discomfort. Petitioner was taking Vicodin intermittently for her knee pain as overseen by her primary care physician. Petitioner felt she had no option but to return to work on a full duty basis. Petitioner was hoping to get a shift change as she had applied for one and she felt it would result in decreased demands on her knee. Dr. Paletta felt that would be beneficial and that she should remain off work until her application was approved. . They discussed various options for treatment of Petitioner's knee and she was to get back with the doctor if she wished to pursue one.(PX 11)

Dr. Paletta also issued a letter on March 6, 2015 with regard to Dr. Farley's additional report (PX11, 3/6/15). In his letter to Petitioner's attorney he specifically referenced an accident date of "2/4/11" and case number "11 WC 008596." He offered the following response:

> Dr. Farley opines that the patient has an "underlying autoimmune or inflammatory condition that may explain her symptoms." He further states that he believes that her symptoms "represent an undiagnosed condition related to the patient and predating the described work injury. He does not believe that the patient's current condition is the result of a work related injury. He notes and agrees with me with respect to the diagnoses of effusion of the knee, synovial chondromatosis, and a popliteal cyst. He also notes evidence of a small meniscus tear.
>
> I want to be very clear that it is my opinion that her synovial chondromatosis is not the result of any work related injury. However, it is my opinion that her meniscal tear is the result of a work related injury. The synovial chondromatosis was a preexisting condition but prior to the work injury she denies any history of significant knee problems.
>
> Based on my examination and my interpretation of the MRI scan, she does have both subjective and objective findings consistent with a symptomatic meniscus tear as well as a reactive effusion

> and synovial chondromatosis. There is no evidence of an autoimmune condition or inflammatory condition other than the reactive effusion. Furthermore, Dr. Farley agrees that additional treatment is appropriate although he does not believe the treatment is related to or necessary as a result of the work injury. *Id.*

In his concluding paragraph Dr. Paletta wrote, "I have been clear in my opinion that the meniscus tear is the result of the work related injury" (PX 11)

Dr. Farley was again deposed on May 5, 2015. He testified consistent with his earlier report and further testified that 85% of the independent medical evaluations he performs are at the request of employers or insurance companies. (RX9, p.25). During cross-examination, Dr. Farley acknowledged that Petitioner's mechanism of injury for the August 2014 incident could certainly produce symptoms and require treatment and/or aggravate pre-existing conditions. *Id.* at 29. He also acknowledged the presence of effusion in her knee following the August 2014 injury. *Id.* at 33. He also acknowledged that Petitioner's level of function decreased after the August 2014 work injury. *Id.* at 45. In the end, Dr. Farley did not disagree that there was something wrong with Petitioner's knee; however, he did not feel it was work-related. (RX 9)

At the arbitration hearing Petitioner testified that she is a Mental Health Technician for Respondent. Petitioner testified that when she saw the resident running towards her, she put her arms and leg up as a barrier.

Petitioner testified that as time progressed, Petitioner began noticing problems in her right knee. She testified that the longer she walked on her knee, the more swollen and painful it became. Petitioner testified that she had no prior right knee injuries or treatment. Petitioner testified that she reported her knee complaints to her chiropractor, Dr. Michael Bowman. Petitioner testified that she "repeatedly told Dr. Gornet about her right knee."

Petitioner testified she was simply trying to live with her condition up until that point. Petitioner testified that the August 11, 2014 incident increased her pain and caused constant swelling. This is supported by the emergency room records which documented that Petitioner was having difficulty bearing weight, x-rays showing increased effusion, and new complaints of a sensation of instability. (PX3, 8/13/14; PX12). Petitioner also testified without rebuttal that her condition has not improved since the second accident despite conservative care.

Petitioner testified that she continues to experience symptoms in her right knee, and wears a brace at work when she works overtime to help manage her pain. She confirmed that she wishes to undergo the surgery recommended by Dr. Paletta.

In concluding that Petitioner's current condition of ill-being in her right knee is not causally connected to Petitioner's February 4, 2011 accident, the Arbitrator notes that Petitioner's testimony that she injured her right knee at the time of her accident was not credible because it was not corroborated by any early medical records or her written incident report. Petitioner further testified that she told her doctors about her right knee pain; however, their records speak for themselves. There is no history of Petitioner injuring her right knee at the time of her accident until Petitioner presented to Dr. Paletta in April of 2012, approximately fourteen months after her

accident. Petitioner testified/contends that her right knee symptoms and complaints were originally thought to be emanating from her low back complaints; however, that isn't corroborated by the medical records either. Petitioner treated with Dr. Bowman from February 11, 2011 through July 6, 2011 and his records contain no reference to a right knee injury at the time of Petitioner's work accident. While his records from April 6, 2011 reference/mention Petitioner's right knee that reference is made within the context of Petitioner's low back pain which was "still very sore into the right knee." The Arbitrator does not view that notation as suggesting a knee injury at the time of the accident. The complaint was also an isolated one as Petitioner went on to treat with Dr. Gornet and he never mentioned any knee pain until December 8, 2011 and clearly stated that the knee complaints were a problem separate and apart from her back. The opinion of Dr. Paletta regarding the issue of causal connection is not persuasive as he relied upon Petitioner's representation that she injured her right knee at the time of her accident and that is not the case. Hence, he relied upon an inaccurate history.

The Arbitrator also notes that Petitioner originally filed her claim herein on March 8, 2011 alleging back, neck, and "body as a whole" injuries. On July 23, 2012 she amended her Application for Adjustment of Claim to allege groin, right hip and right leg/knee injuries. (AX 2) This suggests Petitioner did not associate any right knee injury to her accident until long after the accident itself. There was also a fairly significant gap in treatment between July of 2011 and April of 2012 when she presented to Dr. Paletta.

Finally, the Arbitrator is troubled by Petitioner's possible motivation herein. Dr. Paletta's office notes document that Petitioner's workers' compensation claim had been denied but she could not afford to pursue surgery under her personal health insurance because she would not be paid for her time off from work. If her knee injury were determined to be work-related, she would be paid for her time off from work. Thus, Petitioner's motivation for claiming a work-related knee injury is suspect.

The Arbitrator further notes that a finding of ongoing causation for Petitioner's right knee is further hampered by the Petitioner's subsequent accident of August 11, 2014. The Arbitrator notes that Petitioner testified she was simply trying to live with her condition up until that point. Petitioner testified that the August 11, 2014 incident increased her pain and caused constant swelling. Petitioner testified that her condition has not improved since the second accident despite conservative care. Furthermore, while Dr. Paletta later issued a letter (March 2015) opining that Petitioner's need for surgery stemmed from her medial meniscus injury that was due to her February 4, 2011 accident, he did not consider the impact/role of the subsequent accident in August of 2014.

Petitioner's claim for compensation with regard to her right knee is denied and no benefits are awarded. All remaining issues regarding Petitioner's right knee are moot.

****

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

Crystal Quandt,

Petitioner,

vs.

NO. 14WC033491

16IWCC0762

State of Illinois/Murray Center,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 8, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

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 and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: NOV 2 3 2016
SJM/sj
o-11/3/2016
44

Stephen J. Mathis

David L. Gore

Mario Basurto

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

QUANDT, CRYSTAL
Employee/Petitioner

Case# **14WC033491**

11WC008596

SOI/MURRAY CENTER
Employer/Respondent

16IWCC0762

On 10/8/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 THOMAS C RICH
6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
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0498 STATE OF ILLINOIS
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1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
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SPRINGFIELD, IL 62794-9208

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

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

OCT 8 - 2015

ANDALA A. HARRIN, ACTING Secretary
Illinois Workers' Compensation Commission

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

16IWCC0762

☐ 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)

Crystal Quandt
Employee/Petitioner

v.

State of Illiinois/Murray Center
Employer/Respondent

Case # **14** WC **33491**

Consolidated cases: **11 WC 08596**

An *Application for Adjustment 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 7, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0762

On the date of accident, **August 11, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the **August 11, 2014** injury, Petitioner earned **$41,773.93**; the average weekly wage was **$803.34**.

On **August 11 2014**, Petitioner was **47** years of age, *single* with **0** dependent children.

Respondent *has not* paid all reasonable and necessary charges for all reasonable and necessary medical services regarding Petitioner's right knee.

Petitioner *has* received all reasonable and necessary medical services regarding her right knee.

Petitioner *has not* claimed any temporary total disability or lost time with respect to her right knee.

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

Petitioner failed to prove that her current condition of ill-being in her right knee is causally related to her accident of August 11, 2014. Petitioner's claim for prospective medical care related to her right knee is denied.

Respondent shall pay reasonable and necessary medical expenses in the amount of $2,625.00 as set forth in PX 1, subject to the Medical Fee Schedule. These bills are for services rendered by Dr. Paletta on November 3 and 6, 2014 and the knee MRI. Respondent shall receive credit for any medical bills paid by it.

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

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

Signature of Arbitrator

October 5, 2015
Date

ICArbDec19(b)

OCT - 8 2015

STATE OF ILLINOIS)
) SS
COUNTY OF JEFFERSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CRYSTAL QUANDT
Employee/Petitioner

v. Case # 14 WC 33491

STATE OF ILLINOIS/MURRAY CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT and CONCLUSIONS OF LAW

The parties stipulated that on February 4, 2011 (11 WC 08596) and August 11, 2014 (14 WC 33491), Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent. Both cases were consolidated solely for the purposes of conducting the 19(b) hearing. Two decisions will issue. At the time of arbitration in both cases Respondent only disputed causal connection, liability for medical expenses, and liability for prospective medical care pertaining to Petitioner's right knee injury.

Issue (F): Is Petitioner's current condition of ill-being causally related to the accident of August 11, 2014?

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

Respondent stipulated that Petitioner's current condition of ill-being, except for her right knee condition, was causally connected to her accident of August 11, 2014. Petitioner failed to prove that her current condition of ill-being in her right knee is causally connected to her accident of August 11, 2014 or that she is entitled to any prospective medical care as a result of her August 11, 2014 accident. In support thereof the Arbitrator finds as follows:

Petitioner is a Mental Health Technician for Respondent. On February 4, 2011, Petitioner was involved in an undisputed accident. The incident report reflects that Petitioner was struck in the face and pushed into the railing and wall. (RX2).

As shown in RX 2, Petitioner only reported neck and upper back pain complaints at the time of her February 4, 2011 accident.

Petitioner was seen at St. Mary's Hospital on February 8, 2011. Nothing therein suggests a right knee injury. (PX 3)

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Petitioner underwent a lumbar spine MRI on July 11, 2011 due to low back pain radiating to her right buttocks and leg behind her knee. (PX 7)

Petitioner was examined by Dr. Grandberg on July 20, 2011 through August 10, 2011. No right knee complaints or injuries were noted. On August 10, 2011 he noted mid-back pain radiating down into Petitioner's right knee. (PX 8)

Petitioner presented to Dr. Paletta on April 23, 2012. Dr. George Paletta took the following history:

> This is the first visit for this 46-year-old white female who presents for evaluation of a chief complaint of right knee pain and swelling. She presents for consultation at the request of Dr. Matthew Gornet. She works as a medical care technician at the Murray Center. This is essentially equivalent to a CAN [sic-CNA] –type job. She was injured in February 2011. She was seated at her desk. She was apparently attacked or hit by a male patient where [sic] she estimates weighed about 180 or 190 pounds. The patient came out from the right side and hit her from the anterolateral aspect. She suffered multiple injuries including low back and knee. Most of the attention so far has been directed to the low back, which was the more significant of the issues. However, she has had persistent pain and swelling in the knee since the initial injury. . . (PX11, 4/23/12).

Petitioner gave a further history of persistent swelling, believing her knee was swollen that day although not as bad as it sometimes was. She reported diffuse pain behind her knee, especially the knee cap but no radiating pain or associated complaints. She denied prior surgery on her knee or problems predating her work incident.

Dr. Paletta's physical examination of Petitioner's right knee demonstrated "obvious soft tissue swelling with large area of fluctuance at the superolateral corner of the patella just anterior to the iliotibial band." (PX11, 4/23/12). He also noted moderate tenderness, 1+ effusion, tenderness along the medial joint line, particularly in the mid axillary line and posterior region, and some

medial retinacular tenderness. *Id.* Dr. Paletta suspected a tear of Petitioner's medial meniscus and recommended an MRI. *Id.* Dr. Paletta believed that Petitioner's right knee problems were the result of the February 2011 work incident. *Id.*

Petitioner underwent a right knee MRI on July 6, 2012. It revealed a tear of the posterior horn of the lateral meniscus with abnormal configuration and a linear signal with distortion of the shape of the medial meniscus suggestive of a meniscal tear as well, (but that may have been an older process), diffuse articular thinning with a focal deep fissure in the weight bearing aspect of the tibial plateau, degenerative bone marrow change in the fibular head, large joint effusion without evidence of a loose body, and a large lobulated and probably septated Baker's Cyst. (PX 7)

Dr. Paletta reviewed the MRI documenting his impression of a meniscus tear within the setting of early degenerative joint disease. He also noted the scan demonstrated findings consistent with a tear of the posterior horn of the lateral meniscus and a "probable" meniscus tear. Petitioner's MRI also showed some articular cartilage thinning involving the tibial plateau and a large joint effusion with an associated multifocal Baker's cyst. He recommended arthroscopic debridement and partial meniscectomy. (PX 11, 7/10/12 scan review)

Respondent had Petitioner examined by Dr. Timothy Farley on August 28, 2012. (RX3). Dr. Farley agreed with the diagnosis of medial and lateral meniscus tears, but did not believe that these were the source of Petitioner's swelling. *Id.* He did not believe that Petitioner's described knee pain was in any related to the February 4, 2011 incident. *Id.* Despite Petitioner's lack of a history of right knee problems, he indicated that he did not believe Petitioner sustained any injury, and opined that the majority of the pathology within her knee was attributable to non-work-related conditions. *Id.* In his first report Dr. Farley opined, "[t]here is zero evidence in the medical chart of any comment on knee pain until 10+ months later, in a follow up visit with Dr. Gornet…Moreover, I am not even of the opinion that an injury occurred in that the majority of the condition within her knee represents an underlying different factor such as potential inflammatory arthropathy, gout or even a more odd type diagnosis as pigmented villa nodular synovitis which are conditions not related to her described injury."

Dr. Farley's deposition was taken on February 12, 2013. (RX 4) Dr. Farley testified consistent with his report. Dr. Farley testified that he did not believe any of Petitioner's diagnoses were traumatic in nature. (RX4, p.9, 10). He believed that Petitioner's first complaints of knee pain occurred 10 months later on December 8, 2011. (RX4, p.8). He acknowledged that Petitioner sustained no prior right knee injuries. *Id.* at 14. He acknowledged that there was nothing in the records to indicate that Petitioner had any prior right knee complaints. *Id.* at 14. Dr. Farley also acknowledged that there was no evidence of any intervening trauma contained in the medical records or by way of history. *Id.* at 16. He testified that he did not have any of Petitioner's treatment records beyond July 9, 2012. *Id.* at 23.

Dr. Paletta testified by way of deposition on April 17, 2014. (PX12). Dr. Paletta confirmed that Petitioner had no intervening accidents between February 4, 2011, and the time he saw her in 2012. (PX12, p.7). With regard to causation, he testified:

Q: . . .Given, Sir, the history of overriding low back/spine complaints, Number One, assuming knee complaints following the injury, do you have an opinion, sir, within a reasonable degree of medical certainty, as to whether her pathology was caused by the accident that she complained of?
A: Yes, sir, I do.
Q: And what would that be, please?
A: If her history is accurate and she had pain in the knee as a result of that incident, it's my opinion that her meniscus tear is related to that incident. *Id.* at 7.

Petitioner sought no further care for her right knee until she sustained her second accidental injury on August 11, 2014, when a resident kicked an end table into her leg while she was attempting to keep him seated. Petitioner reported to the St. Mary's Hospital emergency room on August 13, 2014, with significant swelling, pain and difficulty bearing weight and came under the care of Dr. Jha. (PX3, 8/13/14; PX12). X-rays were taken and the impression noted "large knee joint effusion." *Id.* Dr. Jha referred Petitioner to Dr. Houle, who noted on August 18, 2014 that Petitioner's right knee complaints now consisted of sharp, aching, stabbing and burning pain, and swelling accompanied with giving way. (PX12; PX13). Dr. Houle's physical examination noted severe effusion and limited range of motion. (PX13). Dr. Houle recommended a new MRI to assess suspected internal derangement and prescribed Mobic and meloxicam to reduce Petitioner's inflammation. *Id.*

Petitioner returned to Dr. Paletta on November 3, 2014, at which time Dr. Paletta noted that Petitioner had sustained a new injury when a resident pushed a table into her knee. (PX11, 11/3/14). He noted that Petitioner experienced immediate pain and that her symptoms persisted despite the non-steroidal anti-inflammatory medication prescribed by Dr. Houle. Petitioner initially worked light duty (essentially seated duty). She complained of pain both at rest and with activity. Her swelling "waxed and waned." Her knee felt unstable and she experienced stiffness after long periods of sitting. Stairs were particularly difficult but she denied any true give away. . Physical examination showed marked joint line tenderness and significant effusion. *Id.*

Dr. Paletta ordered x-rays. His impression was effusion of the right knee and a possible meniscus tear. She had significant effusion and marked joint line tenderness. Dr. Paletta recommended that Petitioner "aggressively" ice her knee, undergo a new MRI, and try a Medrol Dosepak and non-steroidal anti-inflammatory medication. He concurred with ongoing restrictions of light duty/seated work. He further stated that Petitioner's current right knee condition was caused by the work incident that occurred on August 11, 2014. *Id.* Dr. Paletta further noted:

> As noted previously, I had seen Crystal back in 2012 for problems related to the right knee. At that time, she was diagnosed with a meniscus tear. Recommendation was made for arthroscopy and partial meniscectomy. Crystal states that she did not pursue that because work comp would not approve it. She was never seen back after completion of the MRI scan and the recommendation for surgery. She states that she effectively babied the knee and was able to get by but that the knee was never back to 100%; however,

> since this injury in August, things have been significantly worse with dramatically more swelling and pain as documented in the note above. *Id.*

Petitioner's new MRI of November 3, 2014 showed a large joint effusion and large Baker's cyst with multiple loose bodies and debris. Clinical correlation was recommended. There was also evidence of an abnormal menisci with abnormal configuration and size, particularly in the posterior horns. In the absence of surgery the radiologist felt the findings were consistent with meniscal tearing. The radiologist could not tell if Petitioner had undergone previous surgery or if she had a meniscal tear with some degenerative change. The lateral meniscus was also noted to be abnormal. (PX 7) Dr. Paletta reviewed the MRI scan noting it "once again shows evidence of a medial meniscus tear." He also noted that Petitioner now appeared to have synovial chondromatosis with multiple intraarticular small loose bodies and a "persistent" large effusion. Dr. Paletta recommended arthroscopic debridement, chondroplasty, removal of loose bodies, and partial medial meniscectomy. (PX 11) .

Respondent had Petitioner examined by Dr. Farley a second time on February 2, 2015. (RX8). Dr. Farley reviewed Petitioner's most recent radiographs and his physical examination also demonstrated tenderness over the medial and lateral joint lines. *Id.* Dr. Farley believed that the August 2014 injury had no discernible impact on Petitioner's knee condition, and believed that Petitioner reached maximum medical improvement regarding any pretibial contusions that occurred as a result of the incident. *Id.* He did believe, however, that Petitioner's subjective complaints were supported by the pathology depicted on her radiographs. *Id.*

Petitioner returned to see Dr. Paletta on February 23, 2015 reporting that her claim had been denied and she couldn't afford to take an unpaid leave to have her knee treated under her personal health insurance. She reported that her knee was about the same and that she was also having right-sided low back and hip discomfort. Petitioner was taking Vicodin intermittently for her knee pain as overseen by her primary care physician. Petitioner felt she had no option but to return to work on a full duty basis. Petitioner was hoping to get a shift change as she had applied for one and she felt it would result in decreased demands on her knee. Dr. Paletta felt that would be beneficial and that she should remain off work until her application was approved. They discussed various options for treatment of Petitioner's knee and she was to get back with the doctor if she wished to pursue one. (PX 11)

Dr. Paletta also issued a letter on March 6, 2015 with regard to Dr. Farley's additional report (PX11, 3/6/15). In his letter to Petitioner's attorney he specifically referenced an accident date of "2/4/11" and case number "11 WC 008596." He offered the following response:

> Dr. Farley opines that the patient has an "underlying autoimmune or inflammatory condition that may explain her symptoms." He further states that he believes that her symptoms "represent an undiagnosed condition related to the patient and predating the described work injury. He does not believe that the patient's current condition is the result of a work related injury. He notes and agrees with me with respect to the diagnoses of effusion of the knee, synovial chondromatosis, and a popliteal cyst. He also notes evidence of a small meniscus tear.

> I want to be very clear that it is my opinion that her synovial chondromatosis is not the result of any work related injury. However, it is my opinion that her meniscal tear is the result of a work related injury. The synovial chondromatosis was a preexisting condition but prior to the work injury she denies any history of significant knee problems.
>
> Based on my examination and my interpretation of the MRI scan, she does have both subjective and objective findings consistent with a symptomatic meniscus tear as well as a reactive effusion and synovial chondromatosis. There is no evidence of an autoimmune condition or inflammatory condition other than the reactive effusion. Furthermore, Dr. Farley agrees that additional treatment is appropriate although he does not believe the treatment is related to or necessary as a result of the work injury. *Id.*

In his concluding paragraph Dr. Paletta wrote, "I have been clear in my opinion that the meniscus tear is the result of the work related injury" (PX 11)

Dr. Farley was again deposed on May 5, 2015. He again testified consistent with his earlier report. He also testified that 85% of the independent medical evaluations he performs are at the request of employers or insurance companies. (RX9, p.25). During cross-examination, Dr. Farley acknowledged that Petitioner's mechanism of injury for the August 2014 incident could certainly produce symptoms and require treatment and/or aggravate pre-existing conditions. *Id.* at 29. He also acknowledged the presence of effusion in her knee following the August 2014 injury. *Id.* at 33. He also acknowledged that Petitioner's level of function decreased after the August 2014 work injury. *Id.* at 45. In the end, he agreed Petitioner had problems with her knee; however, they were not work-related. (RX 9)

At the arbitration hearing Petitioner testified that she is a Mental Health Technician for Respondent. Petitioner testified that when she saw the resident running towards her, she put her arms and leg up as a barrier.

Petitioner testified that as time progressed, Petitioner began noticing problems in her right knee. She testified that the longer she walked on her knee, the more swollen and painful it became. Petitioner testified that she had no prior right knee injuries or treatment. Petitioner testified that she reported her knee complaints to her chiropractor, Dr. Michael Bowman. Petitioner testified that she "repeatedly told Dr. Gornet about her right knee."

Petitioner testified she was simply trying to live with her condition up until that point. Petitioner testified that the August 11, 2014 incident increased her pain and caused constant swelling. This is supported by the emergency room records which documented that Petitioner was having difficulty bearing weight, x-rays showing increased effusion, and new complaints of a sensation of instability. (PX3, 8/13/14; PX12). Petitioner also testified without rebuttal that her condition has not improved since the second accident despite conservative care.

Petitioner testified that she continues to experience symptoms in her right knee, and wears a brace at work when she works overtime to help manage her pain. She confirmed that she wishes to undergo the surgery recommended by Dr. Paletta.

In concluding that Petitioner's current condition of ill-being in her right knee is not causally connected to Petitioner's August 11, 2014 accident, the Arbitrator finds the opinion of Dr. Paletta regarding the issue of causal connection to be unpersuasive. His "formal" opinion as set forth in his 2015 letter to Petitioner's attorney addressed Petitioner's 2011 accident and not the 2014 accident. He did not provide any opinion as to the role of the 2014 accident. While his office note of November 3, 2014 contains an opinion regarding causation and the August 11, 2014 accident, that opinion is unpersuasive. The condition for which Dr. Paletta wishes to perform surgery at the present time is the same one Petitioner had in 2012. Petitioner needed surgery before the August 11, 2014 accident and still needs it. However, she failed to prove that she needs the surgery because of the August 11, 2014 accident. He provided no opinion giving full consideration to Petitioner's complete and accurate medical history pertaining to her knee.

Finally, the Arbitrator is troubled by Petitioner's possible motivation herein. Dr. Paletta's office notes document that Petitioner's workers' compensation claim had been denied but she could not afford to pursue surgery under her personal health insurance because she would not be paid for her time off from work. If her knee injury were determined to be work-related, she would be paid for her time off from work. Thus, Petitioner's motivation for claiming a work-related knee injury is suspect.

Petitioner sustained an accident involving her right knee and her initial visit with Dr. Paletta was reasonable. However, she failed to prove that any subsequent care and treatment with him, or his recommendation for prospective medical care, is casually related to her August 11, 2014 accident. Petitioner's claim for prospective care is denied.

Issue (J) Medical Bills.

Respondent only disputed Petitioner's medical bills with regard to her right knee. The only treatment Petitioner has had for her right knee since her accident has been with Dr. Paletta. Petitioner is awarded the bill for her office visit with Dr. Paletta on November 3, 2014 and November 6, 2014 ($625.00) and the cost of the November 2014 MRI ($2,000.00). Petitioner failed to prove that Respondent is liable for any further/subsequent medical bills related to Petitioner's right knee. All other bills pertaining to Petitioner's cervical and lumbar conditions were addressed in case #11 WC 008596. Said bills are awarded pursuant to the Medical Fee Schedule.

****

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

Richard Amato,

Petitioner,

vs.

NO. 14WC018052

Vaccaro Truck Body Repair & Painting NGV Inc.,

16IWCC0763

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 13, 2016 is hereby affirmed and adopted.

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: NOV 23 2016
SJM/sj
o-10/27/2016
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

AMATO, RICHARD
Employee/Petitioner

Case# **14WC018052**

VACCARO TRUCK BODY REPAIR & PAINTING
NGV INC
Employer/Respondent

16IWCC0763

On 4/13/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.35% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1452 CHASE & WERNER LTD
LOUIS G ATSAVES
300 W ADAMS ST SUITE 330
CHICAGO, IL 60606

0507 RUSIN & MACIOROWSKI LTD
JOHN A MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

16IWCC0763

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Richard Amato
Employee/Petitioner

Case # 14 WC 18052

v.
Vaccaro Truck Body Repair & Painting NGV, 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 Arbitrator Ketki Steffen; Arbitrator David Kane, Arbitrators of the Commission, in the city of Chicago, on 10/1/15; 3/24/16. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

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

L. ☒ What is the nature and extent of the injury?

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On 12-19-12, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

In the year preceding the injury, Petitioner earned $17,005.04; the average weekly wage was $ 327.02.

On the date of accident, Petitioner was 55 years of age, married, with 0 children under 18.

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

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

ORDER

This case was initially heard before Ketki Steffen on October 1, 2015. It was reassigned to Arbitrator Kane with additional evidence submitted on March 24, 2016.

The Arbitrator finds that Petitioner was the aggressor in the altercation of December 19, 2012 and, therefore, the accidental injury did not arise out of and in the course of his employment. Wherefore, Petitioner's claim for compensation is hereby denied.

The Arbitrator finds no causal connection between Petitioner's current complaints and the incident of December 19, 2012.

The Arbitrator also finds that Petitioner failed to prove any period of temporary total disability.

Petitioner's claim for medical services is denied based upon the Arbitrator's finding of lack of accidental injury as well as causality.

Given the Arbitrator's finding as to lack of accidental injury Petitioner's claim for penalties is denied. Petitioner's claim for residual permanency is also denied in light of the Arbitrator's finding as to lack of accidental injury and causation.

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

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

April 7, 2016
Date

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APR 13 2016

Richard Amato v. Vaccaro Truck Body Repair & Painting NGV, Inc.
IWCC No. 14 WC 18052

In support of the Arbitrator's finding as to (C) Accidental Injury, the Arbitrator makes the following findings of fact and conclusions of law:

Petitioner testified that he commenced employment with Respondent eight or nine years preceding December 19, 2012.

Petitioner has a number of prior workers' compensation cases consisting of 86 WC 45990, with a date of accident of March 27, 1985, to his back with eight weeks of TTD paid and a settlement of 2.5% of a man (R. Ex. 2); a date of loss of February 5, 1989 under 89 WC 44723, involving his back, neck and right leg with 13 weeks of TTD paid and a settlement of 25% loss of use of the right leg (R. Ex. 3); a date of loss of January 25, 1993 under 93 WC 52514, involving his back for which he underwent back surgery and was off work 44-3/7 weeks and received a settlement of 20% loss of use of a man as a whole (R. Ex. 4); a date of accident of May 11, 1994 under 97 WC 32499 involving his back and abdomen for which he was off work 10-5/7 weeks and received a settlement of 3.5% of a man (R. Ex. 5); and a date of accident of October 15, 2003 and June 29, 2004 under case number 04 WC 36612 and 04 WC 51549 wherein Petitioner allegedly sustained a concussion, sprain/strains, multiple facial fractures and loss of vision in the left eye resulting in him not being capable of returning to his prior work and returning to work at Orland Toyota as a car porter for $10.00 an hour receiving a wage loss settlement of $240,000.00. (R. Ex. 6).

Petitioner admitted that as a result of the facial fracture and eye injury he had a restriction of no lifting greater than 50 pounds. Richard Amato is Carolyn Vaccaro's cousin. Carolyn and Neal Vaccaro testified that Petitioner started work with them on a part-time basis in November of 2008. Petitioner advised Neal Vaccaro at the time of hire of his lifting restriction due to his eye condition. Petitioner drove trucks to and from customers' locations. The job involved no lifting. Petitioner ceased working with Respondent in approximately January of 2012.

Petitioner then returned to work for Respondent on May 14, 2012 in the part-time driver position. Petitioner on occasion would only work one to two days per week. Carolyn and Neal Vaccaro testified that the wage statement (introduced as Respondent's Exhibit No. 8) reflected all earnings Petitioner received from the Respondent.

The Respondent also employed a cartage driver or parts delivery driver by the name of Ray. This position would require lifting up to 10% of the time that may have exceeded Petitioner's lifting restriction. Ray had illnesses in 2012 with Petitioner filling in in his position on occasion when demands of the job assignment allowed. Ray became hospitalized at the end of October of 2012 with Petitioner filling in for Ray's position on more of a full-time basis as reflected by the wage records for the week ending October 28, 2012 through December 2, 2012.

Petitioner testified that Carolyn Vaccaro told him that the full-time position previously being performed by Ray was Mr. Amato's. Carolyn

Vaccaro denies ever making such a statement. Petitioner conceded that Neal Vaccaro never told him he had this position but more or less assumed that it was his. Neal Vaccaro testified that in mid-December they were advised that Ray would not be returning to their employment. Due to the fact that this job position required lifting on occasion greater than Petitioner's limitations they elected to hire another individual to fill Ray's position effective the middle of December 2012.

The Arbitrator notes that when Petitioner was initially seen for care on December 21, 2012 he gave a history as follows: "He states he had recently been driving full time for the company and had been assigned to a particular truck as coverage for an employee who was off on sick leave. He states the other employee did not return from sick leave and so he was expecting to be assigned to that position permanently". (P. Ex. 2). This would contradict Petitioner's testimony that Carolyn Vaccaro had told him that he had the position as Petitioner acknowledged he was merely "expecting" to be given the position.

Petitioner would text Carolyn Vaccaro or speak with Neal Vaccaro via telephone as to whether or not there was any work for him on any given date. The insured had no work for Petitioner on December 17 or December 18. Petitioner was told to report for work on December 19, 2012 at 9 a.m. They had a truck to be returned to a customer by 10 a.m.

Neal Vaccaro testified that Petitioner was late two to three times a week. He also had complaints from customers that Petitioner would roam

around the facility of the customers, talking to the customers' workers, distracting them from performing their work duties.

Petitioner did not arrive at work until 9:45. He was to take the truck to Northlake. Petitioner advised Mr. Vaccaro that he did not know how to get there. Mr. Vaccaro told Petitioner that he had been there previously. Carolyn Vaccaro then provided MapQuest directions for Petitioner.

Petitioner returned to Mr. Vaccaro's office. Mr. Vaccaro was sitting on the couch depicted in photos. (R. Ex. 18 and 19). Carolyn Vaccaro was in Neal Vaccaro's office as her computer was not operating, and she was utilizing Neal Vaccaro's computer to complete the payroll. She was situated at the desk. Richard Amato was leaning up against the credenza adjacent to the desk. Mr. Amato inquired of Mr. Vaccaro why he did not get the parts driver's position as he had called the customer and was informed that someone else was driving the truck. Mr. Vaccaro advised him that it was none of his business and that he should not be contacting the customers, but Petitioner could continue to work for them as he had in a part-time position shuttling trucks. Petitioner had stated that he had purchased insurance on the assumption that he would be working full-time and now would not be able to afford same. Neal Vaccaro noted that Petitioner was agitated. He got up from the couch and stood by the desk. From the credenza that Mr. Amato was by to the desk where Mr. Vaccaro was standing there was roughly 5 feet separating the individuals. The tiles were 18 inches each, and the photos depict approximately 3.8 tiles, or the equivalent of space between the credenza and desk as 68.4 inches; or 5

feet, 8.4 inches. Mr. Vaccaro, given Petitioner's tone, instructed his wife to call the police. Mr. Amato then stated that he would go to the labor board and go to Mr. Vaccaro's customers and tell them what lousy work they performed and ruin his business. Mr. Vaccaro pointed to the door and stated, "You're fired". Mr. Amato then shoved Mr. Vaccaro in the chest, causing him to lean back on the edge of the desk. Mr. Vaccaro indicated he took his open palm and pushed Petitioner off, with Petitioner moved back towards the desk. He then left to deliver the customer's truck as it was already late.

Mr. Vaccaro denied striking Petitioner. Petitioner testified that Mr. Vaccaro struck him on the right side of the temple. He indicated he lost consciousness and fell to the floor. He stated that Carolyn Vaccaro assisted him and gave him his glasses. Petitioner was adamant that he was struck on the right side of the head. Petitioner's sunglasses, which were admitted as Petitioner's Exhibit No. 8, showed damage on the left side frame rather than the right.

Carolyn Vaccaro testified that she was looking in her purse for her phone to call the police and did not see any physical contact between the parties. She did not hear the sound of any fist striking any individual. She also denied that she picked Petitioner up from the floor, that he was on the floor, or that he lost consciousness. She did know whether or not he was wearing sunglasses but did not pick up any sunglasses and hand them to Petitioner.

Carolyn Vaccaro indicated that Neal had left to return the truck to the customer. She then talked with Mr. Amato and advised him she would not call the police and that she would talk to Neal when he got back to see if he could still work in the part-time position.

Petitioner indicated that he drove himself from the facility and took selfie photos with his phone of his face which he alleged had a cut to the nose and bruises. Petitioner produced no such photos at the time of trial.

Petitioner went to the police station, with the police coming to the plant. Carolyn advised what had happened, with the police officer indicating that these types of things were common and to perhaps talk to Mr. Amato. Mr. Amato was not interested in talking. When Mr. Vaccaro returned from delivering the truck he was advised that the police were there, and he himself went to the police station. The criminal proceedings were dismissed with Mr. Vaccaro never convicted of any criminal offense.

Petitioner signed his initial application in this matter on December 21, 2012. He denied that it was his attorneys that referred him to Integrity Medical Group. He indicated a neighbor by the name of Mr. Carver referred him to Integrity. The records for Integrity for the initial visit of December 21, 2012 indicate that Petitioner was seen by Chiropractor Dietz. He gave a history of being struck a second time on the right ear. He states he was leaning against a low file cabinet and slid off the cabinet onto a concrete floor, landing on his low back and left hip.

The Arbitrator notes that the photo acknowledged by each party as accurate (R. Ex. 18 an 19) shows a tile floor.

In the history given to Integrity, Petitioner claims that he was unconscious after the two blows to the head but then alleged that his employer tackled him and continued to punch him while they were both on the ground. (P. Ex. 2). Petitioner did not testify to this version of events at trial.

Petitioner complained to Integrity of low back pain with pain down the back of his left leg, complaints of the left knee and left hip, shooting pain in his right eye and ringing in his ears. He also complained of pain in his jaw. The Arbitrator notes there was no physical finding of Petitioner having any cuts on his face or bruising. He was seen by Chiropractor Dietz on December 28 and lastly seen for medical care on January 16, 2013. X-rays of the pelvis revealed no evidence of osseous or joint pathology. X-rays of the lumbar spine revealed soft tissues within normal limits and no evidence of fracture, and x-rays of the right mandible revealed soft tissues within normal limits and negative.

The Arbitrator notes that when Petitioner was seen on January 16, 2013 at Integrity he now gave a conflicting history of being struck on the left side of the face. It was noted in the past medical history that as a result of the 2004 injury Petitioner was in a coma for 3-1/2 days. Dermatological exam revealed no skin lesion. Petitioner was seen on this date by Internist

Claudia Johnson. Petitioner was last seen for this condition at Integrity on January 17 complaining of low back pain and headaches. (P. Ex. 2).

Petitioner was seen at Advocate Christ Hospital on December 29, 2012. He presented with a history of an incident of December 19 when he was struck in the face and head multiple times by his boss. He stated he lost consciousness and ever since he had been having headaches, occasional blurred vision, difficulty sleeping, and problems with his memory. He had been followed by his primary care physician who had done x-rays that were all normal. No CT had ever been done. Petitioner ambulated with a steady gait. Skin was found to be intact with no neurological symptoms. Musculoskeletal symptoms revealed no back pain. He was found to be alert and in no acute distress. Examination of the head was atraumatic. The neck was supple. Examination of the eye revealed extraocular movements intact with normal conjunctivae but the left pupil dilated chronically from prior injury. Examination of the nose, mouth, and throat revealed no findings. The back was nontender with normal alignment. Musculoskeletal examination, contrary to the findings of Integrity, revealed normal range of motion and normal strength. Neurological examination revealed him to be alert and oriented to person, place, time and situation. There was no focal neurological deficit observed, cranial nerves were intact, normal sensory was observed, normal motor observed, normal speech observed, and normal coordination observed. It was noted incidentally that he had high blood pressure and was to follow up with his primary care physician regarding that. Petitioner underwent a CT of his head on December 29, 2012 which was compared to a prior CT

of the head of October 14, 2003 with the findings being "The sulci and ventricles are unchanged. There is no evidence of acute hemorrhage, midline shift or pathological extra axial fluid". Impression, "No acute change." (R. Ex. 16).

The last medical care Petitioner received was at Palos Community Hospital on March 21, 2013. Petitioner on March 21, 2013 called the North Palos Fire Department who dispatched an ambulance to Petitioner's residence. He gave a history of his boss beating him up three months prior and feeling dizzy from time to time. He indicated he went to the bathroom and felt dizzy. He denied any other problems. He wanted to go to the hospital to get checked out. It should be noted that Petitioner was outside his residence waiting for the ambulance when it arrived. (R. Ex. 17). Petitioner was taken to Palos Community Hospital. They noted him to be alert and oriented x 3 with speech clear and obeying commands. His left eye was dilated from a work accident. They noted that he arrived hypertensive but denied any medical history or medications. Petitioner was previously told at Christ Hospital to follow with his physician for hypertension but denied seeking any such care.

Petitioner was examined by Dr. Khan on March 21, 2013. It was noted that Petitioner had been taking lisinopril but stopped taking it on his own volition. Physical exam did not show the patient to be in any obvious pain or distress. He was restarted on lisinopril. CT was deemed to be unremarkable. He was to be evaluated by neurology. Petitioner was examined by Dr. Christopher D. Fahey. He gave a history of being

assaulted in December and thinking he briefly lost consciousness. He indicated a month and a half prior he began having intermittent double vision or approximately February of 2013. Physical examination revealed him to be in no acute distress with the neck supple. Neurological testing revealed him to be alert and oriented to person, place, and time. Cranial nerve exam was normal. Motor showed good strength. Sensory examination was intact. Dr. Fahey concluded the extraocular muscles to the eye appeared to be intact. In light of the history he suspected possible postconcussion syndrome and ordered an MRI to rule out any structural issues. CT of the head without contrast suggested possible chronic small vessel ischemia, demyelination, but no intracranial hemorrhage. MRI of the brain revealed no evidence of intracranial hemorrhage or mass effect. The emergency room record stated that Petitioner's ER course was essentially unremarkable. He underwent a CAT scan of the head which did not reveal any obvious etiology to the patient's persistent complaints of unsteady gait and recurrent falls and diplopia. (R. Ex. 17).

Petitioner has not had any medical care relative to his head complaints since March 21, 2013.

Generally, where an injury results from physical combat between two employees over the employer's work, the employee who was not responsible for the aggression may be compensated. Fischer v. Industrial Commission, 408 Ill. 115 96 N.E.2d 478 (1951). Injury sustained by the aggressor, being traceable to his own voluntary acts are not within the scope of employment and are not compensable. Armour & Company v.

Industrial Commission, 397 Ill. 433, 74 N.E.2d 704; Ford Motor Co. v. Industrial Commission, 35 Ill. Dec. 752 399 N.E.2d 1280 (1980). Larson, defines the aggressor as the one who initiates the altercation, typically through physical means. *Larson's Workers' Compensation Law*, Section 8.01[5][c] (2002). In Franklin v. Industrial Commission, 274 Ill. Dec. 760, 791 N.E.2d 1171 (2003), the court noted that Illinois denies compensation to the aggressor, usually determined by the one who provides the first physical contact. Such acts are not within the scope of the employment and not compensable. There cannot be two aggressors, and the Commission is to determine who is the initial aggressor. In Karabegovic v. Marina Cartage, Inc., 15 I.W.C.C. 0544, the Commission denied compensation on the basis that the claimant's confrontational and quarrelsome nature precipitated the manager pushing him away, thus making him the aggressor in the confrontation and therefore the aggressor in the altercation and the incident not to have arisen out of the employment.

The Arbitrator does not find Petitioner's testimony to be credible. Petitioner believed he had worked for the insured eight or nine years, when the record suggests that he did not commence work until November of 2008. Petitioner then left the employment in January of 2012 before returning in his part-time role in May of 2012.

Petitioner claims he was filling in for cartage driver Ray who was out on medical leave. The records suggest that the medical leave occurred in October of 2012. Petitioner testified that Carolyn Vaccaro told him that he had Ray's job. This is inconsistent with Petitioner's history when seen for

care at Integrity on December 21, 2012 wherein Petitioner gave a history of merely expecting the job.

Petitioner claims he was struck on the right side of his face. He brought sunglasses that he stated were damaged, with the damage appearing on the left side. Petitioner when at Integrity on January 16 gave a conflicting history stating he was struck on the left rather than right side. He claims he took selfie photos that demonstrated cuts and bruising on the date of incident but did not produce them. The records of care from Integrity and Christ Hospital for the admission of December 29 show the skin intact with no mention of any cuts, lacerations, or bruising.

Mr. Vaccaro was informed in mid-December by full-time cartage driver Ray that he definitely would not be returning to work. Given the fact that the cartage job required lifting 10% of the time greater than what Petitioner's limitations allowed, Mr. Vaccaro needed to fill that position with another individual.

Petitioner on the date of incident of December 19, 2012 was 45 minutes late, arriving at 9:45. He was to arrive at 9 o'clock to take a truck back to a customer that was due at 10 a.m. Petitioner indicated he did not know how to get there despite Mr. Vaccaro stating he had previously been there.

Petitioner then brought up the fact that he had contacted a customer and inquired why another individual was driving a truck. Mr. Vaccaro

indicated it was inappropriate for Petitioner to contact his customers and that was not his concern. Mr. Vaccaro advised he elected to go another way but that Petitioner could work in the part-time position he had worked in with the company for years. Petitioner then was upset, indicating that he had purchased insurance, believing he had a full-time position. Mr. Vaccaro then stood up and went by the desk depicted in photos. (R. Ex. 18 and 19). Mr. Vaccaro instructed his wife to call the police. Petitioner then stated that he would go to the labor board and tell all of Mr. Vaccaro's customers what lousy work he did and ruin him. Mr. Vaccaro then pointed to the door and stated, "You're fired". Petitioner at that point shoved Mr. Vaccaro in the chest, resulting in him having his back lean back against the desk at an angle. Mr. Vaccaro indicated that he merely took his open hand and pushed Petitioner off him by pushing Petitioner in the chest. He never struck Mr. Amato, and Mr. Amato never fell to the ground. Mr. Vaccaro then left to return the truck himself as it was already late.

Mr. Vaccaro made a business decision hiring an individual to do a full-time position who could perform all aspects of the job. Mr. Amato was upset with same. When Mr. Amato told Mr. Vaccaro that he would tell all of Mr. Vaccaro's customers what lousy work he did and ruin him, Mr. Vaccaro told Petitioner he was fired. It was at that point that Mr. Amato initiated the physical contact by pushing Mr. Vaccaro back against the desk. Mr. Vaccaro merely pushed Petitioner off him.

Carolyn Vaccaro, although not seeing any physical altercation as she was looking for her phone in her purse to call the police, did not hear the

sound of any fist striking either individual. Petitioner was also not on the floor nor did she help Petitioner up from the floor nor hand him his glasses.

The Arbitrator does not find Petitioner's testimony credible. The Arbitrator notes that the medical care at Integrity showing reduced range of motion of the low back and cervical spine is inconsistent with records of Advocate Christ Hospital on December 29 that showed a neurological examination with normal strength and tone, the back nontender with normal alignment with no evidence of any back pain. Further, the skin was found to be intact with a CAT scan taken on December 29, 2012 being compared to a prior CAT scan of October 14, 2003 showing no evidence of change.

The records from Palos Community Hospital for the visit of March 23, 2013 also fail to document any positive objective clinical findings. It was noted that the course of treatment at the ER was unremarkable and that the CT scan revealed no obvious etiology of Petitioner's subjective complaints of unsteadiness and recurrent falls. Petitioner had been instructed at Christ Hospital to follow up for high blood pressure. When seen at Palos Community Hospital they noted that he had been taking lisinopril but had stopped taking it on his own prior to Petitioner complaining again of the onset of dizziness and falls for the last month to month and a half. This would place the onset of these symptoms as February 2013. MRI and CAT scan again showed no objective evidence of abnormality.

Wherefore, the Arbitrator would find Petitioner's testimony not credible. The Arbitrator would also find that Petitioner was the aggressor in

any physical altercation and, therefore, it did not arise in and out of the course of his employment. The Arbitrator would also find that Petitioner's version of the altercation was grossly exaggerated and conflicting by his own histories wherein he later stated he was struck on the left side of the head and then tackled and beaten several more times.

The Arbitrator having found Petitioner the aggressor in the assault therefore finds that Petitioner failed to prove accidental injury arising in and out of the course of his employment. Wherefore, Petitioner's claim for compensation is hereby denied.

In support of the Arbitrator's finding as to (F) Causal Connection, the Arbitrator makes the following findings of fact and conclusions of law:

The Arbitrator finds no causal connection between Petitioner's current complaints relative to his head and the occurrence of December 4, 2012. The Arbitrator also notes that Petitioner was instructed by Christ Hospital to see a doctor for high blood pressure. Petitioner when seen at Palos Community Hospital on March 21 indicated he was then on lisinopril but stopped taking it on his own. Petitioner complained of difficulties again of faintness and lack of steadiness for a month and a half. The Arbitrator finds no causation between either hospitalization and the alleged occurrence of December 4, 2012.

In support of the Arbitrator's finding relative to (K) Temporary Total Disability, the Arbitrator makes the following findings of fact and conclusions of law:

Petitioner admitted he was never given a note from Integrity taking him off work. Petitioner applied for and received unemployment compensation benefits, indicating he was ready, willing, and able to work.

Petitioner's claim for temporary total disability is denied in light of the Arbitrator's finding as to lack of accidental injury. The Arbitrator would further find, in any event, Petitioner failed to prove entitlement to any period of temporary total disability.

In support of the Arbitrator's finding as to (J) Medical Services, the Arbitrator makes the following findings of fact and conclusions of law:

Petitioner's claim for medical services is denied in light of the Arbitrator's finding as to lack of accidental injury. The Arbitrator would further find that the treatment at Palos Community Hospital, Christ Hospital, and the ambulance service for transporting Petitioner to Palos Community Hospital was not necessary to cure or relieve Petitioner from the effects of any condition stemming from December 19, 2012. Wherefore, Petitioner's claim for medical services is hereby denied.

In support of the Arbitrator's finding as to (M) Penalties, the Arbitrator makes the following findings of fact and conclusions of law:

Petitioner's claim for penalties is denied based upon the Arbitrator finding lack of accidental injury and/or causality.

In support of the Arbitrator's finding as to (L) Nature and Extent, the Arbitrator makes the following findings of fact and conclusions of law:

Petitioner's claim for permanency is denied in light of the Arbitrator's finding as to lack of accidental injury.

The Arbitrator would further note the records from Christ Hospital and Palos Community Hospital contain no objective findings. A CAT scan taken at Palos and compared to a prior study from 2003 showed no evidence of acute change. In addition, they recommended Petitioner consult a physician for high blood pressure. When Petitioner returned to Palos he indicated he was on lisinopril but stopped taking same on his own volition and developed symptoms again a month to a month and a half prior.

The Arbitrator finds no causal connection between these complaints nor any positive objective clinical findings from the alleged altercation. Wherefore, Petitioner's claim for permanency benefits is hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard Amato,

Petitioner,

vs. NO. 12WC044215

Vaccaro Truck Body Repair & Painting NGV Inc.,

Respondent.

16IWCC0764

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 13, 2016 is hereby affirmed and adopted.

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

16IWCC0764

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: NOV 23 2016
SJM/sj
o-10/27/2016
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0764

AMATO, RICHARD
Employee/Petitioner

Case# 12WC044215

VACCARO TRUCK BODY REPAIR & PAINTING
NGV INC
Employer/Respondent

On 4/13/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.35% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1452 CHASE & WERNER LTD
LOUIS G ATSAVES
300 W ADAMS ST SUITE 330
CHICAGO, IL 60606

0507 RUSIN & MACIOROWSKI LTD
JOHN A MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

16IWCC0764

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Richard Amato
Employee/Petitioner

Case # 12 WC 44215

v.
Vaccaro Truck Body Repair & Painting NGV, 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 Arbitrator Ketki Steffen; Arbitrator David Kane, Arbitrators of the Commission, in the city of Chicago, on 10/1/15; 3/24/16. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ What temporary benefits are in dispute?

☐ TPD ☐ Maintenance ☒ TTD

L. ☒ What is the nature and extent of the injury?

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On 12-4-12, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

In the year preceding the injury, Petitioner earned $17,005.04 ; the average weekly wage was $ 327.02 .

On the date of accident, Petitioner was 55 years of age, married, with 0 children under 18.

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

This case was initially heard before Arbitrator Ketki Steffen on October 1, 2015. The case was reassigned to Arbitrator Kane for a decision.

The Arbitrator finds that Petitioner sustained an accidental injury of December 4, 2012 arising in and out of the course of his employment. The Arbitrator finds a causal connection between the December 4, 2012 incident and a sprain of the left and right foot.

The Arbitrator finds that Petitioner failed to prove any compensable period of temporary total disability and, wherefore, Petitioner's claim for temporary total disability benefits is denied.

The Arbitrator also finds that Petitioner failed to prove any residual permanency relative to the left or right foot, and Petitioner's claim for permanency benefits is hereby denied.

The Arbitrator finds that there is no basis for any claim for penalties. Wherefore, Petitioner's penalty petition is hereby denied.

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

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

April 7, 2016
Date

ICArbDec p. 2

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APR 13 2016

In support of the Arbitrator's finding as to (C) Accidental Injury, the Arbitrator makes the following findings of fact and conclusions of law:

Petitioner testified on December 4, 2012 he made a delivery to Ace Grinding. He testified that this facility worked with metal parts and that the floor was glazed over. When attempting to reenter his truck he stated that his right foot slipped, causing him to fall and twist both ankles. Petitioner did not complete an incident report at Ace Grinding nor identify any witness present. Petitioner, however, did report the incident to Neal and Carolyn Vaccaro. Neal and Carolyn Vaccaro confirmed that Petitioner did report the incident.

Neal and Carolyn Vaccaro testified that Petitioner was offered to be sent to the company clinic, but he refused care.

Based upon Petitioner's testimony the Arbitrator finds that Petitioner sustained an accidental injury on December 4, 2012 arising in and out of the course of his employment.

In support of the Arbitrator's finding as to (K) Temporary Total Disability, the Arbitrator makes the following findings of fact and conclusions of law:

Petitioner testified he did not work December 5 or December 6 but returned to work December 7. Petitioner also worked the following week,

Monday, December 10 through December 14 performing his normal job duties.

Petitioner did not see a physician until December 21, 2012. Petitioner thus had no medical note authorizing him off work relative to this incident for December 5 or December 6, 2012. Section 8(b) of the Act further provides, "If the period of temporary total incapacity for work lasts more than 3 working days, weekly compensation as hereinafter provided shall be paid beginning on the 4th day of such temporary total incapacity and continuing as long as the total temporary incapacity lasts. In cases where the temporary total incapacity for work continues for a period of 14 days or more from the day of accident compensation shall commence on the day after the accident."

In addition to not having a medical note authorizing him off work on December 5 or December 6, 2012, the two days of temporary total disability are not awardable as Petitioner did not lose more than three working days.

Wherefore, Petitioner's claim for temporary total disability benefits is denied.

In support of the Arbitrator's finding as to (F) Causation, the Arbitrator makes the following findings of fact and conclusions of law:

Petitioner when seen by Chiropractor Dietz on December 21, 2012 was diagnosed as having a bilateral ankle sprain/strain. X-rays of the right and left feet on December 26, 2012 (R. Ex. 9 and 10) and repeated on January 30, 2013 were negative. Dr. Vinci evaluated Petitioner on June 11, 2013 and diagnosed Petitioner as having a sprain of the left ankle and compensatory discomfort of the right ankle.

Wherefore, the Arbitrator finds a causation between the incident of December 4, 2012 and Petitioner's complaints relative to the right and left ankle consisting of a sprain.

In support of the Arbitrator's finding as to (L) Nature and Extent of the Injury, the Arbitrator makes the following findings of fact and conclusions of law:

Petitioner worked in his usual capacity on Friday, December 7 and the week of December 10 through December 14, 2012. Petitioner did not receive any treatment until after a dispute with his employer on December 19, 2012 that is the subject matter of case number 14 WC 18052. Petitioner signed his application for adjustment of claim on December 21, 2012 (R. Ex. 1) and initiated care on that date with Integrity Medical Group treating with Chiropractor Dietz. Petitioner's treatment consisted of seeing Chiropractor Dietz on December 21, having x-rays of the left and right ankles on December 26, 2012, each of which revealed the osseous structures unremarkable, soft tissues within normal limits, and no evidence of fracture (R. Ex. 9 and 10), returning to Chiropractor Sperry on

December 27, Chiropractor Dietz on December 28, and seeing Chiropractor Hara on January 22, 2013, at which time his complaints were greater on the right with x-rays of the left and right ankle repeated on January 30, 2013 which again showed the osseous structures unremarkable, the soft tissues within normal limits and being negative. (R. Ex. 11 and 12). Petitioner had no medical treatment for his ankles beyond January of 2013. Petitioner following his termination on December 19, 2012 applied for and received unemployment compensation. Petitioner indicated he has obtained employment in January of 2015 in a similar capacity working 40 hours per week.

Dr. Vinci examined Petitioner on June 11, 2013. Dr. Vinci found Petitioner to be a vague historian. His examination revealed Petitioner to ambulate without any limp. Physical examination of the left and right ankles revealed no positive objective clinical findings with no evidence of popping, grinding or clicking sensation noted. Dr. Vinci reviewed the x-ray and radiographic findings and noted no abnormality. He did not believe the medical treatment at Integrity was medically necessary and found Petitioner capable of working in a regular duty capacity. (R. Ex. 13). Dr. Vinci also did an AMA impairment rating diagnosing a bilateral ankle sprain with no objective abnormal findings on exam or radiographic studies. Based upon the functional history, physical exam, and clinical studies he found Petitioner to have a zero impairment rating. (R. Ex. 14 and 15).

In determining the level of permanent partial disability the Commission shall base its determination on the following factors:

(i) the reported level of impairment pursuant to subsection (a);

(ii) the occupation of the injured employee;

(iii) the age of the employee at the time of injury;

(iv) the employee's future earning capacity; and

(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

The Arbitrator notes that Petitioner returned to work in a similar capacity, now working 40 hours per week, whereas before Petitioner's job was part-time or in a fill-in capacity. Petitioner thus has had no decrease in earnings. The Arbitrator also notes that Petitioner has not had any medical care since January 2013. The Arbitrator does not believe Petitioner's age is a factor in this matter. Based upon the negative x-rays and Dr. Vinci's examination, which is the last examination of record, of June 11, 2013 and the absence of any positive objective clinical findings, the Arbitrator finds that Petitioner has failed to prove any residual permanency relative to the left or right foot.

Wherefore, Petitioner's claim for compensation is denied.

In support of the Arbitrator's findings as to (M) Penalties, the Arbitrator makes the following findings of fact and conclusions of law:

Petitioner filed a petition for penalties indicating that Respondent did not pay TTD or medical. Petitioner according to the Act did not have a compensable claim for TTD as he did not lose more than three working days. Further, although Dr. Vinci opined that Petitioner's medical treatment at Integrity was not necessary, given the fact that he worked from December 7 up until December 19, 2012 without the need for medical care, Respondent in any event satisfied the medical services relative to each foot.

The Arbitrator therefore finds no basis for Petitioner's claim for penalties, and said petition is hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tammy Jo Foles,

Petitioner,

vs. NO. 10WC012960

Sterett Crane and Rigging,

Respondent.

16IWCC0765

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 10, 2016 is hereby affirmed and adopted.

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

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

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: NOV 2 3 2016
SJM/sj
o-11/3/2016
44

Stephen J. Mathis

David L. Moore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FOLES, TAMMY JO
Employee/Petitioner

Case# **10WC012960**

STERETT CRANE AND RIGGING
Employer/Respondent

16IWCC0765

On 3/10/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

2250 LAW OFFICES OF STEPHEN LARSON
RHONDA KATTELMAN
940 W PORT PLZ SUITE 208
ST LOUIS, MO 63146

16IWCC0765

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

Tammy Jo Foles
Employee/Petitioner

v.

Sterett Crane & Rigging
Employer/Respondent

Case # 10 WC 12960

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **February 10, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 12, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$61,568.00**; the average weekly wage was **$1,184.00**.

On the date of accident, Petitioner was **46** years of age, *single* with **0** dependent children.

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

Respondent shall be given a credit of **$14,443.45** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$14,443.45**.

ORDER

Respondent shall be given a credit of **$14,443.45** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$14,443.45**.

Respondent shall pay **for treatment rendered during the timeframe of January 12, 2010 through June 30, 2010** for medical services as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses **for treatment rendered during the timeframe of January 12, 2010 through June 30, 2010** directly to Petitioner. Respondent shall pay any unpaid, related medical expenses **for treatment rendered during the timeframe of January 12, 2010 through June 30, 2010** according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

Respondent shall pay Petitioner the sum of **$664.72/week** for a further period of **28.975 weeks**, as provided in **Section 8(d)2** of the Act, because the injuries sustained caused **5.795% loss of use of the person-as-a-whole.**

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

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

Melinda M. Pace Gillman

Signature of Arbitrator

3/9/16

Date

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Tammy Jo Foles
Employee/Petitioner

Case # **10** WC **12960**

v.

Consolidated cases: **N/A**

Sterett Crane & Rigging
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified at the time of arbitration that she sustained an accident on July 12, 2010. She testified that they were tearing down a crane and undoing cables. She testified that she was at the top of the crane holding a cable in place as it was being reeled in, and that the cable went down and began unraveling. She testified that she was holding onto the cable and did not see what happened, but she was pulled down off the catwalk into the hydraulic pump area of the crane. She testified that on the way down, she got caught on one of the walking forms. She testified that her arm was caught, and that she punctured her lung and had broken ribs. She testified that she believed that it was a 15-20 foot fall, and that she mainly landed on her right side.

Petitioner testified that her co-workers thought she was dead, and that by the time they got to her she could not feel anything. She testified that her co-workers tried to provide assistance, but she did not want to be touched. She testified that she eventually went to the physician and found out that she had fractured her 9th, 10th and 11th ribs on her right side, and that she had a lung injury that was either a contusion or a puncture. She also testified that she understood that she had a thoracic contusion to her right side, and that she also had complaints of neck and scapular pain between her shoulder blades. She further testified that her right leg and her whole right side were purple.

Petitioner testified that after her initial evaluation, she was eventually referred to an orthopedic surgeon in Mt. Vernon named Dr. Kovalsky. She testified that Dr. Kovalsky treated her shoulder, ribs and neck. She testified that she was told that her ribs just needed to heal, but that her right shoulder hurt. She testified that Dr. Kovalsky prescribed pain medications which helped her bumps and bruises. She testified that she also underwent therapy, and that her first round lasted approximately six weeks. She agreed that she was released by Dr. Kovalsky in approximately May of 2010. She testified that she did not return to work for Respondent, but rather she worked out of the union hall.

Petitioner testified that after she was released by Dr. Kovalsky, she continued to have problems and was given easier jobs through the hall. She testified that her back and her breathing were bothering her at that time. She testified that she was unable to lift anything and that her shoulder would freeze, and that she continued to see her primary care physician.

Petitioner testified that she believed she underwent three different rounds of physical therapy, and that during one of the courses of physical therapy she became nauseous due to problems in her neck. She

testified that there were times when she went to physical therapy that she became sick to her stomach. She testified that the therapist told her that they could no longer treat her due to a purported issue with a nerve near her heart.

Petitioner testified that she underwent an MRI on March 16, 2012, and that she believed that she had either two or three MRIs performed in total. She further testified that she was seen by Dr. Raskas as well as having gone to an IME at the request of Respondent in St. Louis. She testified that she was not recommended to undergo any surgery, but that she shrank 2 inches due to her "spinal injury."

Petitioner testified that her back constantly hurts, and that she has had pleurisy every November in the same lung that was injured in the accident. Petitioner testified that when she gets up, her leg is numb and oftentimes does not realizes it until she falls. She testified that she has "knots" on her spine that do not hurt unless you touch them, that her right hand is always cold and that she has headaches which also make her neck hurt. She testified that she has not been able to continue working, and that her pain keeps getting worse. She estimated that she only worked 30-35 days in total in the year prior to arbitration.

Petitioner testified that she was not placed under any restrictions by a physician, but she was no longer able to do as much as she used to. She testified that she no longer has her menstrual periods due to the purported injury to her back.

On cross-examination, Petitioner testified that she was an operating engineer, and confirmed that this was also her position when she was hurt in 2010. She agreed that she testified that she fell approximately 15-20 feet, but indicated that she did not lose consciousness. When asked how she got to the emergency room, Petitioner responded that she drove her Jeep first to her house to change her clothes and then to Harrisburg Medical Center. She testified that the entire crew was told to leave after the accident happened. She testified that a friend met her at the emergency room, and she denied having fallen only 3 feet as referenced in the emergency room records.

On cross-examination, Petitioner agreed that her primary care physician referred her to Dr. Kovalsky and that she saw him approximately three times. She denied telling Dr. Kovalsky that she had fallen 4 feet. She agreed that she underwent the physical therapy as recommended by Dr. Kovalsky in 2010. She further agreed that Dr. Kovalsky released her in June of 2010. She testified that her primary care physician ordered that she return to work light duty, and denied having gone back to work full duty at the end of May of 2010. She agreed that at some point she was returned to work on a full duty basis, and that she continued treating with her primary care physician.

On cross-examination, Petitioner testified that she changed primary care physicians due to her physician having been incarcerated. She agreed that she started treating at Primary Care Group in 2012.

On cross-examination, Petitioner agreed that she has always had neck, shoulder and back problems since she fell. She denied having any headaches prior to her fall. She testified that her physician told her that she shrank 2 inches, and that she believed it was the orthopedic specialist who indicated this to her. She testified that she believed her no longer having menstrual periods was related to the fall, but also testified that she is currently age 52.

On cross-examination, Petitioner testified that at the time of her fall she had been prescribed Xanax but only took it as needed. She denied taking any medications for depression or anxiety at the time of her fall, but admitted that she may have been taking medication for insomnia because she was having trouble sleeping. She agreed that she continues to take medications for insomnia, but denied currently taking Xanax.

On cross-examination, Petitioner testified that she currently has issues with her back and her right leg. She agreed that she remembered seeing Dr. Raskas in St. Louis in August of 2012, and she further agreed that her attorney sent her to him. She agreed that she checked off a series of symptoms that she was having on a form provided by his office. She testified that she had needle-like and burning sensations in her right leg.

On cross-examination, Petitioner testified that he has restricted movement in her neck and shoulder. She testified that she recently had a seizure in the middle of the night, and that she "tore" her left arm out of the socket. She testified that she takes Valium daily for her seizures.

On cross-examination, Petitioner denied having been involved in any other accidents or motor vehicle accidents involving her neck, shoulders, back or legs since the fall on January 12, 2010. She further denied having any problems with her neck, shoulders, back or legs prior to the accident of January 12, 2010. She testified that she did, however, have her nose "cut off" by a mirror for which she underwent reconstructive surgery.

On cross-examination, Petitioner testified that she regularly takes blood pressure, insomnia and pain medications on a daily basis. She testified that she has poor circulation in her feet from either a bulging disc or pinched nerve in her back. When asked if anyone told her that she needed further treatment, Petitioner responded that she was told she would need treatment for the rest of her life.

The Application For Adjustment of Claim was entered into evidence at the time of arbitration as Arbitrator's Exhibit 2. The Application alleged injury to the right side of the body, left leg, lumbar spine and neck after a fall on January 12, 2010. (AX1).

The medical records of Ferrell Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that on March 8, 2010, Petitioner underwent x-rays of the right ribs and chest on that date, which were interpreted as revealing (1) healing non-displaced fractures involving the right 9th, 10th and 11th ribs; (2) mild thoracic scoliosis. The records further reflect that on March 16, 2012, Petitioner underwent an MRI of the cervical spine for chronic neck pain, which was interpreted as revealing (1) mild annular disc bulging C5-6 and C6-7with partial thickness intrasubstance annular tear involving the C6-7 intervertebral disc posteriorly associated with a small central broad-based disc protrusion; findings producing mild spinal canal narrowing C5-6 with minimal spinal canal narrowing C6-7; minimal diffuse disc bulging C4-5; (2) mild degenerative changes producing multi-level neural foraminal stenosis; (3) old compression deformities with mild loss of height C5, C6, T1 and T2. (PX1).

The medical records of Harrisburg Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Petitioner was seen on January 12, 2010 after a fall of 3 feet. Petitioner reported that she sustained injury to her back/ribs. Petitioner reported her severity of pain as moderate, and the noted location of pain/injury was that of the mid-back and right ribs. It was noted that Petitioner's neck was non-tender and that she had painless range of motion. It was noted that Petitioner was on top of a crane, pulling a cable and fell between the man walks. The interpretive report for x-rays of the right ribs performed on that date noted an impression of no acute bony abnormality; small benign band of atelectasis versus fibrosis right lung base. The clinical impression was that of a contusion to the ribs/chest and possible right rib fracture. (PX2).

The medical records of Orthopaedic Center of Southern Illinois were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Petitioner was seen on May 19, 2010, at which time it was noted she had been seen at the end of March for injuries she sustained at work. She was diagnosed with a

right shoulder contusion with early adhesive capsulitis and some loss of motion. She had a contusion of her right thorax with some healing rib fractures. She was placed on anti-inflammatories and sent for outpatient physical therapy for aggressive stretching and strengthening for her shoulder, as well as general conditioning exercises. Petitioner stated she went to therapy for about four weeks, and had completed her therapy one week prior. She stated that she was feeling well and stopped taking her prescription medications, that she had some minor aches along her rib cage with no residual shoulder pain and that she was anxious to go back to work. It was noted that clinically Petitioner was doing well, and she was allowed to return to work full duty. Petitioner was instructed to follow-up in four weeks for a repeat examination and tentative discharge. A Work/School Slip was issued on that date, allowing Petitioner to return to work full duty with no restrictions as of May 20, 2010. (PX3).

The records reflect that Petitioner was seen on June 30, 2010, at which time it was noted she had injured herself earlier in the year when she was working with a cable that snapped and threw her to the ground. Petitioner was diagnosed to have a shoulder contusion with early adhesive capsulitis, thoracic contusion and multiple non-displaced rib fractures. It was noted that she was treated with rest, observation, and a short course of physical therapy and returned to work last month. Petitioner stated she had been working full duty and had not missed any time from work, but she did note occasionally she had some right thoracic pain and a difficult time taking a deep breath. She denied any other residual pain. It was noted that Petitioner also had a couple of occasions where she had some stiffness in the lower lumbar region on the right in the mornings not associated with pain. It was noted that Petitioner had not been taking any prescription medications, used over-the-counter anti-inflammatories occasionally and had not missed any time from work. It was noted that at the completion of the office visit, Petitioner stated that starting approximately three weeks ago she woke up with some numbness and tingling in her hand and had numbness and tingling in her hand intermittently since that time. Dr. Kovalsky thought Petitioner may be developing carpal tunnel syndrome, which he indicated was not related to her recent injury. It was noted that if it continued to bother her, she was to make a separate appointment to see Dr. Ahn, the upper extremity specialist. It was noted that as far as Dr. Kovalsky was concerned, the carpal tunnel syndrome was not related to her recent fall and trauma. It was noted that with regard to Petitioner's rib fractures and thoracic and shoulder contusions, the injuries for the most part were resolved and did not require ongoing follow-up and Petitioner was discharged from care. A Work/School Slip was issued on that date, allowing Petitioner to return to work with no restrictions and she was instructed to follow-up as needed. (PX3).

The records reflect that Petitioner was seen on March 31, 2010, at which time she reported having injured herself on January 12, 2010. Petitioner was on a crane holding a cable, her co-worker had the other part of the cable and he moved. It was noted that the cable loosened and fell down, striking Petitioner on the right side of her chest, lower back and right shoulder. It was noted that Petitioner fell approximately 4 feet between the cat walks, landing predominantly on her right side. She complained of pain in the right shoulder, right side of her lower neck and trapezius areas and the upper rib cage, as well as reporting some left-sided pain over the left lumbosacral junction. She denied prior injury or any significant missed time from work for her neck, shoulder or back problems in the past, and it was noted she had been treated with rest and medication. The clinical impression was that of healing fractures of the ribs, right thoracic contusion and contusion of the right shoulder with resultant adhesive capsulitis. It was noted that due to shoulder dysfunction Petitioner was not able to work, and she was referred to physical therapy for aggressive mobilization of the right shoulder as well as some general conditioning exercises. It was noted that Petitioner was to remain off work until re-evaluated in six weeks. A Work/School Slip was issued on that date, noting that Petitioner was to continue off work. (PX3).

The medical records of Norris City Health Clinic were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Petitioner was seen on July 18, 2012, at which time she reported right shoulder, cervical neck and flank pain. She was seen on March 8, 2012, at which time it was noted she

was continuing to have right side rib, shoulder and neck pain. She was seen on February 9, 2012, at which time it was noted that she had been treated for fractures of the right ribs with repeated episodes of pleurisy after a punctured right lung, and that she continued to work for the past five months but was laid off at that time. The assessment was that of right shoulder and rib pain. She was seen on January 13, 2012, at which time she reported constant pain and swelling over the right shoulder and neck. The assessment was that of cervicalgia, generalized anxiety disorder and insomnia. (PX4).

The records of Norris City Health Clinic reflect that Petitioner was seen on May 15, 2012, at which time she reported chronic neck and right scapula pain. She was seen on June 13, 2012, complaining of chronic neck and right scapula pain as the result of an accident at work. She was seen on November 29, 2011, at which time she was seen for right rib fractures. It was noted that it would be two years in February since her injury, and that she had anxiety and insomnia. She was also seen on April 27, 2011, at which time she reported sciatica and right shoulder pain. It was noted that Petitioner had been undergoing physical therapy at Ferrell Hospital for her shoulder and rib injury. The assessment was that of right sciatica, as well as generalized anxiety disorder and insomnia. (PX4).

The records of Norris City Health Clinic reflect that Petitioner was seen on May 25, 2011 at which time it was noted she was seen for chronic sciatica and generalized anxiety disorder. She was seen on June 24, 2011, at which time she complained of constant pain in her chest and lower back. It was noted that she was in settlement negotiations for her case. She was seen on August 27, 2011, at which time it was noted she complained of constant pain in the lower back and that she had periods of anxiety. She was also seen on September 28, 2011, at which time it was noted that she had old fractures of the ribs when she was hurt after a fall on the job. It was noted that Petitioner had chronic right rib pain, as well as generalized anxiety disorder and insomnia. She was also seen on March 28, 2011, at which time it was noted she had constant pain in the lower back due to prolonged sitting. (PX4).

The records of Norris City Health Clinic reflect the Petitioner was seen on April 7, 2011, at which time she complained of pain in her back after she fell doing physical therapy six months ago and that it was now getting worse. She was seen on December 1, 2010, at which time it was noted she was recovering from rib fractures at work. At the time of Petitioner's visit on December 30, 2010, it was noted that she complained of right rib pain when breathing. She was seen on January 31, 2011, at which time it was noted that she had constant pain in the lower ribs on her right side. It was further noted that she was ready to settle her worker's compensation case. She was also seen on February 26, 2011, at which time it was noted that she was back to full duty and had numbness over the right fourth and fifth digits; she also complained of pain in her chest at that time. At the time of Petitioner's visit on September 10, 2010, it was noted that she had some chest pain on her left side for a few days and that she could not move well. It was noted that she had improved but still had some pain over the right side of her chest and was noted to have been working full-time. (PX4).

The records of Norris City Health Clinic reflect the Petitioner was seen on October 9, 2010, at which time it was noted that she was doing fairly well but had ongoing pain over the right chest. At the time of Petitioner's visit on July 2, 2010, it was noted that she had gone back to work full-time without restrictions but had pain over the right side of her chest that was increased with sudden movements. At the time of the office visit on June 10, 2010, it was noted that she had been laid off that day and had some pain over the right shoulder and lower back that was not as bad as before. At the time of her visit on April 20, 2010, it was noted that Petitioner was seen by an orthopedic physician and was advised to undergo physical therapy for six weeks and that she was doing fairly well. At the time of the May 20, 2010 visit, it was noted that Petitioner's right ribs were tender and that she had pain in the right chest. At the time of the visit on March 8, 2010, Petitioner complained of constant pain over the right lower rib area that increased with movement and turning over. (PX4).

The records of Norris City Health Clinic reflect the Petitioner was seen on March 22, 2010, at which time it was noted she was doing a little better but still had pain over the right lower chest that increased with deep inspiration and coughing. At the time of the office visit on January 22, 2010, she complained of continuous pain over the right lower ribs and right thigh where she had a contusion. At the time of the February 5, 2010 office visit, it was noted that she continued to have pain in the right lower chest, could not get comfortable and had difficulty sleeping. At the time of the January 13, 2010 visit, it was noted that she fell off of a piece of heavy machinery the day before and fractured her ribs. It was further noted that she was unable to abduct the right arm greater than 90° without pain. (PX4).

Included within the records of Norris City Health Clinic was an interpretive report for x-rays of the right ribs performed at Ferrell Hospital on June 25, 2010. The x-rays were interpreted as revealing no acute pathology, and it was noted that there were healed rib fractures on the right. (PX4).

Included within the records of Norris City Health Clinic were various letters directed to Travelers Insurance addressing Petitioner's work status. In the letter dated March 24, 2010, it was noted that Petitioner would be off work until her re-check on April 20, 2010. In the letter dated March 10, 2010, it was noted that Petitioner would be off work until her re-check on March 22, 2010. In the letter dated February 25, 2010, it was noted that Petitioner was to be off work until released, and that her next appointment was scheduled for March 6, 2010. Also included within the medical records was a letter dated February 3, 2010 directed to Sterett Crane & Rigging, referencing that Petitioner was to be off work for the time frame of January 12, 2010 through February 5, 2010. (PX4).

The medical records of Deborah Davis, APN/Primary Care Group were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. Petitioner was seen on July 23, 2012, related to an endometrial biopsy. She was issued a prescription for Hydrocodone-Acetaminophen on July 11, 2012 with a noted diagnosis of cervicalgia. She was seen on May 11, 2012, at which time she presented with neck pain. She reported that her symptoms included neck pain, neck stiffness and shoulder pain, and that the symptoms were located in the entire neck. It was noted that she described the pain as aching, and that her symptoms were exacerbated by turning the head to the left. It was noted that any neck movement made Petitioner nauseous. (PX5).

Included within the records of Primary Care Group were physical therapy notes, including those for date of service of May 8, 2012 at which time Petitioner reported that lifting her arms overhead increased her nausea. Petitioner was seen on May 3, 2012, at which time she stated that she had not been moving her right arm that much, but noted increased pain with painting at home. It was noted that Petitioner's symptoms were located in the right mid-trapezius and levator scapulae and radiated down into the right upper extremity. She was also seen on May 1, 2011, at which time she reported that her stomach seemed to flare-up when she rotated her head. At the time of Petitioner's therapy visit on April 23, 2012, it was noted that the majority of her pain was in the right side of her neck/shoulder. At the time of the visit on April 20, 2012, Petitioner reported her symptoms as sharp and aching, and indicated that her symptoms were located in the right shoulder and cervical spine and were relieved with nothing. It was noted that Petitioner's symptoms were exacerbated by use of the controls on her crane. (PX5).

The records of Primary Care Group reflect the Petitioner was seen on April 18, 2012, at which time she was noted to be changing primary care physicians. It was noted that on January 12, 2010, Petitioner fell from the top of a crane, that she was holding a large cable and that when she dropped the cable she fell over 20 feet and ended up with a punctured long and broken ribs. Petitioner stated she needed an MRI and that her injuries had never healed. She was referred for therapy for a cervical disc disorder. (PX5).

The IME report of Dr. David Raskas/Orthopedic Sports Medicine & Spine Care Institute dated August 1, 2012 was entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The IME report indicated that Petitioner was seen for an independent medical evaluation on that date, and that she reported having been injured 2½ years ago when she fell approximately 20 feet off a crane. Petitioner stated that she was taken to the emergency room where she was seen and evaluated, and that she was told she had some broken ribs and was released. It was noted that approximately one week later she saw her primary care physician and was noted to have a pneumothorax. Her only treatment was physical therapy, and she eventually went back to working full duties until the job ceased in November 2011. It was noted that Petitioner's pain complaints were fairly diffuse, and that most of the aching that she had was diffuse throughout her body. It was noted that it included her head, neck, thorax, the front and back of both legs, and the front and back of both arms. Petitioner stated that the numbness sensation was increasing, and that all of her symptoms were getting worse throughout mostly the right side of her body. (PX6).

The IME report reflected that Dr. Raskas noted that Petitioner could do housework, sit, stand, get dressed, drive and walk with activities of daily living, and that she stated it was much worse getting out of bed in the morning. He noted that Petitioner rated her pain on the date of the examination at a 9/10, and that she denied any history of any prior back problems, back injuries, neck injuries, shoulder injuries or anything of significance. He noted that Petitioner presented with a very diffuse pattern to her aches and numbness for which he could not offer one diagnosis that would explain her symptoms. He further noted that her MRI findings of her cervical spine did not create significant spinal cord compression or anything of that nature that would cause her symptoms. (PX6).

The IME report reflected that Petitioner was not hyperreflexic and exhibited no myelopathic signs. Dr. Raskas noted that he was somewhat concerned about Petitioner's Benzodiazepine use on a chronic basis that predated the injury. He noted that he was at a loss to explain Petitioner's subjective complaints based upon any of the objective data that had been provided, and he noted that he was not sure based upon the pattern of her subjective complaints that any further testing was likely to result in any meaningful discoveries or ideas for treatment. He noted that Petitioner was at maximum medical improvement and he did not necessarily see the need for any restrictions. (PX6).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 7.

The IME report of Dr. Ralph/South County Orthopedics and Sports Medicine dated September 9, 2013 was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The IME report noted that Petitioner was involved in a work-related accident when she fell at work on January 12, 2010. It was noted that Petitioner's injury at the time was to her lower right ribs, and that she was ultimately diagnosed with having fractures of the lower three levels. It was noted that at the time of the IME, Petitioner complained of pain in her lower back, head and neck. She also complained of some numbness in her right upper extremity as well as pain in her right lower back area radiating down the right leg. It was noted that there were no previous complaints made with regard any problems going down the right leg, and that x-rays taken on the day of the examination were within normal limits. Dr. Ralph noted that Petitioner reported that she was told that she has right carpal tunnel syndrome, the diagnosis with which he agreed but he noted was unrelated to the events of January 12, 2010. (RX1).

The IME report reflected that Dr. Ralph's diagnoses were that of (1) status post work-related injury which caused fractures of the lower right ribs, which subjectively and objectively were resolved; (2) subjective complaints of the right and left lower extremity with no objective physical findings; (3) right carpal tunnel syndrome unrelated to the events of January 12, 2010. Dr. Ralph noted that the medical documentation supported a causal relation between the resolved fractured right ribs and lung contusion as well as the resolved right adhesive capsulitis and the work accident, but it did not support any other

injury. Dr. Ralph opined that no orthopedic treatments were reasonable and necessary for the accident, although he did feel that Petitioner certainly had a right to have her back "worked up" further although he doubted it would show anything of significance. He further indicated that he believed Petitioner had right carpal tunnel syndrome which may be symptomatic enough to require surgical treatment, but it was unrelated to the events of January 12, 2010. Dr. Ralph opined that Petitioner had a 0% permanent physical impairment, and that from a functional and orthopedic standpoint, Petitioner had no residual dysfunction. He further opined that Petitioner had reached maximum medical improvement. (RX1).

CONCLUSIONS OF LAW

With respect to disputed issue (F) pertaining to causal connection, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that the three rib fractures, resolved lung contusion and right adhesive capsulitis is causally related to the work accident of January 12, 2010, but has failed to prove that any other conditions of ill-being are causally related to the work accident of January 12, 2010.

The Arbitrator notes that Dr. Ralph noted that the medical documentation supported a causal relationship between the resolved fractured right ribs and lung contusion as well as the resolved right adhesive capsulitis to the accident, but it did not support any other injury. (RX1). Dr. Raskas noted that Petitioner presented with a very diffuse pattern to her aches and numbness for which he could not offer one diagnosis that would explain her symptoms, and further noted that he was at a loss to explain Petitioner's subjective complaints based upon any of the objective data that had been provided. (PX6). As a result thereof, the Arbitrator finds the opinion of Dr. Ralph to be persuasive after considering the record as a whole, and therefore finds that only the three rib fractures, resolved lung contusion and right adhesive capsulitis is causally related to the work accident of January 12, 2010.

With respect to disputed issue (J) pertaining to necessary medical services, the Arbitrator finds that Petitioner's medical treatment up to June 30, 2010 is causally related to the work accident of January 12, 2010, but that any medical treatment received subsequent to June 30, 2010 is not causally related to the accident of January 12, 2010. The Arbitrator finds it to be significant that June 30, 2010 was Petitioner's last date of treatment with Dr. Kovalsky, at which time it was noted that with regard to Petitioner's rib fractures and thoracic and shoulder contusions, the injuries were resolved and did not require ongoing follow-up and Petitioner was discharged from care. (PX3). As a result thereof, the Arbitrator finds that Respondent is liable only for the reasonable and necessary medical treatment incurred up to June 30, 2010, and that Respondent is not liable for any medical treatment received after June 30, 2010 in reliance upon the opinions of Dr. Kovalsky.

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, the Arbitrator finds that while the treatment records are supportive of the three rib fractures, lung contusion and right adhesive capsulitis as being causally related to the underlying accident, the treatment records in this case are not supportive of or consistent with the multitude of Petitioner's subjective complaints as testified to at the time of arbitration. Based on the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 2% loss of use of the person-as-a-whole as provided in Section 8(d)2 of the Act for the three rib fractures and resolved lung contusion, as well as an additional 3.795% loss of use of the person-as-a-whole as provided in Section 8(d)2 of the Act for the right shoulder adhesive capsulitis, for a total permanent partial disability of 5.795% loss of use of the person-as-a-whole.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Trinity Hawkins,

Petitioner,

vs. NO. 10WC040062

Sodexo,

Respondent.

16IWCC0766

DECISION AND OPINION ON REVIEW

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

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

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $12,000.00. 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: NOV 2 3 2016
SJM/sj
o-10/27/2016
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HAWKINS, TRINITY
Employee/Petitioner

Case# **10WC040062**

16IWCC0766

SODEXO
Employer/Respondent

On 2/26/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.45% 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:

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

2337 INMAN & FITZGIBBONS LTD
KEVIN DEUSCHLE
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

16IWCC0766

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

TRINITY HAWKINS
Employee/Petitioner

Case #10 WC 40062

V.

SODEXO
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on December 21, 2015, and February 1, 2016. After reviewing all of the issues, the stipulations of the parties and the evidence, it is hereby found and ordered as follows:

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

L. ☒ What is the nature and extent of injury?

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

N. ☐ Is the respondent due any credit?

O. ☒ Chain of referrals/Choice of physicians?

FINDINGS

- On September 21, 2010, the respondent was operating under and subject to the provisions of the Act.

- On this date, an employee-employer relationship existed between the petitioner and respondent.

- In the year preceding the injury, the petitioner earned $15,908.88; the average weekly wage was $305.99.

- At the time of injury, the petitioner was 32 years of age, single with one child under 18.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $253.00/week for 22-1/7 weeks, from September 22, 2010, through February 23, 2011, which is the period of temporary total disability for which compensation is payable.

- The respondent shall pay the petitioner the sum of $253.00/week for a further period of 25 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 5% of the man as a whole for the injuries to her right elbow/arm, neck and back.

- The respondent shall pay the petitioner compensation that has accrued from September 21, 2010, through February 1, 2016, and shall pay the remainder of the award, if any, in weekly payments.

- The medical care rendered the petitioner for her right elbow/arm, neck and back was reasonable and necessary and is awarded. The medical care rendered the petitioner for right elbow/arm, neck and back after May 4,2011, and the medical care rendered for insomnia, headaches, anxiety and other conditions at St. Catherine was not reasonable or necessary and is denied. The respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act and shall

hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

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

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

Robert E. Williams

2016February 26, 2016
Signature of Arbitrator

February 16,

Date

FEB 26 2016

FINDINGS OF FACTS:

On September 22, 2010, at midnight, the petitioner, a menu specialist, received emergency care at University of Chicago Medical Center with Dr. David Trotter and reported working in the sub-basement at the University of Chicago when a few men broke through a window and pushed her to the ground. The petitioner reported right arm pain from getting her arm caught between an air conditioner unit and lower back and neck pain after an assailant stepped on her back. An x-ray of her right humerus was normal. The physical exam revealed right elbow pain and mild lower back pain elicited away from the midline bilaterally. The petitioner gave a statement to Stephanie Malak on September 24th and reported injuries to her lower back, neck and right arm at the elbow area. On September 24th, the petitioner saw Dr. Earl Thornton at Dr. Earl B. Thornton & Associates for neck, back and right arm pain and reported that an air conditioner fell on her at work. Dr. Thornton's diagnoses were lumbar and cervical strains and right upper extremity contusion. She was prescribed nonsteroidal anti-inflammatory medications and activity restrictions and given infrared and massage therapy. She had repeat therapy modalities on the 27th and 30th and on October 1st and 5th.

The petitioner started care with Dr. Forman on October 11th, however, his treatment notes are not in evidence. Dr. Forman reported on November 10th that the petitioner complained of intermittent sharp neck pain, constant sharp low back pain and constant soreness of her upper arm and elbow for which he recommended warm soaks, a TENS unit, pain management, epidural injections and no work. Dr. Forman's impressions were post-traumatic cervical and lumbar spine strains and right arm/elbow strain/contusion. The doctor opined that MRIs showed posterior disc bulge/herniation at

C4-5 and a posterior disc herniation at L4-S1 with central stenosis and indenting the ventral surface of the thecal sac. The petitioner was given pain medication and muscle relaxers. The petitioner saw Dr. Mehta at Instant Care Medical Group on October 22nd for sharp lower back pain with bilateral radiation into her legs and up to her neck and arms. Dr. Mehta gave the petitioner an L5-S1 interlaminar epidural steroid injection on November 16th.

On December 5, 2010, the petitioner sought emergency care at St. Catherine Hospital in Indiana for chronic headaches. Diagnostic testing of her brain and head revealed abnormalities. The petitioner was discharged on December 7th with a final diagnosis of chronic daily headaches/narcotic rebound headache, anxiety, vaginal bleeding and history of seizure disorder. The petitioner reported continued headaches, low back pain and neck pain to Dr. Amit Mehta on December 14th and followed up again on January 11, 2011, and February 22, 2011.

Dr. Forman noted in an addendum report on May 5, 2011, that he saw the petitioner on April 6, 2011, and May 4, 2011, and that her symptoms persisted. The petitioner was discharged. The petitioner sought emergency care at St. Catherine Hospital on July 23, 2011, for right-sided headaches for four hours radiating down her right neck and to the back of her head. The petitioner returned for emergency care at St. Catherine Hospital on September 19, 2011, for insomnia and headaches.

At the request of the respondent, the petitioner was evaluated by Dr. Graf on August 26, 2015. Dr. Graf opined that the cervical and lumbar MRIs revealed mild disc degenerative changes with desiccation and a slight bulging at L5/S1 and no evidence of a disc herniation or nerve root encroachment for either the cervical or lumbar spine. The

doctor further opined that the petitioner had no objective neurological findings, that three to four weeks of conservative care was reasonable, that she has no work restrictions and that the medical care rendered was excessive.

FINDING REGARDING THE DATE OF ACCIDENT AND WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF THE EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner proved that she sustained an accident on September 21, 2010, arising out of and in the course of her employment with the respondent. While performing her duties at work, the petitioner sustained injuries to her right elbow/arm, back and neck when intruders pushed an air conditioner from a window onto her and someone stepped on her back when she fell. The incident was not an indiscriminant, a total chance or random occurrence that is not compensable under the positional-risk doctrine. For whatever their reasons, the intruders made a decision to enter the respondent's workplace through the window causing the petitioner to panic, resulting in her falling, stepped on and injured.

FINDINGS REGARDING WHETHER TIMELY NOTICE WAS GIVEN TO THE RESPONDENT:

The respondent received timely notice of the petitioner's injury. An Application of Claim was filed on October 18, 2010, with a notice to the respondent on October 19, 2010.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for her right elbow/arm, neck and back was reasonable and necessary and is awarded. The medical care rendered the petitioner for her right elbow/arm, neck and back after May 4,2011, and the medical care rendered

at St. Catherine for her insomnia, headaches, anxiety and other conditions was not reasonable or necessary and is denied.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that the current condition of ill-being with right elbow/arm, neck and back is causally related to the work injury. The petitioner failed to prove that her condition of ill-being with her insomnia, headaches, anxiety and other medical conditions is causally related to the work injury.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

The respondent shall pay the petitioner temporary total disability benefits of $253.00/week for 22-1/7 weeks, from September 22, 2010, through February 23, 2011, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The respondent shall pay the petitioner the sum of $253.00/week for a further period of 25 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 5% of the man as a whole for the injuries to her right elbow/arm, neck and back.

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

Dan Tuttle,

Petitioner,

vs. NO. 10WC038615

The Pacific Company,

16IWCC0767

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, causal connection, notice, repetitive trauma, penalties and fees, permanent disability, temporary disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 28, 2015 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: NOV 2 3 2016
SJM/sj
o-11/17/2016
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TUTTLE, DAN
Employee/Petitioner

Case# **10WC038615**

THE PACIFIC COMPANY
Employer/Respondent

16IWCC0767

On 7/28/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% 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:

0786 BRUSTIN & LUNDBLAND LTD
CHARLES E WEBSTER
10 N DEARBORN ST 7TH FL
CHICAGO, IL 60602

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

16IWCC0767

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

DAN TUTTLE
Employee/Petitioner

Case #10 WC 38615

v.

THE PACIFIC COMPANY
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on April 24 and June 29, 2015. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

L. ☒ What is the nature and extent of injury?

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

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On May 12, 2009, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- In the year preceding the injury, the petitioner's average weekly wage was $1,384.78.
- At the time of injury, the petitioner was 47 years of age, single with no children under 18.

ORDER:

- The petitioner failed to provide notice of a work injury to the respondent within 45 days pursuant to Section 6(c) of the Act.
- The petitioner failed to prove that he sustained an accident on May 12, 2009, arising out of and in the course of his employment with the respondent.
- The petitioner's request for benefits is denied and the claim is dismissed.

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

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

Robert E. Williams
Signature of Arbitrator

July 28, 2015
Date

JUL 28 2015

FINDINGS OF FACTS:

The petitioner received emergency care for chronic mild right shoulder pain at Good Samaritan Hospital around 5:15 pm on May 12, 2009. He reported having a right rotator cuff surgery five years earlier and being awakened at 3:00 am that morning with severe pain in his right shoulder with movement that improved. He further reported using a 90-pound jackhammer for about 45 minutes later in the day and having his right shoulder pain increase again. Right shoulder and cervical x-rays revealed a cervical disc disease but no fractures. The diagnosis was acute bursitis/tendonitis of the right shoulder and possible cervical radiculopathy with cervical muscle spasm. On May 13th, the petitioner saw Dr. Lawrence Lieber at M&M Orthopedics and reported severe posterior shoulder, neck and right upper extremity pain and numbness not associated with any traumatic event that developed the prior night. Dr. Lieber's impression was cervical radiculitis. Physical therapy was prescribed. On May 27th, the petitioner reported some temporary relief with a Medrol Dosepak. Dr. Lieber opined that a cervical spine MRI on June 1st confirmed evidence of a herniated disc at C6-7, consistent with the petitioner's right arm discomfort, a ridge complex at C5-6 and a left paracentral herniation at C4-5. Dr. Dalip Pelinkovic at M&M Orthopedics saw the petitioner on June 12th and noted complaints of posterior right upper arm and ulnar forearm pain. Dr. Pelinkovic's diagnosis was right C7 radiculopathy for which he recommended an anterior cervical discectomy and fusion at C6-7. The petitioner declined surgery at that time.

On May 26th, the petitioner sought chiropractic care with Dr. James R. Lovell at American Chiropractic and Pain for constant moderate right neck pain, constant moderate throbbing, sharp and achy pain radiating to his posterior right upper shoulder and right

medial upper thoracic region and constant moderate right arm numbness. The petitioner reported that he woke out of sleep with it and that there was no injury.

The petitioner participated in Taekwondo in 2009 and earned a red/black belt on July 14, 2009, and a black belt on October 30, 2009. The petitioner received chiropractic modalities through June 21, 2010, at which time he reported some improvement in his right neck area and a slight increase in the severity of his right arm numbness. Dr. Lovell noted that the petitioner was at MMI.

Dr. Steven Mather at M&M Orthopedics saw the petitioner on July 26, 2010, and noted that the petitioner had received 8 to 10 months of chiropractic care with minimal improvement. Dr. Mather's diagnosis was a right C6-7 disc herniation and on September 22nd he performed a C6-7 anterior cervical discectomy, decompression and anterior cervical fusion. The petitioner reported on September 27th that his arm pain had resolved. Dr. Mather discharged petitioner from his care and released him to return to full-duty work on January 7, 2011. Dr. Mather noted on February 11, 2011, that the petitioner had some right neck discomfort if he overdoes it. The petitioner was released to normal activities.

The petitioner moved to Florida and on June 24, 2013, sought care with Costal Orthopedics for left shoulder pain. On August 27, 2013, he had a left shoulder manipulation, arthroscopic SLAP repair and debridement. He had check-ups and therapy through November 6, 2013.

The petitioner reported neck pain to the DuPage Medical Group on April 10, 2014. X-rays the same day revealed no instability or scoliosis, diffuse flowing

spondylosis and diffuse facet arthropathy. The petitioner reported neck pain to Dr. Mather on April 14, 2014, whose impression was cervical spondylosis.

At the request of respondent, Dr. Wehner evaluated the petitioner on February 7, 2011, and reviewed medical records on April 8, 2014. Dr. Wehner's diagnosis was neck pain, cervicaliga and multilevel disc degeneration. Dr. Wehner opined that the petitioner was not injured at work while using a jackhammer and that he could return to full work duties with respect to his cervical and right shoulder complaints.

FINDING WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF THE EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that he sustained an accident on May 12, 2009, arising out of and in the course of his employment with the respondent.

The history the petitioner gave at Good Samaritan Hospital was chronic right shoulder pain since a prior right shoulder surgery and waking up at 3:00 am on May 12, 2009, with severe pain in his right shoulder that improved and worsened again after using a 90-pound jackhammer for 45 minutes. The petitioner denied any traumatic event to Dr. Lieber on May 13, 2009. The petitioner told Dr. Pelinkovic on June 12, 2009, that his symptoms started on May 12, 2009, without any trauma. Dr. Lovell noted on May 26, 2009, that the petitioner reported awakening out of sleep with pain and that there was no injury. On July 26, 2010, the petitioner reported on an in-take questionnaire at Dr. Mather that there was no work injury. After reviewing the emergency medical records, Dr. Mather admitted at his deposition that his opinions were speculative since he believed it was an acute injury due to the use of a jackhammer. He stated further that since the petitioner had significant pain before going to work, he could not give an opinion within

a reasonable degree of medical and surgical certainty that the petitioner's injury was caused by his work duties on May 12, 2009.

The testimony of Janice Gendron and Herman Bradshaw also belie the petitioner's testimony of a work injury on May 12, 2009. Mr. Bradshaw worked with petitioner on May 12, 2009, and did not see the petitioner display any discomfort or hear of any complaints. Ms. Gendron saw petitioner in the office after his return from the worksite on May 12, 2009, and at Good Samaritan Hospital after he called her. Even though he was asked by Ms. Gendron, the petitioner did not report that his condition was due to an injury at work. The petitioner continued to work and perform his regular duties with respondent and engaged in Taekwondo activities and earned a black belt by the end of 2009. The petitioner is not credible. The opinions of Dr. Chmell are not consistent with the evidence and are simply conjecture. The petitioner's request for benefits is denied and the claim is dismissed.

FINDINGS REGARDING WHETHER TIMELY NOTICE WAS GIVEN TO THE RESPONDENT:

The petitioner failed to prove that the respondent received timely notice of his injury. Mr. Bradshaw and Ms. Gendron denied that the petitioner reported a work injury on May 12, 2009, even when Ms. Gendron specifically inquired whether his cervical and arm symptoms were due to his work duties. Nor did the petitioner indicate a work injury to the medical providers at Good Samaritan Hospital or M&M Orthopedics or to Dr. Lovell. Ms. Gendron's first notice of the petitioner's claim of a work injury on May 12, 2009, was a fax from M&M Orthopedics in July 2010. The petitioner failed to provide notice of a work injury to the respondent within 45 days pursuant to Section 6(c) of the Act. The petitioner's request for benefits is denied and the claim is dismissed.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that his current condition of ill-being is causally related to a work injury.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ilinka Mijatovic,

Petitioner,

vs. NO. 11WC006773

Hyatt Corporation D/B/A Hyatt Regency O'Hare, 16IWCC0768

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 9, 2015 is hereby affirmed and adopted.

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

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

No bond is required for 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: NOV 2 3 2016
SJM/sj
o-11/17/2016
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MIJATOVIC, ILINKA
Employee/Petitioner

Case# **11WC006773**

HYATT CORPORATION D/B/A HYATT REGENCY O'HARE
Employer/Respondent

16IWCC0768

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

If the Commission reviews this award, interest of 0.27% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

2461 NYHAN BAMBRICK KINZIE & LOWRY
JIM A MORAN
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

16IWCC0768

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

ILINKA MIJATOVIC,
Employee/Petitioner
v.

Case # **11 WC 06773**

Consolidated cases: ___

HYATT CORPORATION D/B/A HYATT REGENCY O'HARE,
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 **KETKI STEFFEN**, Arbitrator of the Commission, in the city of **CHICAGO**, on **June 9, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

ICArbDec 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 **4/21/2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$29,780.02**; the average weekly wage was **$572.71**.

On the date of accident, Petitioner was **58** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

Temporary Total Disability

Petitioner failed to meet her burden in proving entitlement to temporary total disability benefits.

Medical benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$1,819.79** to **Advanced Occupational Medicine**, **$3,085.46** to **Athletic Imaging, Inc.**, **$441.13** to **Integrated Pain Management**, **$190.14** to **Loyola Univeristy Medical Center**, **$857.39** to **Loyola University Physicians Foundation**, **$(517.47-overpayment)** to **Midwest Orthopedics at Rush**, **$549.55** to **Suburban Orthopedics**, and **$1,323.00** to **Injured Workers Pharmacy** as provided in Sections 8(a) and 8.2 of the Act.

Permanent Partial Disability: Person as a whole

Respondent shall pay Petitioner permanent partial disability benefits of **$343.63**/week for **35**weeks, because the injuries sustained caused the 7% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Kelli Shroff Steffen
Signature of Arbitrator

9/8/15
Date

ICArbDec p. 2

SEP 9 - 2015

FACTUAL HISTORY

The Petitioner, Illinka Majatovic, was 57 years of age and was injured on April 21, 2010 when working for the Respondent. She testified in court with the assistance of a Serbian interpreter. The accident is not in dispute. Petitioner testified that her duties with the Respondent involved cleaning, dishwashing, and work in the kitchen. She testified that she felt pain in her leg and back as she was pushing a cart filled with dishes. She was unable to continue working the rest of the day.

Petitioner returned to work and was placed on light duty and continued to work through January, 2011. She testified her treating physician took her off work on January 25, 2011 and she has not worked since that time.

Shortly after her injury Petitioner had obtained medical care at Advance Occupational Medicine. The attending physician diagnosed a lumbar sprain and recommended home exercises as well as lifting, pulling and bending restrictions. She was also prescribed a back brace and pain medications as needed. Petitioner provided a medical history of her work injury and denied prior injuries. The medical records introduced at trail show a prior history of low back injury.

Prior Medical History

The records from Petitioner's family physician, Dr. Boblick show lower back treatment beginning on May 6, 2007, two years before the accident. On that date, the Petitioner reported that she had injured her lower back, had gone to the emergency room, and was in severe pain. (PX 4, pp. 19-20). She followed up on May 16, 2007 and was placed on a five-pound lifting restriction. The Petitioner continued to treat and

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on July 23, 2007 was diagnosed with degenerative disc disease with a likely herniated disc at L4-L5, osteoarthritis, and radiculopathy. The doctor noted self-limited episodes of low back pain in the past. The Petitioner sought treatment throughout 2009. On May 29, 2009, she was diagnosed with osteoarthritis. (PX 4, pp. 47-48). She underwent lumbar X-rays which were negative. (PX 4, p. 156). She treated through the end of that year.

On December 17, 2009, the Petitioner was seen by a Dr. Fisher who noted lower back pain into the right buttock and thigh. The Petitioner described a four-year history of lower back pain in the same area. (PX 4, pp. 64-65). Dr. Fisher placed a 10 pound lifting restriction. (PX 4, p. 177). On December 26, 2009, Dr. Boblick placed a permanent work restriction of no lifting more than 20 pounds. The Petitioner testified the Respondent accommodated light duty throughout the course of this case.

Medical Treatment following the 4/21/10 Accident

On May 3, 2010 Petitioner returned to Advanced Occupational Medicine and her light duty limitations were continued. She testified that she used her back brace and pain medication.

Conservative management and follow up at Advanced Occupational Medicine continued through May of 2010.

On May 17, 2010, Petitioner underwent an MRI of the lumbar spine which showed mild multi-level spondylosis, most notable at L2-L3. It also revealed bulging disc at T12-L1; bulging disc eccentric to the left causing mild left neuroforaminal stenosis at L1-2; at L2-3 disc bulges caused mild central stenosis and mild to moderate right neuroforaminal stenosis; L3-4 disc bulge is shallow or superimposed left

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paracentral foraminal protrusion, mild facet hypertrophy causing left sub intra articular zone stenosis with mild left neuroforaminal stenosis, right neuroforamen, patently open. On May 17, Petitioner's family physician, Dr. Boblick, read the MRI and opined that it revealed multi-level spondylosis, most notably at L2-3; levoscoliosis with apex at L2-3 and Cobb angle of 22 degrees; epidural fat prominent at L5 through inferior aspect of the visualized portion of the spinal canal consistent with epidural lipomatosis. Petitioner's light duty prescription was extended and return to work limitations were increased limiting lifting only to seven pounds push/pull/lift, avoid climbing stairs, wear her back brace and do therapy three times a week for two weeks and take prescribed medications. Petitioner complied with those recommendations and continued conservative care.

On June 3, 2010, Petitioner's attending physicians referred her to Dr. Salehi for consultation. The doctor's suspected lumbosacral spondylosis. He found her symptoms consistent with right lumbar radiculopathy L5-S1 distribution secondary to lumbosacral spondylosis. Dr. Salehi place her on lifting, pulling, standing and bending restrictions and returned her to work. Petitioner continued to work light duty limitations and physical therapy continued during the month of June 2010.

On June 23, 2010 Petitioner returned to Dr. Salehi who recommended continuation of therapy and epidural steroid injections, continued the light duty limitations and no lifting greater than 20 pounds, no pushing/pulling more than 35 pounds, no repetitive bending and twisting and to alternate sitting/standing every 35 to 45 minutes. Petitioner continued working light duty.

On July 14, 2010 Petitioner was examined by Dr. Tian Xia for pain management.

She complained of pain, mostly on the right side of the back with radiation to the right leg. Dr. Xia reviewed the MRI film and concurred with the prior diagnosis and opined that the back pain is probably caused by facet impingement at L3-4, L4-5 and L5-S1 on the right side. He opined patient's leg pain is probably due to significant L2-3 foraminal stenosis due to disc herniation which is not noted by the radiologist but noted by Dr. Xia. The doctor's treatment recommendations included a right L3-4, L4-5 and L5-S1 facet joint injection as well as right L2-3 and bilateral L5-S1 transforaminal selective nerve root injection for pain control with repeating of said procedure in the future as needed. Dr. Xia also recommended continued use of the lumbar brace. Petitioner continued with her light duty job.

IME DR. Ghanayem-August 4, 2010

On August 4, 2010, the Petitioner was examined by IME Dr. Ghanayem at Loyola Medical Center. He opined that she suffered a lumbar strain which aggravated an underlying degenerative arthritis. He recommended therapeutic exercise and appropriate use of non-narcotic medication, and released her back to her 20 pound pre-injury lifting restriction. Dr. Ghanayem's impression was, "Ms. Mijatovic appears to have sustained lumbar strain/aggravation of her underlying degenerative arthritis from her lifting injuries, as have been documented in the records and as described. She has residual mechanical low back pain." Dr. Ghanayem placed a 20 pound lifting limit based on her age and physical condition. He opined she has reached maximum medical improvement.

Dr. Fetzer and Dr. Bender

Petitioner continued to work within her restrictions and was referred to Midwest

Orthopedics for an evaluation. On September 3, 2010 she was examined by Dr. Fetzer. He doctor reviewed the diagnostic studies and diagnosed that Petitioner suffers from right axial back pain, lower limb radicular pain, consistent with lumbar radiculitis and underlying degenerative disc disease predominantly at L2-3. Dr. Fetzer opined that since she had already failed trial therapy to begin epidural steroid injections on the right at the L4 level.

On September 10, 2010 Petitioner underwent epidural steroid injections. Petitioner complained that her pain had worsened from the injections and Dr. Fetzer provided her with return to work limitations of no lifting, no squatting and continuous wearing her back brace.

Petitioner also had a follow up on September 25 with Dr. Bender. Her work limitations were and she was asked to attend physical therapy three times a week.

Petitioner returned to Dr. Fetzer at Midwest Orthopedics on September 29, 2010. His records indicate that the Petitioner complained that her symptoms has worsened.

The Petitioner continued the injection treatment with Dr. Fetzer through October, 2010 and Dr. Fetzer opined that Petitioner's condition was causally related to her work accident.

Petitioner continued to follow up at Advanced Occupational and completed additional therapy as recommended.

On November 15, 2010 Petitioner returned to Dr. Fetzer who opined Petitioner was able to work with restrictions full time and indicated a lifting limit 10 pounds, limit push, pull, alternate sitting, standing 30 minutes per hour, and minimal bending or stooping, no ladder, no chair climbing. On December 30, 2010 Petitioner returned to

Dr. Bender who examined her and diagnosed lumbago, sacroiliitis, paraspinous muscle spasms, scoliosis, right leg paresthesias with no change to the right greater trochanteric bursitis. He recommended continuing modified duty and commented that Petitioner was to return to Dr. Alexander Ghanayem on January 14, 2011 for a second independent medical evaluation.

MRI September 23, 2010

During the course of her treatment Petitioner also underwent an MRI of the lumbar spine on September 23, 2010 at Athletic Imaging. The radiologist noted: 1) leftward lumbar curvature; 2) T12-L1 disc space narrowing, global disc bulge, mild bilateral neuroforaminal narrowing; 3) L1-2 global disc bulge and moderate narrowing; 4) L2-3 disc narrowing, right endplate, global bulge also present on the left, moderate to severe right sided neuroforaminal narrowing, mild degree central canal stenosis noted; 5) L3-4 bulges but basically normal.

IME DR. Ghanayem-January 14, 2011

Dr. Ghanayem examined the Petitioner and reviewed the additional medical data. He opined that Petitioner's condition was degenerative arthritis involving the lumbar spine and he now noted non-organic behaviors. He further opined that he saw no objective reason for the symptoms and that an ample course of therapy for a lumbar strain and possible aggravation of degenerative arthritis of the back had been given. He opined Petitioner was at MMI and should be able to return to her pre-injury regular duty status.

Release to Regular Work Duty by Dr. Bender

On January 18, 2011 Dr. Bender examined the Petitioner and opined that she

could return to regular duty but recommended she continue to wear her back support.

On February 7, 2011, Dr. Bender reconfirmed that Petitioner could return to regular duty but should wear the low back brace. He also provided a prescription for Celebrex.

Continued Treatment With Dr. Boblick

After her release by Dr. Bender and Dr. Ghanayem, Petitioner returned to Dr. Boblick for treatment on January 25, 2011. Dr. Boblick opined that Petitioner is not able to return to work. In the spring of 2010, Petitioner returned to Dr. Boblick who prescribed an MRI.

MRI-February 15, 2011

Petitioner underwent on an additional MRI scan of the lumbar spine. The radiologist reveals the following findings:

Degenerative changes of the facet joints at L1-2 without significant central stenosis and mild bilateral foraminal narrowing.

At L2-3, bilateral facet hypertrophic changes and ligamentous redundancy results in mild to moderate central disc stenosis or mild right foraminal narrowing.

At L3-4, minimal posterior bulge of the disc without significant central canal stenosis and mild to moderate bilateral foraminal narrowing.

At L4-5 disc demonstrates normal morphology with no evidence of herniation; no central canal stenosis or foraminal impingement.

At L5-S1, disc demonstrates normal morphology with no evidence of disc herniation; no central canal stenosis or foraminal impingement.

Overall impression: Degenerative changes as noted with foraminal narrowing

L1-2, L2-3 and L3-4.

FMLA and No Return to Work

On February 11, 2011 Dr. Boblick completed FMLA documentation indicating Petitioner's condition commenced in April 2010 and was permanent in nature. Petitioner indicated that she has been incapacitated since January 25, 2011 to the present time and not able to work. Petitioner claims temporary total disability due and owing for the period January 25, 2011 through the date of hearing on June 9, 2015, a total of 227-2/7ths weeks. Respondent had not paid TTD benefits and is denying liability.

Dr. McNally

Petitioner was also referred by Dr. Boblick to Dr. McNally. Dr. McNally concurs with Dr. Boblick regarding the diagnosis of lumbar spinal stenosis, lumbosacral spondylosis and scoliosis. Dr. McNally also opined that the work related injury of April 2010 aggravated and accelerated the pre-existing previously asymptomatic degenerative lumbar spinal condition and caused it to become symptomatic and require treatment. Dr. McNally prescribed additional diagnostics screening.

IME Dr. Jesse Butler-2012

Petitioner was given an independent medical examination by Dr. Jesse Butler. Dr. Butler diagnosed a lumbar strain and multi-level degenerative arthritis that was "aggravated" as a result of "lifting injury at work". The diagnosis was lumbar strain and multi-level degenerative arthritis and was "aggravated as a result of the lifting injury at work."

Dr. Butler also opined that the lumbar strain caused by the lifting incident had

likely resolved and that the Petitioner was at MMI. Dr. Butler further opined that the EMG and myelogram CT diagnostic recommended was not required and would not add to the ultimate treatment for this patient.

IME Dr. Jeffrey Coe- August 14, 2012

Petitioner submitted to an independent medical evaluation with Dr. Jeffrey Coe at the request of her counselor. Dr. Jeffrey Coe opined that there was a causal relationship between the injury suffered by Ms. Mijatovic while working for the Hyatt Regency O'Hare in April 2010 and her current lower back and right leg symptoms. Dr. Coe opined that this low back injury caused permanent partial disability to the man as a whole. He placed permanent work restrictions on Petitioner that would include limitation on lifting, repetitive bending or twisting at the waist. He also opined that Petitioner could only perform sedentary physical demand level work

Current Treatment/Condition.

Petitioner continued to treat with Dr. Boblick and had ongoing complaints of low back pain. Her last visit was on January 25, 2015.

On cross examination Petitioner acknowledged that she had received treatment by Dr. Boblick in May 16, 2007 for her low back pain.

Petitioner identified Petitioner's Exhibit No. 1, a compilation of bills for services rendered by her attending physicians and that these bills were partially paid with various outstanding balances.

Petitioner claims she has difficulty standing but does her home exercises. He notices pain upon standing or sit for a long time. He is also unable bend, stoop or squat. She currently takes Tylenol and other prescription pain reliever. She claims she did not

have these problems prior to her work related injury of April 2010.

FINDINGS/ANALYSIS

With regard to the issue of (F), whether the Petitioner's present condition is causally related to her accident, the Arbitrator finds as follows:

The Parties have stipulated that Petitioner suffered a work accident on April 21, 2010. Petitioner testified that she felt pain in her low back and leg as she was pulling a cart loaded with dishes. Initially, Petitioner was diagnosed with a low back sprain. Most of the treating and IME physicians agree that Petitioner sprained her back so the remaining issue is whether her current condition is causally related to the work injury of April 21, 2010. The Arbitrator finds that the Petitioner did suffer a low back sprain/strain at work but that after extensive therapy, including injections and light duty work, Petitioner returned to her earlier condition of health. Although Petitioner has testified that she suffers from back pain and is unable to work, the Arbitrator finds that her current condition is not related to her work accident.

In support of her findings, the Arbitrator notes that in spite of Petitioner's in-court testimony denying any prior low back issues, the evidence of prior back pain and treatment is clear, convincing and well documented. The records from Petitioner's family physician, Dr. Boblick show lower back treatment beginning on May 6, 2007, two years before the accident. On that date, the Petitioner reported that she had injured her lower back, had gone to the emergency room, and was in severe pain. (PX 4, pp. 19-20). She followed up on May 16, 2007 and was placed on a five-pound lifting restriction. The Petitioner continued to treat and on July 23, 2007 was diagnosed with degenerative disc disease with a likely herniated disc at L4-L5, osteoarthritis, and radiculopathy. The doctor noted self-limited episodes of low back pain in the past. The

Petitioner sought treatment throughout 2009. On May 29, 2009, she was diagnosed with osteoarthritis. (PX 4, pp. 47-48). She underwent lumbar X-rays which were negative. (PX 4, p. 156). She treated through the end of that year.

On December 17, 2009, the Petitioner was seen by a Dr. Fisher who noted lower back pain into the right buttock and thigh. The Petitioner described a four-year history of lower back pain in the same area. (PX 4, pp. 64-65). Dr. Fisher placed a 10 pound lifting restriction. (PX 4, p. 177). On December 26, 2009, Dr. Boblick placed a permanent work restriction of no lifting more than 20 pounds.

The evidence of prior back issues and medically documented degenerative condition that had flared up in the past, Petitions indicate that Petitioner's current condition stems from the old underlying issues. This is especially true because Petitioner was able to return back to light duty work with her employer following her April, 2010 injury. There is no reoccurrence or accident that may have caused the Petitioner to leave her job duties. Although her family physician Dr. Boblick opined on January 25, 2011 that she is not able to return back to work, his opinion is contradicted by Petitioner's treating physician, Dr. Bender and by Dr. Ghanayem. Dr. Boblick gives little by way of explanation why a Petitioner who has been working on an accommodated basis is suddenly unable to return back to work in any capacity. The timing of Petitioner's return to Dr. Boblick is also noteworthy.

The Mechanism of petitioner's injury and the objective MRI and imaging evidence also indicate that Petitioner's current condition is not related to her work accident. Petitioner's accident occurred as a strain is placed upon her low back as she is pulling a cart with dishes. It is not a particularly severe event but the Arbitrator finds

that in light of Petitioner's degenerative condition, she did suffer a sprain/strain to her low back. Petitioner's essential argument is that her back injury never improved although she performed only light duty work and underwent injections and physical therapy. The Arbitrator does not find this testimony by the Petitioner convincing. Dr. Ghanayem has indicated that there may be other inorganic causes for Petitioner's continued pain complaints. The Arbitrator also notes that Petitioner was not forthright regarding her pre-existing back condition. The Arbitrator also finds that her current complaints and limitations are not in line with the objective medical evidence that documents her condition. It is noted that Dr. Boblick took Petitioner off work due to her condition but he did not opine that her condition is serious enough to warrant surgery. He also does not indicate why she has not responded to treatment or how the prior injury and condition plays into her current condition.

Therefore, the Arbitrator finds the Petitioner has failed to meet her burden of proving that her ongoing symptoms subsequent to January 14, 2011 are causally related to her back strain. The Petitioner has the burden of proving every element of her claim, including causal connection, by a preponderance of the evidence. The Arbitrator finds that she has failed to do so based upon the opinions of Drs. Ghanayem and Dr. Butler. The Arbitrator gives lesser weight to the opinion of Dr. Coe as he was given an inaccurate history of Petitioner's prior back issue. The Petitioner denied any prior treatment to her lumbar spine subsequent to three months of such treatment in 2007 to Dr. Coe. Although Dr. Coe did find causation, he also conceded that Petitioner had not given an accurate history. This misinformation damages the sanctity of Dr. Coe's opinion.

On the other hand, Dr. Ghanayem's testimony and opinion are credible and supported by objective medical findings. He examined Petitioner on January 14, 2011, and found that she had ample course of conservative care for her lumbar spine. He noted that she suffered from an underlying condition of degenerative arthritis to the lumbar spine. His opinion that she had reached maximum medical improvement relative to her work injury, and could return to her pre-injury regular duty work status is valid and reasonable as it is supported by Petitioner's pre-accident medical records and the MRI. Petitioner's Exhibit 4 show a long history of treatment related to the Petitioner's degenerative lumbar condition.

Dr. Ghanayem's opinion is strengthened and supported by the report and testimony of Dr. Butler who examined the Petitioner on February 23, 2012 and March 22, 2013 and found the Petitioner had suffered a strain, could work without restrictions, and did not need further treatment.

Therefore, the Arbitrator finds that although the Petitioner suffered a sprain/strain from her work accident, her current condition of ill-being is not related to her work accident. The Arbitrator finds that the Petitioner had reached her previous condition of health in regards to her low back on or about to January 14, 2011.

In support of the Arbitrator's findings related to (K), whether the Petitioner is entitled to temporary total disability, the Arbitrator states as follows:

The Petitioner failed to meet her burden in proving entitlement to temporary total disability benefits subsequent to January 25, 2011, the date she stopped working for the Respondent. The Petitioner bears the burden of proving entitlement to temporary total disability benefits by a preponderance of the evidence. Here, the evidence shows the Respondent was able to accommodate any light duty restrictions, both before and

after the Petitioner's alleged accident, that the Petitioner continued to work for nine months after suffering a back strain, and by her own admission never attempted to return to work nor search for a job within her restrictions.

Although the Petitioner told her examining physician, Dr. Coe, that she was working full duty at the time of her accident, the evidence shows she was working pursuant to a permanent 20 pound lifting restriction. (PX 4, p. 178). The Petitioner was released to return to work, at that level or higher, by Dr. Ghanayem on August 4, 2010 (PX 3, p. 14), Dr. Bender on August 12, 2010 (RX 2), Fetzer on September 9, 2010 (PX 5, p. 7), and Dr. Butler on March 22, 2012 (RX 3). Notwithstanding those releases to return to work, the Petitioner testified she never attempted to work subsequent to January 25, 2011, despite her testimony that the Respondent could accommodate light duty.

In alleging entitlement to temporary total disability benefits, the Petitioner relies upon a January 25, 2011 note from Dr. Boblick that did not delineate actual restrictions. As such, the Arbitrator cannot determine whether Dr. Boblick meant the Petitioner could not return to her regular job lifting heavy pots and pans or, in the alternative, could perform under the restrictions placed by Drs. Bender, Fetzer, Ghanayem, and Butler. The Arbitrator adopts the opinions of those four physicians over the unclear opinion of Dr. Boblick. The Arbitrator also rejects the opinion of Dr. Coe who felt the Petitioner could only work a sedentary job as inconsistent with the opinions of the other physicians in this case, as well as because Dr. Coe was ill-informed as outlined above. In so finding, the Arbitrator further notes the Petitioner admitted she did not look for work even within Dr. Coe's restrictions during the four years she is claiming entitlement

to TTD.

In support of the Arbitrator's findings related to (J), whether the Respondent is liable for additional medical bills, the Arbitrator finds as follows:

The Arbitrator finds the Respondent is liable for medical bills totaling $7,748.99 under Sections 8 and 8.2 of the Act. A summary of the medical bills follows:

Summary by Provider	Dates of Service From	To	Billed	Non-WC Adjust	ACTUAL CHARGE (Bill - Adj)	Lesser of Fee Sched or Actual	PMTS	OUTSTANDING BALANCE
Advanced Occupational Medicine	4/21/2010	3/21/2012	$11,127.00	$(2,519.73)	$8,607.27	$8,042.35	$ (6,222.56)	$1,819.79
Athletic Imaging, Inc.	9/24/2010	9/24/2010	$4,170.00	$	$4,170.00	$3,788.54	$(703.08)	$3,085.46
Integrated Pain Management	7/14/2010	7/14/2010	$542.00	$	$542.00	$441.13	$	$441.13
Loyola University Medical Center	4/20/2010	8/6/2014	$22,423.31	$ (157.10)	$22,266.21	$6,414.35	$(6,224.21)	$190.14
Loyola University Physicians Foundation	5/17/2010	1/16/2015	$5,936.00	$ (2,047.29)	$3,888.71	$1,840.45	$(983.06)	$857.39
Midwest Orthopedics at Rush	9/9/2010	11/15/2010	$7,738.50	$ (2,598.88)	$5,139.62	$4,513.00	$(5,030.47)	$(517.47)
Neurological Surgery and Spine Surgery	6/3/2010	6/3/2010	$525.00	$(135.78)	$389.22	$389.22	$(389.22)	$
Suburban Orthopedics	4/7/2011	4/7/2011	$568.00	$	$568.00	$549.55	$	$549.55
Injured Workers Pharmacy	9/2/2011	4/1/2013	$4,072.95	$ (1,837.92)	$2,235.03	$1,323.00	$	$1,323.00
Walgreens	11/8/2010	1/8/2010	$33.46	$	$33.46	$	$	$
Arlington Eye Physicians	6/20/2011	6/20/2011	$305.00	$	$305.00	$	$	$
					$			$
TOTAL			**$57,441.22**		**$48,144.52**	**$27,301.59**	**$(19,552.60)**	**$7,748.99**
Total Outstanding Pursuant to Fee Schedule:								**$7,748.99**

In support of the Arbitrator's findings related to (L), the nature and extent of Petitioner's injuries, the Arbitrator finds as follows:

The Arbitrator notes that the Petitioner's accident date pre-dates the 2011 AMA guidelines amendments to the Act. The Petitioner has met her burden of proving she suffered permanent partial disability as a result of an April 21, 2010 accident. The Arbitrator finds that the Petitioner suffered a lumbar strain that aggravated a pre-existing degenerative lumbar spine condition.

The Arbitrator has found that the Petitioner had reached MMI per the opinion and examination by Dr. Ghanayem examined her on January 14, 2011. The Arbitrator adopts his opinion that the Petitioner who had been treated for her lumbar strain has returned to her pre-injury work status. Three additional physicians released her to those restrictions. Although Petitioner has testified that she suffers from pain and is unable to work the Arbitrator does not find that these are wholly the result of her work accident.

In conclusion, the Petitioner suffered a back strain arising out of her April 21, 2010 accident and she is permanently disabled to the extent of 7% loss of use of person as a whole under Section 8(d)(2).

Ketki Steffen
Signature of Arbitrator Ketki Shroff Steffen

9/5/15
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Paola Gade,
Petitioner,

16IWCC0769

vs.

NO: 14 WC 32889

Stephen Wallace DDS Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 2, 2015, is hereby affirmed and adopted.

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

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

The party commencing 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: NOV 23 2016
o11/16/16
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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

16IWCC0769

GADE, PAOLA
Employee/Petitioner

Case# **14WC032889**

STEPHEN WALLACE DDS INC
Employer/Respondent

On 11/2/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.15% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5317 JOHN J CASTANEDA PC
47 Du PAGE COURT
ELGIN, IL 60120

0507 RUSIN & MACIOROWSKI LTD
MARK P RUSIN
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

16IWCC0769

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

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

Paola Gade
Employee/Petitioner

Case # 14 WC 32889

v.
Stephen Wallace DDS, Inc.
Employer/Respondent

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 Thompson-Smith, Arbitrator of the Commission, in the city of Chicago, on 8/18/2015. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

D. [ ] What was the date of the accident?

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

L. [ ] 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 _____

16IWCC0769

FINDINGS

On the date of accident, 7/31/2013, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being is 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 36 years of age, married, with 3 children under 18.

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

Respondent shall be given a credit of $2,828.57 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 not proven, by a preponderance of the evidence, that there is a causal relationship between the accident and her current state of ill-being therefore, no benefits are awarded, pursuant to the Act.

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

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

FINDINGS OF FACT

The disputed issues in this matter are: 1) accident; 2) causal connection; 3) medical bills; 4) temporary total disability; 5) penalties; 6) attorney's fees; and 7) is Petitioner entitled to prospective medical treatment. *See,* AX1.

Petitioner's testimony

On July 31, 2013, Petitioner was employed as a dental hygienist for Respondent, with duties of setting up her tools, greeting patients and performing teeth cleanings. She would initially perform an oral examination on patients and obtain x-rays, if necessary. She would then perform the cleanings. Petitioner also testified that her duties occasionally involved lifting dental supplies shipped to the office.

Petitioner testified that she began working for Respondent on January 7, 2013 and that she had obtained her dental hygienist certification seven months prior. Before this employment, she had one temporary job as a dental hygienist, at a different dental office, which had lasted two weeks.

Petitioner testified that on July 31, 2013 she was taking x-rays of a patient, when that patient started gagging. Petitioner ran back to help the patient and tripped on a cord, striking her left knee. Petitioner testified she continued working and she saw one more patient for treatment following the incident. She did not identify any witnesses to the accident or state whether the patient witnessed the incident. Petitioner reported the incident to her supervisor, Maria Haryasz, the same day.

Petitioner testified that she pursued no medical treatment for her left knee in the days and weeks following the alleged accident. She continued to perform her normal work, which she testified occasionally involved lifting boxes of dental supplies. She did not complain to her employer about any difficulty performing her work or experiencing knee pain. However, she testified she "favored her left leg" because of pain she was experiencing and took over-the-counter medication. She did not offer into evidence receipts related to over the counter medication. Petitioner testified that she worked continuously and did not take any time off between July 31, 2013 and December 8, 2013. Petitioner also testified that she never saw a doctor during this time for any treatment related to her knee. She never contacted her physician, Dr. Rusco, to complain about a left knee problem. She testified that Dr. Rusco had been her family doctor since 2002.

Petitioner had been reprimanded for some disciplinary issues on the job, including excessive absenteeism and use of a cell phone at work. She denied being reprimanded for swearing on the job.

Petitioner requested a meeting with management on December 3, 2013 regarding a reduction in her work hours. Petitioner denied that her hours were being reduced due to absenteeism. The managers advised petitioner she was unreliable and that they were going to reduce her work schedule. Petitioner believed another hygienist was being brought on staff. December 3, 2013 was the last day

petitioner worked for Respondent. December 8, 2018 was a Sunday. On Monday, December 9, 2013, Petitioner called her workplace and stated that her left knee had been treated the day before due to the incident occurring in July.

On December 8, 2013, Petitioner saw Dr. Garett-Hauser at Christ Advocate Hospital, complaining of left knee pain as a result of a fall. Petitioner complained of knee pain the past two months which was worse with bending or walking. Dr. Garett-Hauser's notes indicate it could not be determined whether the knee problem was work-related. Petitioner was examined and discharged on this date. The records from Christ Hospital indicate a knee problem of unknown etiology and some of the records indicate the problem relates to a fall that occurred two months earlier, which would be approximately October 8, 2013. The alleged work accident occurred at the end July, 2013. Thus, petitioner's physical complaints by history would not be consistent with the timeline of the alleged work accident. The hospital records also reflect that it could not be determined whether the knee problem was work-related. Petitioner was prescribed pain medication. PX1.

Petitioner presented to Dr. Chaudri on December 12, 2013 complaining of both left knee and left foot pain, which she related to an accident at work on July 31, 2013. Petitioner complained of left knee pain, instability, giving way and swelling. She reported her left foot pain started suddenly, but did not state the specific date or time this pain began. Petitioner was examined and diagnosed with left patellofemoral syndrome and peroneal tendonitis. Petitioner was prescribed medication and physical therapy. She was authorized off work and instructed to follow-up with her family physician, Dr. Rusco. She was instructed to return to see Dr. Chaudri in four weeks.

Petitioner saw Dr. Chaudri for a follow-up visit on January 9, 2014 with complaints on pain. Dr. Chaudri ordered MRIs of both the left knee and left foot. An MRI of the left knee performed January 17, 2014 was essentially negative. Specifically, the MRI showed the ligaments and menisci were intact. The MRI was normal with the exception of thinning of the articular cartilage surface of the patella. Petitioner subsequently saw Dr. Chaudri on January 22, 2014. The doctor advised her to continue physical therapy. Petitioner saw Dr. Chaudri sporadically through April 2, 2014, at which point Petitioner ceased seeking treatment with this doctor. PX4.

Petitioner saw Dr. Wehner on February 26, 2014, at the request of Respondent. At the time of Dr. Wehner's examination, Petitioner was wearing a walker boot on the left foot and a Neoprene knee brace. An examination of the left foot showed some mild pain with motion and some tender areas. An examination of the left knee was normal with the exception of mild tenderness. Dr. Wehner reviewed the recent MRI results of both the foot and knee and did not find any significant abnormalities. In addition, Dr. Wehner reviewed pertinent medical records. Dr. Wehner opined that petitioner's condition or complaints were not related to the July 31, 2013 alleged fall, given the 4-1/2 month delay in treatment. Petitioner did not report a left foot injury. Dr. Wehner stated petitioner's

foot and knee problems were due to conditions that frequently appear in the general population and are not the result of any specific trauma. RX2.

Petitioner retained an attorney on September 23, 2014. At that time, she had not seen a doctor in approximately six months. Her attorney referred Petitioner to Dr. Dworsky of Hinsdale Orthopedics, whom she subsequently saw on October 6, 2014. On that date, he reviewed an x-ray of Petitioner's left knee that showed a thinning of the kneecap. Dr. Dworsky ordered an updated MRI since he believed the MRI conducted at Christ Hospital was poor. An October 11, 2014 MRI showed no significant internal pathology, only a mild amount of chondromalacia or fissuring of the patella. On this basis, Dr. Dworsky ordered physical therapy for Petitioner at ATI Oak Lawn, Illinois twice a week. The records of Petitioner's attendance indicate that she did not attend physical therapy consistently. PX3 & 5.
She presented to Dr. Dworsky for left knee complaints on October 6, October 24, November 21 and December 19, 2014. Dr. Dworsky initially stated that Petitioner's problem appeared to be a soft tissue inflammatory type problem. After Petitioner's continued complaints, Dr. Dworsky diagnosed patellofemoral syndrome and suggested arthroscopic surgery, i.e., a lateral retinacula release. Dr. Dworsky's notes of December 19, 2014 indicate Petitioner is to decide whether to have the surgery. Petitioner is not actively pursuing further medical treatment with Dr. Dworsky and has not returned to see the doctor since December 19, 2014.

Deposition of Dr. Bradley D. Dworsky, dated March 24, 2015
Dr. Dworsky testified regarding Petitioner on March 03, 2015. Dr. Dworsky testified that he had not seen any of Petitioner's previous medical records at the time of treatment, and that he was unaware that she had not sought treatment for her injury immediately. He also testified that someone who suffered an acute traumatic event would be expected to have suffered immediate symptoms. Dr. Dworsky further testified that he was unaware Petitioner had ceased to attend physical therapy as of her last visit on December 19, 2014. Further, Dr. Dworsky testified in Petitioner's social history that she was a smoker and did not exercise regularly. Dr. Dworsky then testified as to the negative effects of a lack of physical exercise and how this may impact someone's overall health. Dr. Dworsky also admitted that the fitting of the surface of the joint as seen on the x-ray may also be associated with degenerative changes. PX5.

Petitioner testified she has not worked or applied for work in any capacity since December 2013. She has not collected unemployment compensation or applied for Social Security disability. She testified that she wants surgery by Dr. Dworsky approved in the hopes it will improve the condition of her knee. She denied having any contact with Respondent since on or about October 2014.

Respondent's witness
Ms. Haryasz, the officer manager, testified that the office was small with only five employees, and that she oversaw the other employees. Ms. Haryasz has held the position of office manager since the

practice opened 19 years ago. She testified petitioner was initially hired to work two days a week, as a dental hygienist. In addition, Petitioner did report an accident July 31, 2013, wherein she state that she fell and injured her left knee. Petitioner did not report any injury to her left foot.

Ms. Haryasz identified an accident log prepared on the date of the alleged incident that states that "Employee tripped over cord of x-ray...knee injured...area red...no apparent injury." It lists the location of the event as "back of office." The log also documents an August 01, 2013 visit by Petitioner to the office to pick up her paycheck in which Petitioner reported her knee was "messed up" and that Petitioner was seeing a doctor. Ms. Haryasz testified that she saw Petitioner chasing her kids around the office on subsequent dates. Ms. Haryasz testified that she did not believe Petitioner had an ongoing problem. In the weeks and months that followed, Petitioner was not limping or having any apparent problems with her knee. Ms. Haryasz reported that Petitioner did not miss any time from work and that she continued to perform her normal duties as a dental hygienist without incident or complaint. Petitioner never voiced any complaint of ongoing knee problems during this time. RX4.

Ms. Haryasz testified regarding the disciplinary issues concerning Petitioner and that Petitioner had an absentee problem and was disruptive around the office. Ms. Haryasz testified that Petitioner requested a meeting with Dr. Wallace and herself on December 3, 2013. During this meeting, Petitioner was advised that her work hours were going to be reduced. Ms. Haryasz testified that Petitioner became rude and upset during their meeting and complained that it was Ms. Haryasz who was a problem around the office. Ms. Haryasz confirmed that Petitioner has not returned to work since December 3, 2013. Ms. Haryasz testified that she observed the petitioner working and taking care of her children over the next several months. By her observations, petitioner did not appear to be in pain or limited in her movements, regarding her left knee and that Petitioner did not voice any knee or foot problems during the December 3, 2013 meeting.

CONCLUSIONS OF LAW

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

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

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

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances support the decision. *See generally, Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), *see* also *Seiber v Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill.App. 3d 665, 674 (2009).

Based on the testimony of Petitioner, the testimony of Petitioner's Manager, Ms. Haryasz, and the injury log in evidence, the Arbitrator finds that the petitioner did sustain accidental injuries which arose out of and in the course of her employment July 31, 2015. However, the Arbitrator finds petitioner failed to prove that her left leg and foot conditions and alleged need for medical treatment commencing December 8, 2013, is causally related to the accident of July 31, 2013.

Petitioner reported striking her left knee that date. She did not report an injury to her left foot or any other part of the body. On July 31, 2015, the injury log notes some redness to the knee, but no apparent injury noted. Although Petitioner reported on August 1, 2015 that her knee was "messed up" and she planned to see her doctor, no swelling or bruising was noted on observation. Petitioner stated she planned to see a doctor on August 2, 2015, but she never did so. The records of Dr. Rusco are in evidence. Dr. Rusco is Petitioner's family doctor. His records do not show Petitioner ever contacted him with a complaint of left knee pain on or around the July 31, 2013 accident date. However, the Arbitrator relies on the respondent's log and the petitioner's testimony and finds that the petitioner has proven, by a preponderance of the evidence, that an accident occurred, which arose out of and in the course of her employment by Respondent.

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

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

Petitioner admitted that she never pursued treatment for her left knee or any other part of the body allegedly related to this accident in the weeks and months following July 31, 2013. She continued to perform her normal work. She did not request assistance or any modification in her work duties during this time. Petitioner's manager, Ms. Haryasz, observed Petitioner working over the subsequent months and at times with her children. Petitioner moved about and worked without any apparent difficulty. Petitioner never voiced any complaint of ongoing knee problem to Ms. Haryasz after August 1, 2015.

There has been testimony that Petitioner's work performance was poor in late 2013 and she was apparently reprimanded by management due to issues related to absenteeism and disruptiveness around the office. Her work schedule was to be reduced. In a meeting December 3, 2013, when Petitioner was advised that her work hours were to be reduced, she became rude with her manager during this conversation and accused the manager of being the problem around the office. Petitioner has not returned to work since December 3, 2013, nor has she sought work.

Petitioner has sought treatment for left knee and left foot conditions of patellofemoral syndrome and tendonitis. These are not traumatically induced conditions. The Arbitrator relies on the opinions of Dr. Wehner that petitioner's left leg and foot conditions and need for treatment commencing December 8, 2013, is unrelated to the accident of July 31, 2013.

Petitioner has not proven, by a preponderance of the evidence, that her current condition of ill-being is causally related to the accident, therefore, no benefits are awarded, pursuant to the Act. As the petitioner has not proven causation, all other issues are moot and will not be addressed.

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION
14WC32889
SIGNATURE PAGE

Signature of Arbitrator

November 2, 2015
Date of Decision

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

George Heard,

Petitioner,

vs.

NO: 14 WC 11107

16IWCC0770

Chicago Transit Authority,

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 5, 2016, is hereby affirmed and adopted.

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

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

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

The party commencing 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: NOV 2 8 2016
o111716
DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

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

HEARD, GEORGE
Employee/Petitioner

Case# **14WC011107**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

16IWCC0770

On 4/5/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5419 LEONARD S BECKER
311 N ABERDEEN
SUITE 200D
CHICAGO, IL 60607

0515 CHICAGO TRANSIT AUTHORITY
ANDREW ZASUWA
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

GEORGE HEARD
Employee/Petitioner

Case #14 WC 11107

V.

16IWCC0770

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on March 2, 2016. After reviewing all of the issues, the stipulations of the parties and the evidence, it is hereby found and ordered as follows:

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

K. ☐ What temporary benefits are due: ☐ TPD ☐ Maintenance ☐ TTD?

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

M. ☐ Is the respondent due any credit?

N. ☒ Prospective medical care?

FINDINGS

- On September 25, 2013, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $65,041.60; the average weekly wage was $1,230.80.
- At the time of injury, the petitioner was 50 years of age, single with no children under 18.
- The parties agreed that the respondent paid $17,934.39 in temporary total disability benefits.
- The parties agreed that the respondent paid all the related medical services provided to the petitioner.

ORDER:

- The petitioner's request for prospective medical care for his right shoulder is denied.
- In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of temporary total disability, medical benefits, or compensation for a permanent disability, if any.

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

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

below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Robert E. Williams

Signature of Arbitrator

April 5, 2016
Date

APR 5 - 2016

FINDINGS OF FACTS:

The petitioner, a bus driver, struck the right rear side of a white pickup truck on September 25, 2013, when the driver turned right from a lane left of the bus. He received medical care at Concentra on September 26, 2013. The treatment record is not in evidence, only a physician's work activity status report, which indicated a diagnosis of a cervical strain, and back and shoulder contusions.

The petitioner saw Dr. Robert Rosman at University of Illinois Hospital & Health Science Systems on November 13, 2013, and reported right arm, shoulder and hand pain since October 25, 2013. He saw Dr. Terry Nicola at University of Illinois Hospital & Health Science Systems on December 5th and complained of right shoulder pain with occasional radiation from his neck to his shoulder and numbness in his whole right arm and hand that started a few days after September 25th. Dr. Nicola noted that his physical examination revealed a positive Spurling's with recreation of radiating symptoms down his right back and right arm, but that subsequent tests failed to reproduce the symptoms. The petitioner had a positive moving Mayo sheer test, Andrews, KIM-1 and Kimura, and a negative Hawkins, O'Brien's, lift off, scarf, Yergason's and Neer's. No work restrictions for petitioner's right shoulder were imposed. An EMG of his right upper extremity on December 30th was normal. An MRI of his right shoulder on March 11, 2014, revealed a linear SLAP type superior labral tear, a small full-thickness tear of the distal infraspinatus tendon, a smaller undersurface tear of the distal supraspinatus tendon and moderate to severe tendinopathy of the remaining supraspinatus and infraspinatus. The MR arthrogram suggested a full-thickness rotator cuff tear. On March 26th, Dr. Hutchinson suggested arthroscopic debridement of labral tissue and a rotator cuff repair

or conservative care since the tear was not retracted. Dr. Hutchinson noted on July 17th that the petitioner's symptoms and complaints had not changed and that he had pain at night and while driving a bus. The physical examination of his right shoulder revealed a full range of motion, no tenderness to palpation over any bony prominence, some mild pain with an impingement test, a negative crossover sign and 5/5 strength in all rotator cuff musculature, however, some pain with infraspinatus provocation. Work status reports on November 14th and January 8, 2015, indicated a diagnosis of rotator cuff tendinopathy and a release to work without restrictions. On February 19, 2015, the diagnosis was right shoulder impingement. Restrictions were given the petitioner of no lifting, carrying, pushing and pulling over 28 pounds, no repetitive overhead lifting and no overhead lifting over 25 pounds. On August 3, 2015, Dr. Hutchinson recommended a diagnostic arthroscopy, subacromial bursectomy and partial synovectomy, which the petitioner requests.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that his current condition of ill-being is causally related to the work injury. Channel 6 of the security video from the petitioner's bus on September 25, 2013, shows a white truck making a right turn in front of the bus when contact is made. The white truck did not stop and appears to have an impact dent on its right rear side. Channel 1 of the bus video shows the petitioner driving and a rider standing near the doorway and after the impact with the truck, the petitioner raised his right arm as if in exasperation. Thereafter, the petitioner used and moved his right arm without any apparent hesitation. Moreover, there is no medical evidence that the petitioner complained of a right shoulder strain on

September 25, 2013. The petitioner's first complaint of right shoulder symptoms that he attributed to the impact with the truck was on December 5, 2013. Further, there is no visible trauma to the petitioner's right shoulder. Although three adult passengers were standing, neither fell or were thrown forward during the impact nor did they appear to have any difficulty staying upright during the impact and deaccleration of the bus. Also, Dr. Cherf opined on May 11 2015, that the petitioner's right shoulder condition is more likely than not due to his pre-existing rotator cuff and labral pathology. The petitioner is not believable or credible. The petitioner's request for prospective medical care for his right shoulder is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mark Angellotti,
Petitioner,

vs.

NO: 12 WC 04106

Village of Elk Grove,
Respondent,

16IWCC0771

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 16, 2015, is hereby affirmed and adopted.

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

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

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

DATED: NOV 2 8 2016
O111716
DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ANGELLOTTI, MARK
Employee/Petitioner

Case# **12WC004106**

VILLAGE OF ELK GROVE
Employer/Respondent

16IWCC0771

On 12/16/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.58% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2439 ROBERT ARNOLD, LAW OFFICES OF
119 N NORTHWEST HWY
PALATINE, IL 60067

1139 NOBLE & ASSOCIATES PC
MICHAEL E MAHAY
1979 N MILL ST
NAPERVILLE, IL 60563

16IWCC0771

M Angellotti v Village of Elk Grove Village, 12 WC 04106

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

Mark Angellotti
Employee/Petitioner
v.
Village of Elk Grove
Employer/Respondent

Case # 12 WC 04106

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **October 7, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **12-5-2011**, 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 **$65,000.00**; the average weekly wage was **$1,250.00**.

On the date of accident, Petitioner was **52** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$48,035.00** for other benefits, for a total credit of **$48.035.00**.

Respondent is entitled to a credit of **$47,105.97** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner **temporary total disability benefits of $833.34/week for 60-4/7 weeks, commencing 12/6/2011 through 2/5/2012**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$695.78/week for 86 weeks** because the injuries sustained caused the **40% loss of use of Petitioner's right leg**, as provided in Section 8 (e)12 of the Act.

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

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

Signature of Arbitrator

December 16, 2015
Date

FINDINGS OF FACT

Petitioner worked for Respondent in the Street Division. Petitioner testified that on December 5, 2011, he was working with an outside crew on an excavation site. Petitioner was operating a Gradall, a large construction vehicle. (PetEx. 2) The weather was sleet and rain. At about 10:15 am, Petitioner slipped and fell while exiting the machine. His foot slipped and caught on a lower rung of the ladder. He felt a pop or twinge in his right knee. He had pain. He did not continue to work. His crew continued to work and Petitioner sat in a pickup truck. Petitioner ate lunch at Respondent's shop at 11:00. At the shop, as Petitioner was walking around a corner, his knee popped again. The job finished around 1:45 pm. Petitioner then reported the injury to John Nicholas, the Public Works Foreman.

Nicholas prepared an OJI Supervisor's Investigation Report, dated December 7, 2011, which Petitioner and Nicholas signed. The accident was described as: "As the employee was exiting the Grad-all his right foot slipped off the ladder to the next rung and the employee reports that he felt a twinge of pain. At approximately 11:45 am as the employee walked from the lunch room he felt his kneecap pop out of place. By the end of his shift, the employee felt more pain but was hopeful that some anti-inflamatory medication and rest would improve the situation." (PetEx. 1) Petitioner did not drive the Gradall anymore on December 5, 2011. Petitioner did not seek medical care on the date of injury, choosing to ice his knee and see if it got better.

Petitioner was 50 years old and 6'5" tall, weighing 265 pounds, on the date of accident.

Petitioner first sought medical care from Dr. Richard Chams at IBJ on December 6, 2011. Petitioner had previously treated with Dr. Chams for right knee problems. The history documented by Dr. Chams was that the patient was fine for 6 months and yesterday turned a corner and felt a pop and immediate swelling. The physical exam was consistent with torn menisci and 90cc of serous fluid was evacuated from the knee. Dr. Chams ordered an MRI, prescribed crutches and therapy and took Petitioner off work. (ResEx. 4)

Petitioner testified that he was seen at Respondent's clinic, but no records from this provider were submitted.

The MRI revealed recurrent torn menisci and severe 3 compartment OA of the right knee. Dr. Chams offered Petitioner a right total knee atrhroplasty, which was performed on October 5, 2012. Petitioner had therapy and was released to return to work by Dr. Chams, effective December 10, 2012. Apparently, Respondent would not accept Petitioner back to work until February 5, 2013. Petitioner had made a diligent effort at rehabilitation and obtained the release to return to work earlier than the 4 to 6 months that Dr. Chams had anticipated. Dr. Chams apparently responded to Respondent's inquiry regarding return to work in December of 2012, stating that full duty RTW was appropriate as of December 10, 2012, but healing would continue for 6 months. Petitioner had good function as of December 4, 2012 and there is no follow-up visit in the records of Dr. Cham. (ResEx. 4)

Petitioner was off work from December 6, 2011 through February 4, 2013. He returned to work on February 5, 2013. He was paid full salary from December 5, 2011 through July 24, 2012, sick time from July 26, 2012 through August 9, 2012 and 9/17/2012 through 9/30/2012, and vacation from 8/20/2012 through 9/16/2012, per the stipulation of the Parties. The Parties stipulated that Respondent had paid Petitioner $48,035.00 in "other benefits".

Petitioner returned to work for Respondent in a different position, making the same pay. He is able to perform his job. The job change was not related to work restrictions, as Petitioner had been released to work without restrictions by Dr. Chams.

Petitioner presented the testimony of Robert Cooke, a fellow Street Department employee of Petitioner. Cooke has been employed by Respondent for 35 years. He was working with Petitioner of December 5, 2011. He saw Petitioner limping and was told that he tweaked his knee. Petitioner told Cooke that he had slipped on the Gradall. Petitioner said he fell out of the Gradall. Cooke did not see Petitioner fall. After lunch, Petitioner did not work. He sat in the truck. Petitioner did not drive the Gradall later that day. Cooke had not seen Petitioner limp before December 5, 2011.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below. Petitioner's testimony is found to be credible.

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

The Arbitrator finds that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on December 5, 2011 when he slipped getting out of the Gradall and injured his right knee, based upon the credible testimony of Petitioner, the testimony of Mr. Cooke and the OJI Report (PetEx. 1)

The Arbitrator does not place great weight on the history contained in Dr. Chams' chart of only the turning the corner incident. Petitioner testified about the turning the corner incident and it is documented on the OJI Report which was completed on December 7, 2011. Petitioner reported the accident to Nicholas on December 5, 2011 and, again the OJI report details the slip/fall and the turning the corner incidents. One can assume that Nicholas would have noticed a change in history from December 5 to December 7 if there was one.

The Arbitrator is persuaded that Petitioner injured his right knee when he slipped exiting the Gradeall, an accident that obviously arose out of and in the course of his employment by Respondent.

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

The Arbitrator finds that Petitioner' current condition of ill-being regarding his right knee (status post right knee TKA) is causally connected to the injury, based upon Petitioner's testimony and the medical records. The injury obviously aggravated the 3 compartment OA condition that existed in Petitioner's right knee, leading to the TKA procedure.

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

The Parties stipulated that the medical bills had been paid by Respondent's group carrier and that Respondent was entitled to a $47,105.97 §8(j) credit.

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's testimony and the medical records establish that Petitioner was temporarily and totally disabled as a result of the injury from December 6, 2011 through February 4, 2013, a period of 60-4/7 weeks. While Dr. Chams released Petitioner to full, duty effective December 10, 2012, Respondent did not allow him to return to work. Dr. Chams thought that Petitioner would reach MMI 6 months after surgery. Therefore, as Respondent did not accommodate Petitioner's return to work in December of 2012, TTD benefits are owed until the date that Petitioner actually returned to work. See: Interstate Scaffolding v. Workers' Compensation Comm'n, 236 Ill.2d 132 (2010)

The Parties stipulated that Respondent paid $48,035.00 in other benefits as a result of the injury.

The Arbitrator is without power to reinstate sick days or vacation days as requested by Petitioner and he therefore declines to do so.

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

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records.

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factor used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. Therefore, this factor is given no weight in determining PPD.

With regard to subsection (ii) of §8.1b(b), the Arbitrator notes that Petitioner's occupation was that of a street department worker for Respondent and he was able to return to work in that position, albeit at a different job (with no loss in pay) after the accident. Therefore, this factory is given little work in determining PPD, as Petitioner has had a good result from the surgery and he returned to work for Respondent.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 50 years old at the time of the accident. This factor is given some weight in determining PPD, as Petitioner will likely have to live with the effects of the TKA procedure for a long time.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner had a good result from the surgery and, therefore, this factor is given some weight in determining PPD.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner had a good result from the surgery and Dr. Chams' records do not provide much evidence of disability. This factor is given little weight in determining PPD, other that the fact that Petitioner did undergo a TKA procedure which involves excision of a portion of the femur and implantation of a prosthesis, with a modification of the tibia and implantation of a prosthesis, with a concurrent disruption of the structural anatomy of the knee. This is a major surgery and Petitioner's knee will never be the same.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 40% loss of use of Petitioner's right leg, pursuant to §8(e)12 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
KANKAKEE

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Foltz,
Petitioner,

vs.

NO: 13 WC 17555

State of Illinois Department of Corrections,
Respondent,

16IWCC0772

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 January 22, 2016, is hereby affirmed and adopted.

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

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

DATED: NOV 28 2016
o111716
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FOLTZ, ROBERT
Employee/Petitioner

Case# **13WC017555**

ST OF IL DEPT OF CORRECTIONS
Employer/Respondent

16IWCC0772

On 1/22/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.37% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
DIRK A MAY
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

5782 ASSISTANT ATTORNEY GENERAL
KELLY KAMSTRA
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1350 CENTRAL MANAGEMENT SYSTEMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

JAN 22 2016

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

16IWCC0772

STATE OF ILLINOIS)
)SS.
COUNTY OF KANKAKEE)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Robert Foltz
Employee/Petitioner

v.

State of Illinois Department of Corrections
Employer/Respondent

Case # **13** WC **17555**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Kankakee**, on **November 13, 2015** and **December 15, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☐ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☒ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **July 25, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident as explained *infra*.

In the year preceding the injury, Petitioner earned **$86,400.00**; the average weekly wage was **$1,661.53** as explained *infra*.

On the date of accident, Petitioner was **47** 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 **$67,767.11** for TTD, **$8,335.82** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$76,102.93** as explained *infra*.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act. See AX1.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner failed to establish his entitlement to temporary partial disability benefits as claimed. By extension, Petitioner's claim for temporary partial disability benefits is denied.

Permanent Partial Disability: Wage differential

Respondent shall pay Petitioner permanent partial disability benefits, commencing August 16, 2015, of $627.69/week until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

January 21, 2016
Date

JAN 22 2016

16IWCC0772

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Robert Foltz
Employee/Petitioner

v.

State of Illinois Department of Corrections
Employer/Respondent

Case # **13** WC **17555**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute are Petitioner's earnings and average weekly wage, Petitioner's entitlement to a period of temporary partial disability benefits commencing August 16, 2015 through November 13, 2015, and the nature and extent of Petitioner's injury including whether he is entitled to wage differential benefits. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Robert Foltz (Petitioner) testified that he was employed by the State of Illinois Department of Corrections (Respondent) beginning in December of 1983. On the date of his undisputed accident, July 25, 2012, Petitioner was employed as a Correctional Lieutenant. He explained that he was escorting a restrained offender who became combative and, during a struggle, he strained his back. Petitioner testified that he felt instant pain in his low back and leg, which prompted medical care beginning the following day.

Previously, Petitioner had a condition in the low back at L5-S1 and had two surgeries. The medical records reflect that Petitioner previously underwent a lumbar fusion on January 27, 2010 and a revision fusion surgery on April 21, 2011. PX1. Petitioner testified that he returned to work in the same position as a Correctional Lieutenant in a full duty capacity after the second surgery in April of 2011. Petitioner explained that, before this injury at work, he was walking three-to-five miles per day during his shift with no complications.

Petitioner presented to Dr. Atwater for medical treatment on July 26, 2012. PX1. At that time, Dr. Atwater noted that Petitioner was status post a revision fusion surgery at L5-S1. *Id.* Dr. Atwater ordered a lumber MRI and recommended an epidural steroid injection at L4-L5 for the acute leg pain. *Id.*

Petitioner underwent the recommended MRI on August 6, 2012 followed by an injection, physical therapy and an EMG/NCV. PX1. Under Dr. Atwater's care, Petitioner also underwent epidural steroid and facet injections at L3-L4 and L4-L5 for continued low back pain and leg pain through 2013. *Id.* Petitioner testified that from his date of accident through June of 2013, he experienced a lot of pain and limited mobility.

Beginning on January 31, 2013, Dr. Atwater recommended a provocative discogram to locate the source of Petitioner's symptoms. PX1. Petitioner eventually underwent the discogram on October 28, 2013 at L4-L5. *Id.* The discogram results showed concordant pain at L4-L5. *Id.* Dr. Atwater recommended surgery. *Id.*

On June 30, 2014, Petitioner underwent surgery including the following: (1) posterior decompression at L4-L5; (2) transforaminal interbody lumbar fusion surgery at L4-L5; (3) biological insert placement and PEEK cage; (4) exploration of fusion at L5-S1; (6) posterior instrumentation at L4-S1; and (7) removal of hardware at L5-S1.

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party.

PX3. Petitioner then underwent post-operative physical therapy and follow up medical care with Dr. Atwater. *Id.* He testified that he experienced inflammation after his surgery. Petitioner then began medical treatment with Dr. Craig Carmichael, a physiatrist, and colleague of Dr. Atwater. PX1.

Eventually, Petitioner underwent a two-day functional capacity evaluation, which was performed on November 13 and 14, 2014. PX7. The results of the evaluation were valid with Petitioner putting forth maximal effort. *Id.* When Petitioner returned to Dr. Carmichael on November 20, 2014, he reviewed the functional capacity evaluation results and placed Petitioner at maximum medical improvement. *Id.* Dr. Carmichael also imposed permanent work restrictions with no lifting greater than 10 pounds frequently or 20 pounds occasionally, no repetitive bending, lifting, or twisting and accommodations to allow Petitioner to sit or stand as needed. PX6.

Thereafter Petitioner provided the functional capacity evaluation results to Respondent and attempted to return to work, but Respondent was unable to accommodate his restrictions. Petitioner testified he began vocational rehabilitation on April 21, 2015. He retired early from his position with the Illinois Department of Corrections on May 31, 2015. Petitioner was successful in obtaining employment through vocational rehabilitation and he was offered the position of Operations Manager with Woodrey Trucking Inc. paying $18.00 an hour. PX2. Petitioner testified that he declined this job offer because his grandfather needed his assistance with hip surgery and he moved to Florida. Petitioner moved to Florida in August of 2015 and is not employed.

Regarding his current condition, Petitioner testified that he is limited in his activities and he experiences pain and swelling in his back. Everyday activities, such as mowing the grass, cause symptoms. Petitioner testified that he is limited to 30 pounds lifting. To relieve his symptoms, Petitioner applies ice, rests and takes ibuprofen as well as hydrocodone at least once per day as prescribed by his primary care physician.

Respondent called Michael Price (Mr. Price) as a witness. Mr. Price is the Workers' Compensation Coordinator for Public Safety Shared Services. He testified regarding the procedures used in determining step increases, cost of living adjustments and the credit of serviceable time applicable to Petitioner pursuant to the ASFCME master contract applicable to Respondent and Petitioner as a member of his union as well as pay plan Appendix A (Negotiated Rates of Pay) applicable to Petitioner as a Correctional Lieutenant. JX1 & PX9.

Mr. Price testified that Petitioner went on a non-work related leave of absence from February 2, 2010 until January 17, 2012. Mr. Price explained that Petitioner would have been at step 5 as of May 1, 2012 before his accident at work were it not for his prior non-occupational leave causing a 714 day delay in accrual to the next step. Thus, Petitioner did not have the required creditable service to reach step 5 before his accident at work and he was properly at step 4 at that time. Mr. Price's testimony regarding Petitioner's step level before his accident at work is uncontroverted.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at the hearing as follows:

In support of the Arbitrator's decision relating to Issue (G), what were Petitioner's earnings/average weekly wage, the Arbitrator finds the following:

On the Request for Hearing form, Petitioner stipulated that he is entitled to an average weekly wage of $1,728.23 based on earnings during the year preceding his injury of $89,868.00. AX1. Respondent stipulated that Petitioner was only entitled to an average weekly wage of $1,661.53 based on earnings during the year preceding his injury of $86,400.00. *Id.* The parties' dispute regarding Petitioner's earnings and average weekly wage centers on whether Petitioner should have received a step increase in May of 2012.

Section 10 of the Act states in pertinent part that the average weekly wage is to be computed based on the "actual earnings of the employee in the employment in which he was working at the time of the injury." 820 ILCS 305/10. While Petitioner contends that his earnings and average weekly wage should have been calculated differently, inclusive of a step increase that he did not receive in 2012 before his undisputed accident at work, the Act requires an assessment of Petitioner's actual earnings. Petitioner's allegation that he was improperly paid by Respondent during that period of time, and improperly denied a step increase are issues outside the scope of the Arbitrator's authority and should be addressed within the confines of the employment relationship under the applicable union contract. Neither party submitted records establishing Petitioner's earnings from Respondent during the prior year of employment. However, the parties are bound by their stipulations on the hearing form. *Walker v. Industrial Commission*, 345 Ill. App.3d 1084, 1088 (4th Dist. 2004).

Based on the foregoing, the Arbitrator finds that Petitioner's earnings in the year preceding his injury were $86,400.00 resulting in an average weekly wage of 1,661.53.

In support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to temporary partial disability benefits, the Arbitrator finds the following:

Section 8(a) of the Act states the following in pertinent part:

> When the employee is working light duty on a part-time basis or full-time basis and earns less than he or she would be earning if employed in the full capacity of the job or jobs, then the employee shall be entitled to temporary partial disability benefits. *Temporary partial disability benefits shall be equal to two-thirds of the difference between the average amount that the employee* would be able to earn *in the full performance of his or her duties in the occupation in which he or she was engaged at the time of accident* and *the gross amount which he or she* is earning *in the modified job provided to the employee by the employer or in any other job that the employee is working.*

820 ILCS 305/8(a) (LEXIS 2012) (*emphasis* added).

Petitioner asserts that he is entitled to temporary partial disability benefits commencing August 16, 2015 through November 13, 2015. No evidence was submitted that Petitioner was employed in a modified job

provided by Respondent or in any other job. Based on the foregoing, the Arbitrator finds that Petitioner failed to establish his entitlement to temporary partial disability benefits as claimed.

In support of the Arbitrator's decision relating to Issue (L), the nature and extent of Petitioner's injury, the Arbitrator finds the following:

Section 8.1b of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b (LEXIS 2011). Specifically, Section 8.1b states:

> For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:
>
> (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.
>
> (b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:
>
> (i) the reported level of impairment pursuant to subsection (a);
> (ii) the occupation of the injured employee;
> (iii) the age of the employee at the time of the injury;
> (iv) the employee's future earning capacity; and
> (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. *Id.*

Considering these factors in light of the evidence submitted at the hearing, the Arbitrator addresses the factors delineated in the Act for determining permanent partial disability.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report was offered into evidence. As a result, the Arbitrator assigns no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a Correctional Lieutenant. As a result, the Arbitrator gives significant weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 47 years old at the time of the accident. As a result, the Arbitrator gives significant weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner was released back to modified duty work with permanent restrictions pursuant to a valid functional capacity evaluation. He received an offer of employment for $18.00 per hour as an Operations Manager in 2015, which is less than what he would have been able to earn as a Correctional Lieutenant. Indeed, Petitioner claims entitlement to wage differential benefits and Respondent asserts that Petitioner's injury resulted in loss of use of the person as a whole pursuant to Section 8(d)(2) of the Act. The Illinois Appellate Court's recent decision in *Jackson Park Hospital v. Illinois Workers' Compensation Comm'n*, 2016 IL App (1st) 142431WC, *39-43 (1st Dist. January 8, 2016) and its decision in *Wood Dale Electric v. Illinois Workers' Compensation Comm'n*, 2013 IL App (1st) 113394WC, 986 N.E.2d 107, 369 Ill. Dec. 158 (1st Dist. February 11, 2013) are instructive.

"When section 8(d)(1) is construed in conjunction with section 8(d)(2), it becomes clear that the crucial issue in the present case in determining which type of PPD award is appropriate is whether the claimant has suffered an impairment of her 'earning capacity.'" *Jackson Park Hospital*, 2016 IL App (1st) 142431WC at *42. To qualify for a wage differential award, a claimant must prove that he is partially incapacitated from pursuing his usual and customary line of employment and that there is a "difference between the average amount which [she] would be able to earn in the full performance of [her] duties in the occupation in which [she] was engaged at the time of the accident and the average amount which [she] is earning or is able to earn in some *suitable employment* or business after the accident." *Jackson Park Hospital*, 2016 IL App (1st) 142431WC at *40 (citing 820 ILCS 305/8(d)1); see also *Wood Dale Electric*, 2013 IL App (1st) 113394WC at *22 (citing 820 ILCS 305/8(d)1). A claimant's voluntary decision to remove himself from the work force does not preclude a wage differential award. *Wood Dale Electric*, 2013 IL App (1st) 113394WC at *23.

Petitioner was employed as a Correctional Lieutenant at the time of his accident. He would have been able to earn $1,661.53 per week in that position. After an initially unsuccessful job search, he received a job offer earning $18.00 per hour ($720.00 per week) as an Operations Manager. Petitioner's temporary total disability benefits were terminated effective August 15, 2015[2]. AX1. Thus, the Arbitrator finds that Petitioner has established a partial incapacity from pursuing his usual and customary line of employment and an earnings capacity impairment (i.e., a difference between the average amount he would be able to earn in the full performance of his duties as a Correctional Lieutenant and the average amount he is able to earn in suitable employment as an Operations Manager). As a result of the foregoing, the Arbitrator gives significant weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator finds that Petitioner's testimony was credible because it was corroborated by the medical records. Petitioner credibly testified about lumbar condition, the ensuing medical treatment including a fusion surgery at L4-L5, a modified release to return to work and ongoing symptoms including pain for which he takes at least one prescribed pain medication per day and lifestyle changes to accommodate his ongoing symptoms. As a result, the Arbitrator gives significant weight to this factor.

Based on all of the foregoing, and in consideration of the factors enumerated in Section 8.1b, which does not simply require a calculation, but rather a measured evaluation of all five factors of which no single factor is

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[2] Respondent stipulated that Petitioner's temporary total disability benefits—which appear to, albeit not explicitly, include Petitioner's undisputed entitlement to maintenance benefits for a period of time while in engaged in vocational rehabilitation—were properly terminated on August 15, 2015. AX1; see also *Walker*, 345 Ill. App.3d at 1088 (parties are bound by their stipulations at a hearing).

conclusive on the issue of permanency, the Arbitrator finds that Petitioner has established his entitlement to a Section 8(d)1 wage differential benefit of $627.69[3] per week until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act. Petitioner shall be entitled to receive such benefits beginning on August 16, 2015 following the cessation of his entitlement to temporary total disability and maintenance benefits as agreed by the parties on August 15, 2015. See AX1.

In support of the Arbitrator's decision relating to Issue (N), whether Respondent is entitled to any credit for temporary total disability and temporary partial disability benefits paid, the Arbitrator finds the following:

While the parties' have indicated a dispute regarding the credits claimed by Respondent for temporary total disability and temporary partial disability benefits paid, the dispute is not as to Respondent's entitlement to this credit; rather, whether Petitioner was paid temporary total disability and temporary partial disability benefits at the correct rate based on the disputed average weekly wage. As noted above, the Arbitrator finds that Petitioner's average weekly wage is $1,661.53. Thus, the Arbitrator finds that Respondent is entitled to a credit for $67,767.11 for temporary total disability benefits paid and $8,335.82 for temporary partial disability benefits paid.

[3] The Arbitrator calculates Petitioner's benefits pursuant to Section 8(d)1 of the Act as follows: $1,661.53 - $720.00 = $941.53 x 2 ÷ 3 = $627.69.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Causal connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Clifford Ekkert,
Petitioner,

vs.

NO: 13 WC 29508

16IWCC0773

Village of Oak Brook,
Respondent.

DECISION AND OPINION ON REVIEW

Respondent appeals the decision of Arbitrator Flores finding that Respondent has not rebutted the rebuttable presumption set forth in Section 1(d) of the Illinois Occupational Diseases Act and Petitioner has established that he was exposed to an occupational hazard resulting in a compensable injury that arose out of his employment and resulted in a disease manifested on September 23, 2011. As a result Petitioner was temporarily totally disabled from January 24, 2012 through March 12, 2012 for 7 weeks under Section 8(b) of the Act and is permanently partially disabled to the extent of 10% man as a whole under Section 8(d)2 of the Act. The primary issue on Review is whether Petitioner's claim is compensable. The Commission, after reviewing the entire record, reverses the Arbitrator's decision and finds that Petitioner failed to meet his burden of proof.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a 56 year old firefighter, testified he has worked for Respondent for 20 years. For the first seven years of his employment, he worked as a firefighter/paramedic with the majority of his time being dedicated to paramedic duties. Followed this, he spent the next 11 years as a lieutenant and the last five years as a battalion chief. He was also on

the technical rescue team, which involved confined spaces and structural collapses. He would estimate that as a firefighter/paramedic he was exposed to fire and smoke on the front line 10-12 times a year. Petitioner agreed that weeks or a month could go by without him being called to a fire. As a battalion chief since 2008, his first responder role decreased and most of his job was more administrative and supervisory in nature. Never the less when he worked as battalion chief, he might have been exposed to fire and smoke more often than on average because he was required to be a safety officer for another town as well.

2. Petitioner testified that he initially did not use his self-contained breathing apparatus (SCBA) that often. When he worked in a supervisory capacity, he would not require that the firefighters have their SCBA equipment on at all times. If he was working as a lieutenant and saw a firefighter/paramedic take off his gear during a post fire overhaul, he would not discipline the firefighter because removal of the SCBA had already been allowed by the chief. When he was a lieutenant there was very seldom any testing to see if the atmosphere was okay prior to performing an overhaul. It was common at that time to take your gear off during an overhaul. Over the last 6-8 years, they would use a monitor to check the levels prior to being advised that they could take their gear off. After checking for carbon monoxide as the safety officer, he would allow them to take their SCBA equipment off while they performed the overhaul. Even after the okay was given they were still subjected to ash upon overturning something that had been burnt. He agreed that the fire district protocol was to use his SCBA equipment. Over the years, policies changed. The department became more protective and he used the SCBA equipment more on all fires. Over the last 12-15 years, they pretty much had yearly fit testing for the SCBA equipment. Even then he still did not use the SCBA equipment during the post fire overhaul phase of his job which entailed pulling apart car, furniture or taking down walls to look for hot spots. The general rule of thumb is that if one exhausted one's oxygen while the fire was not contained one could go for a second bottle of oxygen. Otherwise, one pretty much dumped one's equipment, went without the SCBA equipment and then continued to work the overhaul. He would estimate that from 30-50 times he performed these job duties without utilizing his SCBA equipment. These overhaul phases could take hours to complete and during this time he was still exposed to smoke. After a structural fire or overhaul phase, if he blew his noise black ash would come out onto the Kleenex. He would also have soot around his face and eyes. Often times, he would not be able to shower and get the soot out until the next day when he was going home.

3. Petitioner testified that new equipment/clothing used by a fireman was issued every 7-10 years. If one's gear was still in usable condition one would keep it for training and so forth. During a fire, the gear would get contaminated with smoke, ash, carbon. Early on in his career they did not have a heavy duty washing machine known as an extractor that was built to wash the gear. They did not get such a machine until after he was working there for 10 years. So the gear would smell for days and weeks. Sometimes they would

use another department's extractor. Most of the time the gear did not get cleaned or it was just cleaned using a general washing machine. Before the extractor was purchased, he would estimate that he washed his gear a few times a year. They would handle the gear daily and their skin would come in contact with the dirt/grime from the gear. Later in his career they were told to wash their gear after every fire.

4. In the first 10-11 years of his job, he was exposed to diesel fumes through the ventilation system of the firehouse whenever an engine was started or backed into the station. With the exception of the command vehicles, all the vehicles were diesel powered. He worked 24 hour shifts as a firefighter and lieutenant where he slept in a bunk room next to the apparatus floor. There was no partitioning between the apparatus room and the workout room. They were all out in the open. This cause the gear to occasionally smell like diesel fuel and it was almost like one had followed a bus down the road. This changed in 2001-2002 when the old station was torn down, the new station was built and new ventilation was built into the station.

5. Petitioner testified that even if he was not in a structure he was close enough to a structure that he could be exposed to particulate matter, smoke and fumes. This would happen 5-6 times a year. He would estimate that he participated in live burn training the first 5-6 years of his career without using any equipment. At the scene, the engines of the response vehicles were never shut off. They were always running and if you were around them you breathed in the exhaust. He was intermittently an engineer during his career and would have to stand near the engine during the whole fire.

6. During his career, he was also a fire inspector for two towns. In this role, he would conduct pre-construction and general inspections to check for safety or fire violations. In performing this position, he was not exposed to smoke. He also worked as a pediatric allergist, but he was not exposed to smoke in this job either. He would consider himself to be a casual smoker, which means he smokes less than a pack of cigarettes a month. There were two periods. One period was 7 years in duration and the other period was 2 years in duration where he did not smoke at all. He denied drinking on a daily basis when he was not on shift.

7. As part of his job, he went through a yearly physical exam. In March of 2010, he was told he had an elevated PSA after his annual exam. He was asymptomatic when he was told his PSA was elevated. As a result of the elevated PSA, he saw Dr. Nguyen in September of 2010 and he ordered a biopsy of Petitioner's prostate. The biopsy was negative but in March of 2011 Petitioner's repeat PSA was again elevated. In May of 2011, Dr. Nguyen performed another biopsy. As a result of the biopsy and other PSA tests, in September of 2011, Dr. Nguyen diagnosed prostate cancer. On January 24, 2012, Petitioner underwent surgery to remove the prostate. He was taken off of work for surgery and was released to return to work on March 13, 2012.

8. His father, who was a machinist, was diagnosed with prostate cancer at the age of 77-78.

9. Petitioner testified he last saw Dr. Nguyen on March 20, 2013. Dr. Nguyen agreed that as long as Petitioner's PSA was okay he did not need to see the urologist. He has not seen Dr. Nguyen since that time. He continues to undergo periodic PSA testing with his general practitioner every six months. Since the surgery, he has experienced periods of incontinence when lifting and bending over. By November 16, 2012, he told Dr. Nguyen that his incontinence was essentially resolved. He has also experienced some sexual dysfunction. He went back to his regular job as a battalion chief and preformed his job without restrictions until he took a regular retirement in June of 2014. He is not currently working and no doctor has restricted his ability to work.

10. The medical records show that on August 12, 2010, Petitioner saw Dr. Nguyen who noted that Petitioner is 55 year old male with an elevated PSA and slight prostatic enlargement. Petitioner reported he has complete exam at work which included a PSA that was elevated to 3.9 ng.ml (3/2010 per patient) compared to prior level of 3.3. ng/ml the prior year (3/2009 per patient). Petitioner's father was diagnosed with prostate cancer approximately 10 years ago but he subsequently died of brain cancer rather than prostate cancer.

11. Petitioner claims that September 23, 2011 is the manifestation date for the alleged claim. On September 23, 2011, Petitioner followed up with Dr. Nguyen. The doctor noted that he spent nearly 30 minutes again discussing the clinical significance of the prostate biopsy results as well as the recent PSA results. The Petitioner's PSA continues to rise and his percent free PSA is low. In context of his biopsy results and family history, he felt that the Petitioner likely has early, small volume prostate cancer. The Petitioner was offered a repeat biopsy to confirm the diagnosis, an expert review of the pathology from Johns Hopkins or continued close surveillance. The Petitioner elected to undergo a repeat biopsy in 2-3 months. In the meantime, an expert review will be requested. If the expert review diagnoses prostate cancer, we will bring the patient in to discuss treatment options and we will cancel the biopsy.

12. On January 19, 2012, Petitioner followed up with Dr. Nguyen who noted Petitioner is presents for pre-operative visit. Petitioner is 56 year old male. He has a history of a mildly enlarged prostate without modules associated with a progressively increasing PSA of 5.18 ng/mL. percent free 9.16%, free PSA 0.57 ng/mL (AdvUro 3/24/11). These were increased from prior levels of 4.8 mg/mL (Quest 2/12/11), 3.9 mg/mL (2010) and 3.3 ng/mL (2009) which were drawn as part of an annual employee health screening. TRUS volume was 31.9 cc and pathologic examination revealed atypical small acinar proliferation in 1 of 12 cores with the pathologist commenting that "this focus shows features consistent with Gleason 3+3 adenocarcinoma, but is of insufficient size to fulfill the diagnostic criteria for adenocarcinoma. Patient was offered repeat TRUS biopsy versus an expert review of pathology at John Hopkins. Patient elected instead to repeat a

PSA which was stable at 6.23 ng/mL, percent free 10.07 free PSA 0.63 ng/mL(AdvUro 9/9/11). The patient was again counseled regarding options of repeat biopsy versus expert review at John Hopkins. The patient elected an expert review and was felt to have a "small focus of adenocarcinoma. Gleason score was 3+3=6 involving less than 5% of one core" when reviewed at John Hopkins. Today his IIEF-5 score is 4+4+5+5+5=23/25.

13. On November 18, 2012, Petitioner was seen by Dr. Co for pre-surgery clearance scheduled for January 24, 2012 at St. Joseph's Hospital with Dr. Ngyuen. It was noted that Petitioner is a current one pack a month smoker and he drinks 6-8 beers a week.

14. On January 24, 2012, Petitioner underwent surgery. The post-operative diagnosis was adenocarcinoma of the prostate. The procedure consisted of a robot assist laparoscopic radial prostatectomy with bilateral nerve sparing, robot assisted laparoscopic bilateral pelvic lymph node dissection.

15. During the July 26, 2012 and November 16, 2012 follow up visit with Dr. Nguyen, it was noted that there was no evidence of recurrence of malignant prostate cancer. Petitioner's incontinence was nearly resolved but he was experiencing problems with impotency.

16. On March 20, 2014, Dr. Nguyen noted that Petitioner's most recent PSA was .02 ng.mL (4/9/13 Adv Urol). Petitioner further reported that his PSA taken at the fire station and was reported as negative. The Petitioner reported he is doing well. He only has occasional episodes of incontinence when bending over to pick something up. He estimates that this occurs one to two times a month. He is occasionally is able to sexually be functional. Dr. Nguyen noted that Petitioner is transitioning his care to another doctor.

17. On May 9, 2014, Dr. Nguyen wrote a letter titled "To Whom It May Concern" in which he indicated that Petitioner has been under his care for prostate cancer. He was first diagnosed on September 30, 2011 at the age of 55. Dr. Nguyen opined that a review of the medical and scientific literature reveals that there are several studies that link Petitioner's occupation as a firefighter to an increased risk of developing cancer with some studies specifically correlating the increased risk in those younger than 65 years of age. He footnoted three of these studies in his letter.

18. Petitioner saw Dr. Chiodo in an office building. He told the Dr. Chiodo that he was a fire suppressor. Petitioner said he did not offer and he was not asked specific questions as to what that entailed.

19. On February 12, 2015 Dr. Chiodo was deposed. He testified that he is licensed to practice medicine in Illinois, Michigan, New York and Florida. He is both a doctor and an attorney. He has a masters of public health from Harvard, master of science in biomedical engineering from Wayne State, master of science in threat response management ie. biological, radiological and chemical defense from the University of Chicago, master of

science in occupational and environmental health science with specialization in industrial toxicology from Wayne State, master of business administration with a concentration in economics from the University of Chicago. He is board certified in internal medicine, occupational medicine, which is usually the specialty which determines whether or not someone has an occupational or environmental exposure that causes a disease such as cancer, and epidemiological, which relates to CDC hot zones or is for medical directors of majority city health departments, and he holds a bio-statistical specialty, which is in public health and general preventive medicine. About 20 years ago, he served as the medical director of the Detroit Health Department. He is additionally board certified in the engineering and public health discipline of industrial hygiene, which is an exposure expert that sorts out whether or not an injury is due to occupational and environmental circumstances. He has also served as a medical director of a number of municipal police and fire pension boards. He has held a faculty position in the department of medicine and department of family practice in the division of occupational medicine at Wayne State University. He has also served as an adjunct assistant professor of industrial hygiene and industrial toxicology at Wayne State. He was on the faculty for approximately 20 years. Currently, he teaches toxic tort law at John Marshall and Loyola Law School in Chicago.

Dr. Chiodo noted that the doctor that determines the likelihood of something being cancerous or not would be a nephrologist. He is not board certified in nephrology but he has had training, has expertise and has passed his boards in internal medicine in nephrology. On cross-examination, Dr. Chiodo acknowledged he is also not board certified in oncology or urology.

Dr. Chiodo testified that he has three offices. His main office is in the suburban Detroit. The others are in Chicago and West Palm Beach. While he is licensed in the state of Illinois, he does not have an active medical practice in the state. He performed the exam in a Chicago office where he has an exam table in the closet. He agreed that it would be fair to say that the only medical work that he does in the State of Illinois is medical/legal work. He only practices medicine in the State of Michigan. He would estimate that he has about 100 general internal medicine patients. He does not pretend to have a busy general internal medicine practice. He does not recall how many of the 100 or so patients he sees had prostate cancer. He had a patient in the past with that but he does not currently have any patients with that now. The other part of his practice is to act as a consultant and to see people and determine if they are ill due to some occupational and environmental exposure. He performs independent medical evaluations frequently. He also performs record reviews in medical/legal cases at the requests of attorneys. He probably does more record reviews than independent medical evaluations. Dr. Chiodo testified that he is very familiar with a firefighter's job duties and has had exposure to firefighters and paramedics. He testified that he has probably seen issues like this more than most doctors. He would estimate he had performed this service of determining if someone is disabled or if a matter is duty related more than ten times for the pension

boards in the Chicagoland area. In this case, he understood what the Petitioner's attorney would like as an opinion but he cannot "buy" his opinion.

Dr. Chiodo addressed an April 2010 article published by the Underwriters' Laboratory, Inc. entitled "Firefighter Exposure to Smoke Particulates." which states the smoke production is greater in fires that are in residence and autos and said he agreed with this statement. He also agreed that the article states that smoke particulates are produced when combustion occurs in various materials in residence, auto or dumpster fires. He testified that the particles can be inhaled into one's lungs or skin or be ingested. The particles can contain various chemicals such as benzene, phenols, arsenic, lead and other carcinogens that a person being exposed will absorb into his body. He testified that a respirator is a mechanism to attempt to decrease the exposure but not to eliminate it. The SCBA are helpful but they are by no means completely protective.

He is familiar with a document from World Health Organization (WHO), International Agency for Research on Cancer regarding Carcinogenic Risks to Humans and its list of category 1 causes of the high risk development of cancers. He agreed that there are a number of items in category 1 where carcinogenic chemicals are generated as a result of a fire.

He is familiar with articles from the American Journal of Industrial Medicine that dealt with the development of cancers in firefighters and the epidemiology of those cases. He has seen an article from that journal that is entitled "Cancer Incident Amongst Male Massachusetts Firefighters 1987 to 2003" that was published in 2008. The article addresses general causation and that such exposures can cause prostate cancer in firefighters.

He is familiar with the American Journal of Industrial Medicine entitled "Cohort Mortality Study of Philadelphia firefighters" and states that it supports his opinion that exposure to chemicals in fire suppression can cause prostate cancer in firefighters.

He is also familiar with a study entitled "Cancer Risk Among Firefighters: a review and meta-analysis of 32 studies". This is good research in that it is not just his opinion but it includes a hierarchy of studies, including the meta-analysis, which is at the highest hierarchy. It is more powerful in that there are a large number studies in which to obtain a result. The article says there is an increased risk of developing prostate cancer in firefighters. If you have a carcinogen, there is no safe level of exposure. The more often you are exposed the more likely you are going to have a problem.

He does not recall if he was given a document from Petitioner's attorney as to what Petitioner's fire response activities entailed. The only information he has about the number or type of fire responses is the statement that Petitioner worked as a firefighter for Respondent since 1991. He agreed that there was nothing beyond the above statement

as to the specific nature of Petitioner's job or the amount of exposure he had. He does not recall any specificity about what Petitioner said he did. He does not know if Petitioner was also a paramedic. It does not make a difference as to how much time he worked as a paramedic. The important point is that he worked as in fire suppression for about 20 years. Dr. Chiodo testified that he believes that information is sufficient to render his causation opinion. He does not believe the frequency of fire suppression factors into to how much fire fighters are exposed to toxic chemicals. The literature does not break it down in that manner. It just designates fire suppression. He is not aware of any epidemiologic studies that state that if a firefighter responds to 30 fires a month or does overhaul he have more cancer. It does not matter what type of SCBA equipment Petitioner wore. The literature just says fire suppression. It does not break it down as to whether or not one wore protective gear. On redirect examination, Dr. Chiodo testified that he did not need to know the number of times Petitioner was involved in fire suppression. It was sufficient to know that in general he was involved in fire suppression and the fact that if one is involved in fire suppression they have an increased risk of prostate cancer. In terms of the mortality study, there is something known as the healthy worker effect. A lot of the time hazardous exposures jobs have lower mortality rates associated with them because people who get sick or cannot handle the exposure drop out so you just have healthy people that continue on in the profession.

He would agree that prostate cancer is more likely to be diagnosed if there is more aggressive screening. He would not necessary agree that if firefighters are routinely screened for prostate cancer on an annual basis that there is a greater likelihood that they will receive an early diagnosis of prostate cancer than men in the general population. He does not know whether firefighters have greater screening for prostate cancer than the general public. He identified the meta-analysis study from the Journal of Occupational and Environmental Medicine as being a reliable paper from a reliable journal. With the exception of the Underwriters' study, he cannot say with certainty that the articles he was given by Petitioner's attorney were seen by him prior to the deposition date. He does not recall reading the article entitled Mortality of Municipal Worker Cohort. He answered general questions regarding the reliability of the Journal and he commented on some of the holdings of the article when he was asked about them but he did not read the article. The general takeaway from the article is that there is an increased risk of cancers in firefighters. He agreed that it does not specifically say prostate cancer. It says cancer of the bladder which in his opinion could extend to cancer of the prostate. The only mention of prostate cancer is in table 3 on page 677 and this study shows that the deaths among firefighters was actually lower than what they would have anticipated in the general public. At this moment, he does not recall whether the Underwriters' article dealt with prostate cancer. The only article that is needed is the meta-analysis from the American Journal of Occupational and Environmental Medicine. These other articles were articles that that Petitioner's attorney may think were good, important and necessary. However, his opinion stands that there is a strong epidemiological basis based on the meta-analysis from the Journal of Occupational and Environmental Medicine.

Dr. Chiodo was asked to evaluate Petitioner on November 6, 2014. He reviewed his records, examined Petitioner and abstracted some peer-review articles. He opined that in this particular case it was very important to get the exposure information and it is not something that is well reflected in the average medical records. There was no proper occupational and environmental medical history that was taken. The cancer was treated in a proper manner. They were treating the Petitioner and not trying to sort out causation. In order to sort out causation, you have to take a proper occupational and environmental medical history, which was not done until he saw the Petitioner in his office. Of particular note, is that the Petitioner has a long history of working in fire suppression. He was found to have an elevated PSA just under 20 years after he started as a firefighter. So, he had approximately 19 years of exposure to the types of materials that cause prostate cancer. Secondly, he was 55 year of age when he was diagnosed with prostate cancer, while the median age is 72. Seventy five percent of these diagnoses are with men who are older than 65. There is a history of prostate cancer in his father, who was a machinist by trade, but his father did not develop cancer until the typical age of 76-77. Being a machinist, also subjected his father to an increase risk of prostate cancer. He noted that Petitioner was a light smoker and he agreed that cigarette smoking can be a risk factor for developing prostate cancer. In his opinion, Petitioner's light smoking did not explain his development of prostate cancer. His history of fire suppression explains why he got prostate cancer at such a young age. He performed an examination to determine if there was an alternative cause for his prostate cancer, but he did not find any other explanation.

Dr. Chiodo testified that there are 3 components for the determination in this case. They are: 1. was there exposure 2. what is the epidemiological causation, 3. Is there meta-analytical support in the literature to support an increased risk of prostate cancer in firefighters. Dr. Chiodo opined that most doctors are not trained to sort out specific causation but doctors who are board certified in occupational medicine and public health and general preventative medicine are able to rule in/out other causes of Petitioner's prostate cancer other than his work in fire suppression.

Dr. Chiodo opined that Petitioner's physical examination did not point out an alternative explanation other than fire suppression. He cited to various articles in his report that corroborate his knowledge, training and experience that firefighters have an increased risk of prostate cancer. Dr. Chiodo opined based on a reasonable degree of medical and scientific certainty that there is a direct causal connection between Petitioner's work as a firefighter and his development of prostate cancer. His testified that his opinion is based on his knowledge, training and experience in being able to do such evaluations in addition to his long history of working in fire suppression and the support from the literature.

20. Dr. Elterman was deposed on April 21, 2015. He is board certified in urology and has an active practice in the discipline. He sees 3-4 patients a day with prostate cancer. The risk factors for developing prostate cancer are heredity, ethnic origin, age and diet. If someone had a father with prostate cancer, the risk associated with developing the same would be twofold compared to the average population. For high risk patient, we start the screening at age 40.

There are no known risk factors for firefighters with respect to the risk of prostate cancer. While there is a large body of literature looking at this, to his knowledge, there is no clear evidence that a firefighter's exposure would lead to increased risk of prostate cancer formation.

He performed a record review of Petitioner's case. He assumed that Petitioner had come into contact with products of combustion. As a urologist, he feels qualified to provide a causation opinion as to whether the prostate cancer is related to Petitioner's firefighting. He reviewed the literature on causation in order express his opinion. He issued a report dated February 20, 2014 in Petitioner's case. He noted that Petitioner's father had prostate cancer and further noted that the genetic predisposition may become evident at different ages. Petitioner was diagnosed at age 56 and this is an age in which one would have an increased risk for the development of prostate cancer. Several articles were provided to him specifically addressing risk of prostate cancer occurrence in firefighters.

The article titled "Cancer Incidence Among Males Massachusetts Firefighter" on page 333, Table 3 starting with the word prostate states it has the confidence level of 1, which means the actual number would be generated by chance. With an interval encompassing 1 it means that we cannot be certain whether there is increased or decreased risk of cancer formation compared to the controlled population.

The study from the Occupational Environmental Medicine journal titled "Mortality and Cancer Incidence in a Polled Cohort of US Firefighters from San Francisco, Chicago and Philadelphia" reviewed mortality and cancer incidence in firefighters. It said on page 5 of the article that the incidence of prostate cancer in firefighters was within the expected range. There is a table on page 4 that talks about the incidences for certain types of cancer. With a confidence interval encompassing 1, it means that we cannot be certain whether it increases or decreases the exposure. This study was published on October 14, 2013. The metaphysical study was published in 2006. On page 8, there is a relationship between diligent screening and an increased incident of prostate cancer. He agreed that if firefighters are screened on an annual basis and their annual exam included screening for prostate cancer that individual would be more likely to be diagnosed earlier than the general population. This is supported by page 8 of the study. Bladder and ureteral cancers are generally known to be affected by environmental factor to a much greater extent than prostate cancer. If there is a

suggestion that the causation of bladder cancer and prostate cancer are similar that would be inaccurate.

On cross examination, Dr. Elterman testified that for the last 15 years his practice had focused on urology and urological surgeries. He has not taken any courses in nor is he board certified in toxicology, occupational or environmental science, epidemiology or industrial hygiene. Nor has he been involved in any research studies involving cancers in firefighters. He would estimate that 70-80% of his medical-legal work is performed on behalf of the defense. He performs 3-4 independent medical evaluation for workers' compensation claims a year. He has had training all the way along in causation in the field of urology.

The article on "Mortality and Cancer Incidence in a Polled Cohort of US Firefighters from San Francisco, Chicago and Philadelphia" examined environmental exposures of firefighters and concluded that the incidence of prostate cancer was similar to the expected incidence, which means that it is more likely than not a causative factor. He agreed that page 5 of the report states that there was a significant age-at-risk difference in the standardized incidence ratios for prostate cancer and bladder cancers in firefighters. Furthermore on page 8 it states that excess bladder and prostate cancer incidence are found among firefighters less than 65 years old. He agreed that further down it states that "the early onset of these cancers suggests an association with firefighters". Dr. Elterman opined that this article represents the lack of definitive knowledge of the association between exposure and firefighting. He agreed that most cancers are multifactorial and no one can say with absolute certainty that there is one factor that causes prostate cancer. The greatest factor of the likelihood of Petitioner having cancer would be heredity. He is not familiar with the World Health Organization's categorization of certain elements that cause or may lead to the development of cancers. He agreed that it is plausible that the one hit theory/onetime exposure to carcinogen could conceivably lead to the development of cancer. In terms of the Underwriters Laboratories study of "Firefighter Exposure to Smoke Particulates", he does not have an opinion because he does not professionally look into the fire, smoke and carcinogen composition themselves. He does not have an opinion of whether or not if a firefighter is exposed to certain types of carcinogens during the suppression of fires and the overhaul stages where they are covered in chemicals, whether or not these chemical can be absorbed through the skin. He is familiar with the "Cohort Mortality Study of Philadelphia Firefighters". He agreed that page 474 states that there is an elevated SMR for prostate cancer among firefighters with less than 19 years of employment but then the authors further states that it goes down to normal when one looks at long term employees. While there are theories on carcinogenesis and single hit, there are other theories on how toxins and carcinogens act. What is important is that you see a change in the result as you change the dose of certain medication or a chemical and oftentimes it is treated as a causation. He does not have an opinion on whether the more one is exposed to carcinogens the more likely one is to getting cancer. He does not recall if he received information on the number of times

Petitioner was exposed to fires or the aftermath of the same. There is a limit to meta-analysis in that researchers rely on published data and base their conclusions on review of reports that have already have been generated by other researches. So they do not deal with the primary data and do not go through the charts. They only go through available information. Based on that there are limitations to that type of research but there are advantages in the fact that the numbers are greater. He did cite to this study in his report and he thought it provided the basis for his opinion. While he read ten reports in preparation for his opinion, he decided not to lists them all. There were some pieces of literature that provided opinions about increased risk, others that provided opinions of no risk and because of this disparity in opinions he formed his own opinion that there was no causation in this case. He agreed that what he cited to is not related to the incidence of prostate cancer but is the standardized mortality ratio. The table that was cited dealt with mortality as it often is an indicator or severity of diseases. He agreed that the study also contains Table 2 beginning on page 1196 that shows the incidence rate for prostate cancer and it is found to be 1.29 which is higher than the 1.14 listed in his report. He testified that the confidence is between 1.09 to 1.51 and that it shows a probable risk that developing prostate cancer for firefighters is greater than the general public. What he put in his report is that to a reasonable degree of medical certainty he opined that Petitioner's prostate cancer was not causally related to his work environment as a firefighter.

On redirect, Dr. Elterman testified that Table 2 shows a total of four incident studies. The studies do not show the size of the studies. The studies were performed between 1980 and 2001. Between the four studies, there were 147 observed prostate cancers. This is contrasted with the mortality study which was conducted in 2013 and showed that there were 1,261 observed prostate cancers. What page 8 of the Cohort study shows is that they have screened the general population as well as the firefighters and found that the firefighters have a greater incident in that age group of prostate cancer. He agrees that while the cohort study showed that there was a prostate excess in ages between 45-59, he believes it could be explained by the fact that there was increased screening among the firefighters at that time. The studies also showed that although a compound may be carcinogenic it may not necessarily be carcinogenic when it comes to the prostate cancer.

Taking into consideration all of the above, Dr. Elterman opined that the occurrence of prostate cancer in Petitioner was not causally related to his profession as a firefighter. His opinion is based on a review of Petitioner's medical records, and particularly his family history of prostate cancer along with a review of the current literature. He believes Petitioner's genetics played the greatest role in his development of prostate cancer. He is not aware of any specific substantial environmental risk factors that may be pertinent to this case. The idea has been out there that there may be an increase in the development of prostate cancer due to various environmental exposures and while he took that idea into consideration, he is awaiting more definite outcomes in the medical articles.

The legislature has recently enacted a new provision of the Illinois Workers' Occupational Diseases Act. Section 1(d) of the Act (820 ILCS 310/1(d) (West 2014)) creates among other things a rebuttable presumption that, after five years of service, a firefighter's cancer arises out of and in the course of his employment and that the same is causally related to his employment. Additionally, it specifically states that the rebuttable presumption "shall narrowly be construed". Id, The Commission finds that the application of this new provision of the Act presents a case of first impression. In applying the provision to the case at bar, the Commission turns to the Illinois Supreme Court and Appellate Court for guidance.

It has been recognized by the Courts that "[t]here is a good deal of confusion on [the] general proposition of what evidence, if any, overcomes a presumption, particularly a legislative one." *In re Marriage of Landfield,* 209 Ill. App. 3d 678, 691 (1991). The Illinois Supreme Court has explained:

> "The prevailing theory regarding presumptions that Illinois follows *** is Thayer's bursting-bubble hypothesis: once evidence is introduced contrary to the presumption, the bubble bursts and the presumption vanishes. (McCormick, Evidence sec. 345, at 821 (2d ed. 1972); see *Coal Creek Drainage & Levee District v. Sanitary District* (1929), 336 Ill. 11.) It is consistent with the Thayer approach that the party producing evidence to rebut the presumption must come forward with evidence that is 'sufficient to support a finding of the nonexistence of the presumed fact.' (Graham, Presumptions in Civil Cases in Illinois: Do They Exist? 1977 S. Ill. U. L.J. 1, 24.) ." *Franciscan Sisters Health Care Corp. v. Dean,* 95 Ill.2d 452, 462-63 (1983).

The Court continued:

> " '[O]nce evidence opposing the presumption comes into the case, the presumption ceases to operate, and the issue is determined on the basis of the evidence adduced at trial as if no presumption had ever existed. (See 1 Jones, Evidence sec. 3:8 (6th ed. 1972).) . The burden of proof thus does not shift but remains with the party who initially had the benefit of the presumption.' " *Franciscan Sisters,* 95 Ill.2d at 460-61, quoting *Diederich v. Walters*, 65 Ill. 2d 95, 100-03 (1976) .

Lastly,

> "The amount of evidence that is required from an adversary to meet the presumption is not determined by any fixed rule. A party may simply have

to respond with some evidence or may have to respond with substantial evidence. If a strong presumption arises, the weight of the evidence brought in to rebut it must be great. 5 A.L.R.3d 19, 39 n.14 (1966)." *Franciscan Sisters*, 95 Ill.2d at 463; see also *In re Marriage of Landfield*, 209 Ill. App. 3d at 691-92.

With this framework in mind, the Commission now turns to the rebuttable presumption set forth in Section 1(d) of the Act. It bears emphasizing that this presumption is a legislative one. As such, it requires stronger evidence to overcome. Having reviewed all the evidence in the case at bar, the Commission finds that Respondent has successfully rebutted the presumption by providing strong evidence through its board certified urologist expert's opinions along with Petitioner's own health history, work history and Petitioner's own testimony to show there were other causes of Petitioner's prostate cancer and his condition is not related to his employment as a firefighter.

The presumption having successfully been rebutted, the Commission now weighs the evidence to determine whether Petitioner has met his burden of proving by a preponderance of the evidence that his prostate cancer arises out of a risk peculiar to or increased by his employment with Respondent so that it is compensable under the Occupational Diseases Act. It further examines whether the disease appear to have it origin or that there is an aggravation in a risk connected with Petitioner's employment. The evidence in the case at bar shows as follows: Petitioner has a family history of prostate cancer. More specifically, Petitioner's father was diagnosed with prostate cancer at the age of 77 or 78. Dr. Elterman opined that if a man has a father with prostate cancer the risk associated with developing the same would be twofold compared the average population. Furthermore, while Petitioner's diagnosis occurred at an earlier age of 56 this maybe attributable to his annual screening for the disease which statically takes place more often than a member of the general public. Petitioner has been working as a battalion chief since 2008. Petitioner testified that as a battalion chief his first responder role decreased and most of his job was more administrative and supervisory in nature. However at times and in that capacity, he might have been exposed to fire and smoke more often than on average because he was required to be a safety officer for another town as well. Petitioner agreed that weeks or a month could go by without him being called to a fire. Some responses were related to false alarms while other were related to an actual fire. Furthermore, the fires themselves varied in intensity and at times some of them would be relative minor in nature. For the first seven years of his employment, Petitioner worked as a firefighter/paramedic with the majority of his time being dedicated to paramedic duties. This was followed by spending the next 11 years as a lieutenant and the last five years as a battalion chief. When he was on the front line as a firefighter/ paramedic, he would estimate that he was exposed to fire and smoke 10-12 times a year. While Respondent's facility lacked enforcement of fire district protocol at the outset of his career, in the last several years it have increased its awareness of and taken

preventative steps to alleviate and/or dissipate the employees' exposure to smoke, diesel fumes and other combustion products through purchasing and using specialized equipment to monitor overhaul sites, wash turnout gear, decrease exposure to diesel equipment with the installation of a new state-of-the-art ventilation systems built into the new station as well as providing annual physical examinations and fittings of SCBA equipment. Petitioner testified after his treatment for prostate cancer he was able to return to and perform his fully duty employment without any restrictions until he chose to exercise his right to retire on his own in June of 2014.

Petitioner was seen for a one time evaluation by Dr. Chiodo, a board certified internal and occupational medicine doctor and epidemiologist. While Dr. Chiodo provided an extensive and impressive list of various credentials he holds, he conceded that he is not board certified in nephrology, oncology or urology. He also testified that he had a small internal medicine practice out of state. He does not regularly treat patients with prostate conditions in general or specifically with prostate cancer. Rather, the vast majority of his time is spent on providing medical evaluations and record reviews in medical/legal cases at the requests of attorneys. After having opined that in this particular case it was very important to get the exposure information and this is not something that is well reflected in the average medical records, he was provided with and received at best a generic understanding of Petitioner's job duties. Dr. Chiodo then performed a one-time evaluation of Petitioner in an office building with a table stored in a closet. In addition, to reviewing Petitioner's records and examining Petitioner, he abstracted some peer-review articles which discussed a causative link between firefighting exposures in general and the development of various types of cancer, including but not limited to prostate cancer. Based on Petitioner's history, his examination and the peer review articles, Dr. Chiodo concluded that Petitioner's work place exposures were causally related to his development of prostate cancer.

On Respondent's behalf, Dr. Elterman, a board certified urologist with an active practice treating patients with prostate conditions and prostate cancer, was called to testify. As noted earlier, Dr. Elterman found that the highest risk factor for the development of prostate cancer is a family history of the same. He noted that there were some pieces of literature that provided opinions about an increased risk of cancer among firefighters while others provided no opinions regarding a risk and because of this disparity in opinions he opined that there was no causation in this case. Overall, Dr. Elterman found that the prevailing literature in the field of urology does not establish a link between firefighting activities and the development of prostate cancer.

Having weighed the credentials and foundational basis for the claimed expertise of Drs. Chiodo and Elterman, the Commission finds that Dr. Elterman is better credentialed and possesses a greater understanding of Petitioner's condition than Dr. Chiodo. As such, the Commission assigns greater weight to the causation opinions of Dr.

16IWCC0773

Elterman over those of Dr. Chiodo. The Commission, therefore, finds that this case is not compensable.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's claim for compensation is hereby denied.

The party commencing the proceedings for review in Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 2 8 2016

Mario Basurto

MB/jm

O: 9/29/16

Stephen Mathis

43

Dissent

I respectfully dissent from the majority decision and would affirm the Arbitrator's well reasoned decision in its entirety. Petitioner, a 56 year old firefighter, testified that he has worked for Respondent for 20 years. Petitioner testified that during his employment with Respondent he has been exposed to smoke, fumes combustible fuels and other particulate matter. Petitioner stated that he and other firefighters regularly performed duties without wearing SBCA equipment causing direct exposure to smoke, fumes, toxins and carcinogens. Petitioner also testified to being regularly exposed to diesel fumes within the firehouse living and sleeping quarters prior to its renovation in 2001. Petitioner also testified to the condition of his gear both before and after the fire house purchased equipment specifically designed to wash gear clean. Petitioner testified to consistently inhaling diesel fumes in the fire house for years and being exposed to smoke, soot and other particulate matter during live fires as well as fire suppression training activities during his entire employment with Respondent whether he was acting as a firefighter, Lieutenant or Battalion Chief. Petitioner's unrebutted testimony was he recalled inhaling smoke, fumes, and combustible materials as well as smelling the remnants of those on his gear and expelling soot from his nose.

Section 1(d) of the Act (820 ILCS 310/1(d) (West 2014)) creates a rebuttable presumption that after five years of service, a firefighter's cancer arises out of and in the course of his employment and that the same is casually related to his employment. Additionally, the Act specifically states that the rebuttable presumption "shall be narrowly construed", Id.

Respondent's independent medical expert, Dr. Elterman, board certified in urology, opined that Petitioners prostate cancer was not casually related to his employment as a firefighter. However, besides Petitioner's father being diagnosed with prostate cancer in his mid to late 70's, Dr. Elterman did not opine any potential causes for Petitioner's condition. Dr. Elterman conceded that the study he relied upon to deny a casual connection suggested an association between firefighting and the early onset of cancer, including prostate cancer. Dr. Elterman also acknowledged that he couldn't rule out environmental exposures as a possible cause of Petitioner's prostate cancer. Furthermore, Dr. Elterman acknowledged that based upon the literature there was a probable increased risk for firefighters to develop prostate cancer as compared to the general public.

Petitioner's independent medical expert, Dr. Chiodo, board certified in internal and occupational medicine, opined that there was a direct causal connection between Petitioner's work as a firefighter and his development of prostate cancer. Dr. Chiodo noted that petitioner was 55 years old when he was diagnosed with prostate cancer while the median age of diagnosis is 72. Dr. Chiodo further noted that 75 percent of prostate cancer diagnosis's are with men older than 65. Although Petitioner's father was diagnosed with prostate cancer, the cancer did not develop until he was approximately 76 years of age, the typical age of prostate cancer development. Additionally, Petitioner's father was a machinist which also subjected him to an increased risk of prostate cancer.

Dr. Chiodo cited to the same study as Dr. Elterman (which suggested an association between firefighting and the early onset of cancer) to support his contention of the causal connection between Petitioner's condition and his employment with Respondent.

Although there is disagreement within the medical community regarding whether firefighting activities and exposure to carcinogens, toxins and other particulate matters can increase the risk of developing prostate cancer and is a competent cause of the disease, the evidence submitted by respondent in this case is insufficient to successfully rebut the statutory presumption established by Section 1(d) of the Act. Dr. Elterman conceded that the literature that he based his opinion on suggests an association between firefighting and the early onset of cancer, including prostate cancer. Dr. Elterman further concedes that based upon the literature there was a probable increased risk for firefighters to develop prostate cancer as compared to the general public. Dr. Elterman's opinions are clearly insufficient to rebut the statutory presumption of Section 1(d).

However, assuming arguendo, that Respondent was successful in rebutting the presumption; given the causation opinions presented, the medical literature cited and relied upon by Drs. Elterman and Chiodo, the specialization and experience of both physicians, and the concessions made by Dr. Elterman, the opinions of Dr. Chiodo are more persuasive than those of Dr. Elterman. Accordingly, I would affirm the Arbitrator's well-reasoned decision in its entirety.

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

EKKERT, CLIFFORD A
Employee/Petitioner

Case# **13WC029508**

VILLAGE OF OAK BROOK-FIRE DEPARTMENT
Employer/Respondent

16IWCC0773

On 1/22/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.37% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1497 MORICI FIGLIOLI & ASSOC
DAVID FIGLIOLI
150 N MICHIGAN AVE SUITE 1100
CHICAGO, IL 60601

0075 POWER & CRONIN LTD
JOHN FASSOLA
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

16IWCC0773

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPAGE)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Clifford A. Ekkert
Employee/Petitioner

v.

Village of Oak Brook-Fire Department
Employer/Respondent

Case # **13** WC **29508**

Consolidated cases: **None**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Wheaton**, on **November 20, 2015**. After reviewing all of the evidence presented, the undersigned Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On September 23, 2011, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment as explained *infra*.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident as explained *infra*.

In the year preceding the injury, Petitioner earned $104,338.00; the average weekly wage was $2,006.50.

On the date of accident, Petitioner was 56 years of age, *married* with no dependent children.

Petitioner *has* received all reasonable and necessary medical services.

Respondent *has* paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $0 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $0.

Respondent is entitled to a credit for any bills paid through group insurance as agreed by the parties, under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner has established that he developed a compensable occupational disease while working as a firefighter for Respondent that manifested on September 23, 2011 pursuant to the Illinois Occupational Diseases Act ("Act"), and that he also established a causal connection between his occupational disease and employment with Respondent.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $1,261.41/week for 7 weeks, commencing January 24, 2012 through March 12, 2012, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from September 23, 2011 through November 18, 2015, and shall pay the remainder of the award, if any, in weekly payments.

Permanent Partial Disability: Person as a Whole

Respondent shall pay Petitioner permanent partial disability benefits of $695.78/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.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

January 19, 2016
Date

JAN 22 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Clifford A. Ekkert
Employee/Petitioner

v.

Village of Oak Brook-Fire Department
Employer/Respondent

Case # **13** WC **29508**

Consolidated cases: **None**

FINDINGS OF FACT

At this hearing the issues in dispute include accident, causal connection, Petitioner entitlement to temporary total disability benefits commencing on January 24, 2012 through March 12, 2012 and the nature and extent of Petitioner's injury. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

As of September 23, 2011, Clifford A. Ekkert (Petitioner) had been employed with the Village of Oak Brook Fire Department (Respondent) for approximately 20 years since 1991. Petitioner filed his Application for Adjustment of Claim with the Illinois Workers' Compensation Commission on September 9, 2013 alleging that his prostate cancer developed as a result of "exposure to carcinogens in [the] course of performing duty-related functions." PX5. He began as a firefighter and paramedic for approximately eight years. Petitioner then became a Lieutenant and remained in that position for approximately 10 years. Finally, Petitioner was promoted to Battalion Chief and held that position for approximately two years.

Petitioner passed his initial physical examination and his ongoing determinations of fitness for duty through the years. He also testified that he was a casual smoker and smoked maybe one pack per month, although there were periods of seven and two years when he did not smoke at all.

During his career, Petitioner would respond to and extinguish structure fires, dumpster fires, car and brush fires approximately 10 to 12 times per year. On cross examination, Petitioner testified that these fires varied in size and the response time necessary to suppress the fires. Petitioner acknowledged that there could be weeks or months without being called to respond to a fire.

As a Battalion Chief, he would respond to the scene of these types of fires more frequently because he would be in charge of the scene and, thus, required assign firefighters and give direction to as to how to extinguish the fire. While at these fire scenes, Petitioner testified that he would be exposed to and would inhale smoke, fumes and particulate matter that was generated by the burning of the materials at the fire scene. On cross examination, Petitioner acknowledged that it was less likely that he would go into an engaged building while employed as the Battalion Chief, unlike when he was a firefighter or Lieutenant. He conceded that his work as a Battalion Chief was more administrative in nature. However, he also testified that as a Battalion Chief, he would enter an overhaul site without wearing his Self Contained Breathing Apparatus (SCBA) equipment and he explained that, as the safety officer, he did not always ensure that the firefighters wore their SCBA

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. Exhibits attached to depositions will be further denominated with "(Dep. Exh. _)."

equipment. In his capacity as a safety officer, Petitioner testified that he would check for CO levels, and if he felt it was safe, he would allow the firefighters to take off their equipment.

To that end, Petitioner testified that early in his career, firefighters did not really use SCBA equipment during car or grass fires. He was not required to wear an SCBA during fires, which could last hours sometimes in a smoke-filled room. However, this changed later during his career and the department required all firefighters to utilize an SCBA when extinguishing a fire. Nonetheless, he explained that there were times when the oxygen in the SCBA would run out and he would still breathe in smoke and fumes after removing his mask. On cross examination, Petitioner testified that the protocol when responding to a fire required him to wear the SCBA equipment and that this was the procedure during the entire time that he worked for Respondent. However, he testified that he was not fitted for the gear until later in his career starting sometime around 10-15 years ago.

As a command officer on a fire scene, the petitioner testified that he would also be exposed to fire smoke, fumes and particulate matter approximately five to six times per year. Although he acknowledged that he might not go into the structure that was on fire or be one of the firefighters who actually extinguished the fire, the smoke and fumes were be present where he stood causing him to be exposed to them and causing him to inhale both.

Petitioner also testified that during the first five years or so of his career, the department would conduct safety exercises where they would have "live burns" before the EPA discontinued the practice. He explained that someone would act as the "stoker" and start the fire in the building. Petitioner performed this function on occasion and he did not wear the SCBA equipment at the time. Petitioner also cleared out materials by hand or with shovels. He testified that he was exposed to smoke and fumes during these live burn activities.

Another aspect of his job duties as a firefighter and also as a Lieutenant was what is called the "overhaul phase." This is the time after the fire is extinguished and the firefighters are in the structure determining if there are other "hot spots" or small fires that may be inside interior walls or in pieces of furniture that need to be extinguished so they do not flare up and cause a new fire. The firefighters can spend hours in the structure opening walls and ceilings with their equipment, throwing out smoldering furniture and making sure all of the fire is extinguished. During this phase, Petitioner testified that they are not wearing their SCBA and inhale fire smoke, fumes and particulate matter that remain in the structure. Petitioner testified that he was involved in overhaul phase work at fire scenes constantly throughout his career. He testified that he was similarly exposed while investigating the cause of the fire or when acting as the designated safety officer on the fire scene who was in charge of making sure the fire personnel were performing their duties safely and consistent with the department regulations.

On cross examination, Petitioner testified about his duties during overhaul activities while employed as a Lieutenant. Petitioner explained that there was very little, if any, testing to determine if the atmosphere was ok. During overhaul activities, he explained that it was common practice for him to remove his gear although he was supposed to wear his respirator while responding to an overhaul situation. Petitioner testified that there were also Standard Operating Guidelines ("SOG") with respect to overhaul situations. If the battalion chief tested the air and said it was ok, then firefighters could take off their gear when alerted through the proper chain of command. Petitioner testified that while he was a Battalion Chief, he did not discipline any firefighter if he observed the firefighter without his gear during an overhaul.

Petitioner also described the condition of the protective clothing used by firefighters called "turn out gear." Petitioner described this gear to include a jacket, pants, boots, gloves, helmet, etc. Each firefighter received one set and then new gear every 7-10 years. If the old gear was still in usable condition when he got new gear,

Petitioner testified that he would keep it. He also explained that, depending on the type of fire, his gear was dirty and became contaminated with smoke, ash and carbon or whatever other particulate matter with which he came into contact. For approximately 10 years during his early career, Petitioner further testified that there was no washing machine also known as an "extractor" so his gear smelled for days or weeks. If the gear was really bad, occasionally Petitioner would use the extractor from another department particularly if there was exposure to gasoline or a similar combustible. Petitioner testified that his gear came into contact with his skin and there were times when he had grime or black residue on his hands. Petitioner used his gear during any activated fire alarm.

In addition, Petitioner described the conditions within the fire house. He explained that he was exposed to diesel exhaust from several pieces of apparatus used by the department such as the engines and ambulances. The older engines would visible exhaust fumes that would fill the bay with smoke where they were parked in the fire station. Over time, the walls and ceilings would turn black with soot. Petitioner explained that firefighter gear was located in the apparatus bays and smelled of diesel exhaust. It was not until 2001 or 2002 when the new fire station was built that there was a venting system utilized to trap and eject the diesel exhaust out of the apparatus bay where the pieces of equipment were parked.

It was not until approximately 2001 or 2002 that a "plymovent" exhaust system was installed when the new fire house was built. The department also purchased an extractor for gear. After this extractor was purchased, Petitioner testified that Respondent instituted policies and directives about washing gear after every fire, but before that time there were no directives, and if there were, they were not followed by fire fighters. Petitioner testified that even after the extractor was purchased he only washed his gear a few times per year.

Regarding his respiratory system, Petitioner testified that, mostly after overhauls or structure fires, he would have to blow his nose and black ash would come out. He also had soot on his face and in his eyes. Depending on the time and number of calls, Petitioner testified that he would try to shower, but a lot of times he could do nothing to get the soot out of his hair because he did not have time due to his firefighter duties. In these circumstances, Petitioner testified that he would likely shower the next day before going home.

Finally, while Petitioner was a Battalion Chief, he testified that his exposure to fires declined as a first responder, but if he was on the scene he entered most or all of the fires during "rehab" to check on the building. He estimated that he may have also answered more calls as a Battalion Chief because he was also the safety officer during that period of time. There was an agreement with the town of Westmont, for example, and he was always there for all of their fires.

Petitioner was the Battalion Chief from 2008 until his retirement in 2014. He testified that while he was a Battalion Chief he was on the scene of fires more frequently because he was the highest command officer on that shift. He was diagnosed with prostate cancer while employed in this position.

Prostate Cancer Diagnosis & Medical Treatment

In March of 2010 Petitioner underwent his annual department examination with Dr. Michael Fragen. RX2. Although he passed this physical examination, he was advised by Dr. Fragen that his prostate specific antigen (PSA) levels were high. *Id.*

Petitioner then sought treatment from an urologist, Dr. Thai Nguyen. PX2. At the initial evaluation on August 12, 2010, Dr. Nguyen recommended a biopsy procedure of the prostate. *Id.* The results of the September 2010

biopsy were negative for prostate cancer, but Dr. Nguyen recommended continued monitoring. *Id.* Subsequent PSA test results at his annual examination in March of 2011 showed an increasing level of PSAs. RX2. A repeat biopsy was performed by Dr. Nguyen in May. PX2. These results showed the development of prostate cancer. *Id.* Dr. Nguyen confirmed the diagnosis of prostate cancer and informed Petitioner at an office visit on September 23, 2011. *Id.*

Petitioner then underwent a surgical procedure to remove his prostate with Dr. Nguyen on January 24, 2012. PX2. The surgery was a robot-assisted laparoscopic radical prostatectomy at Provena St. Joseph Hospital. *Id.* Petitioner followed up with Dr. Nguyen on a monthly basis thru July of 2012 and sporadically thereafter. *Id.* Petitioner last saw Dr. Nguyen was on March 20, 2014. *Id.*

Petitioner was placed off work from the date of surgery through March 13, 2012 when he was released to return to unrestricted work. Petitioner returned to work for Respondent as a Battalion Chief on March 13, 2012. During that seven week period, Petitioner used his accrued sick days and received his full pay. He then retired from the department in July of 2014. Petitioner has followed up with his primary care physician for PSA testing every six months. He testified that his cancer has not recurred.

Records Review – Dr. Elterman

At Respondent's request, Dr. Lev Elterman issued a report dated February 20, 2014 in which he rendered opinions regarding Petitioner's condition and its relatedness, if any, to his employment for Respondent. RX1 (Dep. Exh. 2). He reviewed Petitioner's treating medical records from Health Endeavors, Silver Cross Hospital, Advanced Urology Associates and Provena St. Joseph Medical Center. *Id.*

Dr. Elterman indicated that he made a comprehensive review of the literature and it revealed "at most probable association of being a firefighter with increased risk of prostate cancer as particularly evidences by an article titled Cancer Risk Among Firefighters: A Review and Method Analysis of 32 Studies published in November 2006 in the *Journal of Occupational and Environmental Medicine* … where meta-analysis showed that the relative risk of prostate cancer developing as a result of firefighting activities meta-relative risk being 1.14 with 95-percent confidence interval between 0.93 to 1.39. In other words, the possible association between higher rates of prostate cancers and occupational exposure as a firefighter could have been observed by chance alone and casual [sic] relationship has not been proven. Other studies support the same finding. This leads me to the conclusion that [Petitioner's] prostate cancer is not causally related to his work environment as a firefighter to a reasonable degree of medical certainty." *Id.*

Section 12 Examination – Dr. Chiodo

On November 6, 2014, Petitioner was evaluated at his attorney's request by Dr. Earnest Chiodo. PX4. Dr. Chiodo physically examined Petitioner, reviewed his treating medical records and took a history from Petitioner. *Id.* He authored a report dated November 6, 2014 in which he opined that Petitioner's prostate cancer was causally related to his work as a firefighter. *Id.* He specifically disagreed with the opinions of Respondent's examiner, Dr. Elterman, noting that the peer reviewed literature shows an increased risk of prostate cancer in firefighters. *Id.* In doing so, he noted that Dr. Elterman misquoted from the mortality table of a particular study[2] instead of the numbers for increased risk and further noted that the study findings were statistically significant given the 95% confidence interval. *Id.*

[2] "Cancer Risk Among Firefight[ers]: A Review and Meta-analysis of 32 Studies." *Id.*, at 5.

Dr. Chiodo also noted the young age at which Petitioner was diagnosed with prostate cancer, 55 years of age, compared to the median age of prostate cancer diagnosis of 72 years of age. *Id.* He also noted that Petitioner's father suffered from prostate cancer, but he was diagnosed at approximately 76 or 77 years of age, beyond the median age of prostate cancer diagnosis. *Id.*

Ultimately, Dr. Chiodo opined that given the known risk of prostate cancer in firefighters, combined with the long history of Petitioner's work and his young age at the time of diagnosis, the differential diagnosis of etiology "strongly supports the opinion that the prostate cancer in [Petitioner] was caused by his employment as a fire fighter [for Respondent]." *Id.*

Deposition Testimony[3] *– Dr. Chiodo*

On February 12, 2015, Dr. Chiodo gave testimony at an evidence deposition. PX3 (Vol. 1). He gave further testimony after the deposition was continued on April 16, 2015. PX3 (Vol. 2).

Dr. Chiodo is a board-certified physician specializing in internal medicine, occupational medicine and public health and general preventative medicine. PX3 (Vol. 1) at 5-7. He is also certified in industrial hygiene by the American Board of Industrial Hygiene and has a Master of Science degree in Occupational and Environmental Health Sciences with a specialization in Industrial Toxicology. *Id.*, at 7-11. In addition, Dr. Chiodo has worked as the medical director for municipal police and fire pension boards including the boards for the City of Lansing, Michigan and, for 20 years, he was the medical director of the City of Detroit Health Department. PX3 (Vol. 1) (Exh. 1); *Id.*, at 6-7. Dr. Chiodo referenced his education and experience in these capacities, and as reflected in his *curriculum vitae*, extensively throughout both depositions. See generally PX3 (Vols. 1 and 2). Notwithstanding, Dr. Chiodo highlighted his belief that he is very familiar with the job duties of firefighters as a result. PX3 (Vol. 1) at 16-18.

Dr. Chiodo noted various significant factors in ultimately developing his opinion in this case. PX3 (Vol. 1) at 24-29. First, he noted Petitioner's long history of working in fire suppression and exposure to materials that can cause prostate cancer that arise in fire suppression. *Id.*, at 24. Second, Dr. Chiodo noted that Petitioner developed prostate cancer at a young age, 55 years old, when initially diagnosed in comparison to the median age for the diagnosis of prostate cancer which is 72 years of age. *Id.*, at 24-25. Third, Dr. Chiodo noted that Petitioner's father was diagnosed with prostate cancer at age 76 or 77, which is the typical age for this diagnosis. *Id.*, at 25-26. Additionally, Dr. Chiodo testified that Petitioner's physical examination did not disclose any findings to lead to a conclusion that some other source, other than exposure to materials during fire suppression activity, could have lead to his development of prostate cancer. *Id.*, at 28-29. Dr. Chiodo also testified that he found no other alternative explanation for Petitioner's prostate cancer other than his fire suppression work. *Id.*, at 29.

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[3] Dr. Chiodo gave deposition testimony on two dates. PX3 Vols. 1 & 2. The parties' attorneys agreed to continue the deposition for Respondent's counsel to review literature that had not been referenced by Dr. Chiodo in his report or produced to Respondent's counsel 48 hours before the beginning of the first deposition. PX3 (Vol. 1) at 69-71. This circumstance caused a lengthy exchange between the parties' counsel as to the propriety of various questions on direct examination by Petitioner's counsel posed to Dr. Chiodo pursuant to the holding in *Ghere v. Industrial Comm'n*, 278 Ill. App. 3d 840 (4th Dist. 1996) from Respondent's counsel. Respondent's counsel later withdrew those objections at the outset of the continuation of Dr. Chiodo's deposition on April 16, 2015. PX3 (Vol. 2) at 77.

Ultimately, Dr. Chiodo testified that "...there is a direct causal connection between [Petitioner's] work as a firefighter and his development of prostate cancer." *Id.*, at 31. He based that opinion on his knowledge, training and experience as well as Petitioner's long history of fire suppression, the literature including meta-analysis of 32 studies regarding the cancer risk among firefighters which supports "general causation that fire suppression work can cause prostate cancer" and Petitioner's diagnosis at a young age. *Id.*, at 31-32.

While Dr. Chiodo testified—at length—about his understanding of the overall literature regarding the cause of cancer in firefighters generally, in his report he noted one article[4] reviewing 32 studies cited by Respondent's Section 12 examiner, Dr. Elterman, which he contends supports his opinion that Petitioner's prostate cancer is causally related to his work as a firefighter as reflected in the literature. PX4; PX3 (Vol. 1) at 60-69. Specifically, Dr. Chiodo disagreed with Dr. Elterman's interpretation of the article. *Id.* He maintained that Dr. Elterman incorrectly cited to a mortality statistic instead of the summary statistics which would identify how many individuals died from prostate cancer instead of how many developed it as a result of their firefighting activities. *Id.*

On cross-examination, Dr. Chiodo admitted that he was not provided with documentation regarding the extent or frequency of Petitioner's fire response activities, other than the medical records and other documents that he reviewed, however he obtained some history from Petitioner regarding his specific activities at work as noted in his report. PX3 (Vol. 2) at 102-111; see also PX4. Ultimately, Dr. Chiodo maintained that the amount of times that a firefighter performed fire suppression activities was irrelevant in determining whether cancer is developed in a firefighter because the literature does not focus on frequency although that could increase the firefighter's risk of cancer development. PX3 (Vol. 2) at 110-111, 113-114.

Deposition Testimony – Dr. Elterman

On April 21, 2015, Dr. Elterman gave testimony at an evidence deposition. RX1. He is a board-certified surgeon specializing in urology with an active practice treating approximately half of his patients for prostate conditions. RX1 at 5-7; RX1 (Dep. Exh. 1).

Dr. Elterman testified that, to his knowledge within the field of urology, there was no clear evidence in the literature establishing that firefighters were at an increased risk to develop prostate cancer. RX1 at 11. Dr. Elterman testified about increased risk factors, generally, for the development of prostate cancer including heredity, ethnic origin, age and diet. *Id.*, at 9-10. Ultimately, Dr. Elterman testified consistent with the opinion contained in his report that Petitioner's prostate cancer was not causally related to his employment as a firefighter. *Id.*, at 19.

Dr. Elterman also reviewed Dr. Chiodo's report, the literature cited in his report and the additional literature presented to Dr. Chiodo and discussed with him at the time of his deposition. RX1 at 19-20. Dr. Elterman maintained that those studies reinforced his own opinion looking at confidence intervals and statistics of each. *Id.*, at 20-27.

On cross examination, Dr. Elterman acknowledged that he does not specialize nor is he board-certified in toxicology, occupational or environmental medicine, epidemiology or industrial hygiene. RX1 at 28-29. He also testified about the articles he testified support his opinion that Petitioner's prostate cancer was not caused by his firefighting activities. *Id.*, at 41-76. He was presented with a study titled "Mortality and Cancer

[4] PX4; PX3 Vol. 1 at 60-69; RX1 (Dep. Exh. 5).

Incidence in a Pooled Cohort of US Firefighters from San Francisco, Chicago and Philadelphia (1950-2009)." RX1 (Dep. Exh. 6)[5].

Dr. Elterman admitted that in this study[6] the authors noted that "[t]he early onset of these cancers [including prostate cancer] suggests an association with firefighting[.]" *Id.*, at 49. Dr. Elterman agreed that, as with most cancers, prostate cancer was multifactorial. *Id.*, at 50-51. He also acknowledged that he could not rule out with absolute certainty that environmental exposures were a possible cause of Petitioner's prostate cancer. *Id.*, at 53. He explained that environmental exposures could potentially be a cause, but it was unknown and he could only look for known factors that would elevate Petitioner's risk. *Id.* Dr. Elterman also acknowledged that there are studies proposing that one-time exposure to carcinogens could conceivably lead to the development of cancer and indicated that was plausible. *Id.*, at 58-59.

Dr. Elterman also testified on cross examination that he reviewed more than ten articles before rendering his opinion on causation in Petitioner's case, but cited to one of those studies based on multiple criteria including how the studies were conducted, how many subjects were in the study, whether there were biases in the studies, etc. and determined to cite to only one study[7]. RX1 at 74-75. He could not recall the other studies he reviewed, but acknowledged that there is a difference of opinion in the literature regarding risk factors related to development of prostate cancer. *Id.* Dr. Elterman further admitted that given the reported incidence rate in firefighters for prostate cancer, the study concluded that there was a probable risk for them to develop prostate cancer when compared to the general public. RX1 at 76-82, 95-97.

Additional Information

Petitioner testified that he was also employed as a Fire Inspector by the Village of Oak Brook and Lockport Fire Protection District performing pre-construction inspections and yearly inspections from approximately 2005 through 2010 and with the Village of Oak Brook for approximately eight years. Petitioner testified that he was not exposed to fire, smoke or fumes while working in any job other than for Respondent.

Regarding his current condition, Petitioner testified that he has periods of incontinence with lifting and sometimes experiences incontinence with bending over. Petitioner testified that this occurs depending on the activity and that it increases with fluid intake. He also testified that he has been unable to engage in sexual activity despite medication to treat the condition although it was sometimes effective, but caused other side effects.

On cross examination, Petitioner acknowledged that a note in his medical records reflecting that his incontinence was essentially resolved as of November 16, 2012. He also testified that he has not seen a specialist or urologist for prostate cancer since March 20, 2014.

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[5] This study concluded that their results showed evidence of a relation between firefighting and cancer and that "[e]xcess bladder and prostate cancer incidence was found among firefighters less than 65 years of age. Interestingly, the prostate cancer excess was limited to ages between 45years [sic] and 59 years, which was consistent with recent observations in Nordic firefighters. … The early onset of these cancers suggests an association with firefighting." *Id.*; see also RX1 at 47-50.

[6] See RX1 (Dep. Exh. 6) (Mortality and cancer incidence in a pooled cohort of US firefighters from San Francisco, Chicago and Philadelphia).

[7] See RX1 (Dep. Exh. 5) (Cancer Risk Among Firefighters: A Review and Meta-analysis of 32 Studies).

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at hearing as follows:

In support of the Arbitrator's decision relating to Issue (C), whether Petitioner sustained an accident that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

After reviewing the particular evidence in this case in its entirety, the Arbitrator finds that Petitioner has established that he was exposed to an occupational hazard resulting in a compensable disease that arose out of his employment pursuant to the Illinois Workers' Occupational Diseases Act ("Act") on September 23, 2011.

Under the Act, an "occupational disease" is one "arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment." 820 ILCS 310/1(d) (LEXIS 2011). To establish that his injury arose out of his employment, a claimant must establish a causal connection between a work condition and his disease; that is, that his disease originated from or was aggravated by a risk connected to his employment and that his disease naturally resulted from that risk. 820 ILCS 310/1(d) (LEXIS 2011). The length of hazardous exposure is irrelevant if the employee is "employed in an occupation or process in which the hazard exists." *Id.* An aggravation of a disease must "arise out of a risk peculiar to or increased by the employment and not common to the general public." *Id.* In addition, Section 1(d) of the Act states the following in pertinent part:

> *Any condition or impairment of health of an employee employed as a firefighter*, emergency medical technician (EMT), emergency medical technician-intermediate (EMT-I), advanced emergency medical technician (A-EMT), or paramedic *which results directly or indirectly from* any bloodborne pathogen, lung or respiratory disease or condition, heart or vascular disease or condition, hypertension, tuberculosis, or *cancer resulting in any disability (temporary, permanent, total, or partial) to the employee shall be rebuttably presumed to arise out of and in the course of the employee's firefighting*, EMT, EMT-I, A-EMT, or paramedic *employment and, further, shall be rebuttably presumed to be causally connected to the hazards or exposures of the employment*. This presumption shall also apply to any hernia or hearing loss suffered by an employee employed as a firefighter, EMT, EMT-I, A-EMT, or paramedic. However, *this presumption shall not apply to any employee who has been employed as a firefighter*, EMT, EMT-I, A-EMT, or paramedic *for less than 5 years at the time he or she files an Application for Adjustment of Claim concerning this condition or impairment with the Illinois Workers' Compensation Commission. ....*

Id., (*emphasis* added).

Petitioner asserts that his prostate cancer arose out of and in the course of his employment as a firefighter, with no evidence offered by Respondent to rebut the statutory presumption under Section 1(d) of the Act. Respondent asserts that, although there is a rebuttable presumption delineated for firefighters in Section 1(d) of the Act, the provision should be narrowly construed and an analysis must still be performed to determine whether the exposures faced by the Petitioner as a firefighter were a cause of his prostate cancer.

Several facts are undisputed in this case. Petitioner was employed by Respondent for approximately 20 years beginning in 1991 through the date of his alleged accident on September 23, 2011. During his employment, he

held several positions after being promoted. Petitioner began as a firefighter/paramedic, then became a Lieutenant and was ultimately promoted to Battalion Chief through his regular retirement in 2014.

It is also undisputed that Petitioner had elevated PSA levels noted during a routine annual physical examination for the fire department in 2010. He remained working for Respondent and underwent regular follow up for his elevated PSA levels. However, Petitioner was eventually diagnosed with prostate cancer by his urologist, Dr. Nguyen. He ultimately underwent a robot-assisted laparoscopic radical prostatectomy in January of 2012. Petitioner has not had any recurrence of the cancer and continues to follow up regularly with his primary care physician for testing.

Additionally, Petitioner gave testimony regarding his firefighting activities and exposure to smoke, fumes, combustible fuels and other particulate matter throughout his employment with Respondent. He testified about the frequency and extent to which he was exposed to the foregoing in each of his positions while working for Respondent throughout his years of employment. He explained that he and other firefighters regularly performed duties without wearing his SBCA equipment causing direct exposure to smoke, fumes, toxins or carcinogens.

Petitioner also described the conditions within the fire house before it was renovated in approximately 2001 such that diesel fumes were present throughout the living and sleeping quarters. He also described the condition of his gear both before and after the fire house purchased an extractor designed specifically to wash his gear clean. In sum, Petitioner was consistently, although not constantly, inhaling diesel fumes in the fire house for years and exposed to smoke, soot and other particulate matter at different fire suppression activities during training exercises and at live fires whether he was acting as a firefighter, Lieutenant or Battalion Chief. He recalled inhaling smoke, fumes or combustible materials as well as smelling the remnants of these on his gear and expelling soot or other matter from his nose after having done so. No contrary evidence was submitted.

However, the question remains whether Petitioner's fire suppression activities, resulting in exposure to carcinogens as he claims, were sufficient to have been a cause of his prostate cancer. It is not intuitive that prostate cancer would result from exposures described by Petitioner. However, Section 1(d) of the Act does exclude any particular type of cancer and the parties provided reports and explanatory testimony from two independent medical experts—Dr. Chiodo for Petitioner and Dr. Elterman for Respondent—to support or refute the contention that Petitioner's prostate cancer was in some way linked to his employment as a firefighter. While both physicians testified and addressed various studies, they both focused on one study entitled "Cancer Risk Among Firefighters: A Review and Meta-analysis of 32 Studies." RX1 (Dep. Exh. 5).

As delineated in detail in the Findings of Fact above, Dr. Elterman performed a records review and rendered opinions for Respondent. He did not examine Petitioner, and he acknowledged that he has no particular training in toxicology, occupational or environmental medicine, epidemiology or industrial hygiene other than that which is incidental to his work as a urologist. However, the reliability of Dr. Elterman's opinion that Petitioner's prostate cancer was not related to his work as a firefighter in any way was significantly eroded on cross examination.

Dr. Elterman initially maintained that there were four main risk factors for the development of prostate cancer including heredity, ethnic origin, age and diet and he ultimately concluded that Petitioner's prostate cancer was not causally related to his employment as a firefighter. However, during his deposition Dr. Elterman conceded that the Cancer Risk Among Firefighters article noted that "[t]he early onset of these cancers [including prostate cancer] suggests an association with firefighting[.]" RX1 at 49. He also acknowledged that he could not

absolutely rule out that environmental exposures were a possible cause of Petitioner's prostate cancer and conceded that there was a difference of opinion within the medical community given the literature regarding risk the factors related to an increased development of prostate cancer. Dr. Elterman even admitted that based on the literature there was a probable risk for firefighters to develop prostate cancer as compared to the general public.

Based on the medical literature admitted into evidence it is clear that there is an ongoing effort to determine the risk factors associated with firefighting activities that increase the onset of various cancers, including prostate cancer. There is also an evident disagreement among the members of the medical community, particularly between Dr. Elterman and Dr. Chiodo in this case, regarding whether firefighting activities and exposure to various carcinogens, toxins and other particulate matter can increase the risk of developing prostate cancer such that it can be competently considered a cause of the disease. Given the causation opinions presented, the medical literature exhaustively reviewed and analyzed by both physicians, the specialization, experience and training of both physicians and the concessions made by Dr. Elterman on cross examination, the Arbitrator finds the opinions of Dr. Chiodo to be more persuasive than those of Dr. Elterman in this case.

Thus, the Arbitrator finds that the rebuttable presumption delineated in Section 1(d) of the Act has not be rebutted by Respondent and Petitioner has established that he was exposed to an occupational hazard resulting in a compensable injury that arose out of his employment and resulted in disease manifesting on September 23, 2011.

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:

As explained in the accident analysis above, Petitioner has established that his employment activities as a firefighter resulted in a compensable occupational disease manifesting on September 23, 2011. The Arbitrator also finds that Petitioner's current condition of ill-being is causally related to the occupational disease. In so finding, the Arbitrator notes the consistency of Petitioner's testimony with the medical records submitted into evidence and finds his testimony to be credible. The Arbitrator also relies on the opinions of Dr. Chiodo and the medical evidence contained in Dr. Nguyen's treating medical records describing Petitioner's prostate cancer condition and ensuing medical treatment. Based on the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to occupational disease manifesting on September 23, 2011.

In support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

In light of the accident and causal connection analyses explained above, the Arbitrator addresses Petitioner's claim that he is entitled to temporary total disability benefits for the disputed period beginning January 24, 2012 through March 12, 2012.

"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." *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 886 (2nd Dist. 1990). The dispositive test is whether the claimant's condition has stabilized, i.e., reached MMI. *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC at *28 (opinion filed June 26, 2014); *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003).

As explained above, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to his

occupational disease. Moreover, Petitioner was placed off work by Dr. Nguyen for treatment of his prostate cancer condition. No contrary medical evidence was submitted at trial to suggest that Petitioner could have worked during this period of time.

Based on all of the foregoing, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits as claimed from January 24, 2012 through March 12, 2012.

In support of the Arbitrator's decision relating to Issue (L), the nature and extent of Petitioner's injury, the Arbitrator finds the following:

Section 8.1b of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b (LEXIS 2011). Specifically, Section 8.1b states:

> For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:
>
> (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.
>
> (b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:
>
> (i) the reported level of impairment pursuant to subsection (a);
> (ii) the occupation of the injured employee;
> (iii) the age of the employee at the time of the injury;
> (iv) the employee's future earning capacity; and
> (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. *Id.*

Considering these factors in light of the evidence submitted at trial, the Arbitrator addresses the factors delineated in the Act for determining permanent partial disability.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report was offered into evidence. As a result, the Arbitrator assigns no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a Battalion Chief at the time of onset of his occupational disease. Previously, Petitioner had

been employed by Respondent as a firefighter/paramedic and Lieutenant during almost two decades. As a result, the Arbitrator gives significant weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 56 years old at the time of the accident. As a result, the Arbitrator gives significant weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner was released back to full duty work and continued to work as a Battalion Chief for Respondent earning the same pay until his regular retirement in 2014. As a result, the Arbitrator gives significant weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator finds that Petitioner's testimony was credible because it was corroborated by the medical records and consistent during both direct and cross examination. Petitioner credibly testified about his prostate cancer condition, the ensuing medical treatment including a laparoscopic radical prostatectomy surgery and limited ongoing symptoms including episodes of incontinence and limited sexual activity as a result of his condition or the associated medical treatment. As a result, the Arbitrator gives significant weight to this factor.

Based on all of the foregoing, and in consideration of the factors enumerated in Section 8.1b, which does not simply require a calculation, but rather a measured evaluation of all five factors of which no single factor is conclusive on the issue of permanency, the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 10% loss of use of the person as a whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KATHY JENKINS,

Petitioner,

vs.

NO: 05 WC 48729

16IWCC0774

JACKSON PARK HOSPITAL,

Respondent.

DECISION AND OPINION ON SECOND REMAND

This matter had previously been heard and the Decision of the Arbitrator had been filed on June 21, 2011. The Arbitrator awarded Petitioner a 40% loss of use of her person as a whole due to "loss of trade." Both parties filed a timely Petition for Review. The Commission affirmed the Arbitrator's ruling on November 5, 2012.

Petitioner subsequently sought review in the Cook County Circuit Court, which reversed the Commission's award, remanding it for a determination of an §8(d)(1) award rather than the §8(d)(2) award. In keeping with the Circuit Courts Order, the Commission awarded §8(d)(1) benefits as requested by Petitioner.

Respondent appealed to the Appellate Court, seeking a reinstatement of the Permanent Partial Disability (PPD) award. Conversely, Petitioner requested an affirmation of the wage differential award that was granted on remand. Alternatively, Petitioner requests that both the PPD and wage differential awards be vacated, and the case be remanded for an additional hearing purposed for determining Petitioner's true earning capacity.

FACTUAL BACKGROUND

Petitioner was employed as a Stationary Engineer by Respondent. She injured her back and knee in a work-related accident on October 25, 2005. She was diagnosed with cervical and

16IWCC0774

lumbar strains, as well as an unstable undersurface tear of the posterior horn of the medial meniscus, chondromalacia of the patella and medial femoral condyle, hypertrophic synovitis and a contusion to the anterior cruciate ligament. Following the accident, Petitioner worked for Respondent in the Finance Department and the Security Department. Her Security position is light duty, as she is not required to confront individuals. She sits in a tower above a parking lot. Due to her ongoing back and knee pain, Petitioner is unable to perform the duties of a Stationary Engineer.

Despite her physical limitations, Respondent continued to pay Petitioner her Stationary Engineer salary while she worked in Security.

ORDER ON REMAND

With there being insufficient evidence in the record to determine Petitioner's earning capacity, the Commission remands the case to the Arbitrator so that a hearing on the same be conducted, for the purpose of determining the proper wage differential award.

IT IS THEREFORE ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for a hearing on Petitioner's earning capacity.

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: NOV 3 0 2016
DLG/wde
O: 11/17/16 (Discussion Only)
45

David L. Gore

Mario Basurto

Stephen Mathis